STATE OF ARIZONA
FILED

MAR 22 2001

DEPT. OF INSURANCE
BY ____

STATE OF ARIZONA
DEPARTMENT OF INSURANCE

In the Matter of: **CENTRAL BENEFITS NATIONAL LIFE INSURANCE COMPANY (NAIC No. 63541)** Respondent.	Docket No. 01A-078-INS CONSENT ORDER

A health care appeals audit was made of Central Benefits National Life Insurance Company, hereinafter referred to as "Central Benefits," by the Health Care Appeals Examiner for the Arizona Department of Insurance (the "Department") and was completed on October 2, 2000. The audit covered informal reconsideration and formal appeals from July 1, 1998, through December 31, 1999, and external independent review appeals from July 1, 1998, through June 7, 2000. Based upon the audit results, it is alleged that Central Benefits has violated the provisions of A.R.S. §§20-461, 20-2533, 20-2535, 20-2536 and 20-2537.

The Examiner reviewed Central Benefits' health care appeals procedures, expedited, informal, formal, and external health care appeals files, and other materials sent to the Department in response to a May 1999 health care appeals survey and in response to the audit call letter.

Central Benefits wishes to resolve these matters without formal adjudicative proceedings, admits the following Findings of Fact are true and consents to entry of the following Conclusions of Law and Order.

FINDINGS OF FACT

1. Central Benefits is an Ohio domiciled life and disability insurer authorized to transact health insurance business pursuant to a certificate of authority issued by the Director.

2. The Examiner was authorized by the Director to conduct a heath care appeals audit of Central Benefits and has prepared a Report of Examination of the Health Care Appeals of Central Benefits ("the Report").

3. The Examiner reviewed Central Benefits' health care appeals information packet and found that the packet states that denied claims for services already provided may not be processed at the informal reconsideration level, but instead must begin the appeals process at the formal appeal level. Central Benefits' processing of such appeals, however, indicates that some cases involving denied claims may be treated as informal reconsiderations. Therefore, Central Benefits' appeals packet does not accurately reflect how Central Benefits, in fact, processes appeals involving denied claims.

4. The Examiner reviewed 26 informal reconsideration appeals, and found that all 26 files contained at least one deficiency. The deficiencies are as follows:

a. Central Benefits failed to send an acknowledgement letter to the member in 17 cases.

b. Central Benefits failed to distribute a health care appeals information packet to the member in 17 cases.

c. Central Benefits failed to send written acknowledgement of the request for appeal to the treating provider in 17 cases.

d. Central Benefits failed to send a health care appeals information packet to the treating provider in 17 cases.

e. Central Benefits failed to send the acknowledgment letter within five business days after receiving the original appeal request in two cases.

f. Central Benefits failed to include the clinical reasons and criteria used in the notification letter rendering the decision in nine cases.

g. Central Benefits failed to render four informal reconsideration decisions within 30 calendar days of receiving the appeal request.

h. Central Benefits informed members in three cases that the informal reconsideration appeal would be completed within 30 days of receipt of the necessary information to conduct the appeal.

i. Central Benefits failed to mail written notice of the appeal decision to the treating provider in ten cases.

j. Central Benefits failed to mail written notice of the appeal decision to the member in ten cases.

k. Central Benefits limited the timeframe allowed by law in which members may request an informal reconsideration following an original denial in three cases.

l. Central Benefits failed to inform members in four cases of the right to request a formal appeal following the informal reconsideration, and if the formal appeal is upheld, an external independent review.

m. Central Benefits informed members in three cases that the member may request an external review, which would require omitting the informal reconsideration and formal appeal stages.

n. Central Benefits noted in two files that informal reconsideration appeals were available only when requested by the member, not the provider.

5. The Examiner reviewed 21 formal appeals, and found that 18 files contained at least one deficiency. The deficiencies are as follows:

a. Central Benefits failed to include the criteria used and clinical reasons for the decision in six formal appeal decision letters.

b. Central Benefits failed to complete two formal appeals of denied claims within 60 days of receiving the appeal request.

c. Central Benefits failed to complete one formal appeal for denied services within 30 days of receiving the appeal request.

d. Central Benefits failed to send acknowledgement letters to 12 treating providers upon receiving the appeal request.

e. Central Benefits failed to send acknowledgment letters to five members upon receiving the appeal request.

f. Central Benefits failed to send health care appeals information packets to five members upon receiving the appeal request.

g. Central Benefits failed to send three formal appeal acknowledgment letters within five business days of receiving the appeal request.

h. Central Benefits limited the timeframe allowed by law in which a member may appeal a denied claim in one case.

i. Central Benefits rejected one appeal of a denied claim that was properly appealed within two years following the denial.

j. Central Benefits failed to notify two members of the right to request external independent review after the formal appeal was upheld.

k. Central Benefits failed to send notice of the decision to one member following the formal appeal.

l. Central Benefits notified two members of timeframes in which Central Benefits must complete formal appeals that were inconsistent with the timeframes provided by law.

m. Central Benefits failed to have one formal appeal decision rendered by a physician or other appropriate health care professional as defined by law.

6. The Examiner reviewed three external independent reviews and found that two files contained deficiencies. The deficiencies are as follows:

a. Central Benefits failed to forward an external independent review of a coverage issue to the Director within five business days of receiving the request.

b. Central Benefits failed to send to the Director a summary description of the applicable issues in one external independent review case involving an issue of coverage.

c. Central Benefits failed to send the Director's decision to one member and treating provider following the external review of a coverage issue within 30 days of receiving the external appeal request.

d. Central Benefits failed to send a decision letter to one treating provider following completion of the external independent review within three business days of receiving the external reviewer's notification.

e. Central Benefits disclosed to the external reviewer the names of the member and treating providers in one case.

7. Central Benefits' deficiencies outlined above indicate that its general business practices do not comply with the provisions of Arizona's health care appeal laws.

CONCLUSIONS OF LAW

1. Central Benefits violated A.R.S. §20-2533(C) by failing to reflect in its health care appeals information packet how it processes appeals involving denied claims.

2. Central Benefits violated A.R.S. §20-2535(B) by failing to send members and their treating providers acknowledgment letters of informal reconsideration appeals requests.

3. Central Benefits violated A.R.S. §20-2535(B) by failing to include health care appeals information packets to members and their treating providers with the acknowledgment letters of informal reconsideration appeal requests.

4. Central Benefits violated A.R.S. §20-2535(B) by failing to send written acknowledgement letters within five business days after receiving the original requests for informal reconsideration appeals.

5. Central Benefits violated A.R.S. §§20-2535(D) and (F) by failing to include the criteria and clinical reasons for its decisions in informal reconsideration decision letters.

6. Central Benefits violated A.R.S. §20-2535(D) by failing to render informal reconsideration decisions within 30 days of receiving the appeal requests.

7. Central Benefits violated A.R.S. §20-2535(D) by failing to send members and treating providers written notice of its decision following informal reconsideration appeals.

8. Central Benefits violated A.R.S. §20-2535(F) by failing to inform members of the right to request a formal appeal following an informal reconsideration, and if the informal appeal is upheld, an external independent review.

9. Central Benefits violated A.R.S. §20-2536(E) by failing to include the criteria and clinical reasons for its decisions in all formal appeal decision letters.

10. Central Benefits violated A.R.S. §20-2536(E)(2) by failing to complete formal appeals for denied claims within 60 days of receiving the appeal requests.

11. Central Benefits violated A.R.S. §20-2536(E)(1) by failing to complete formal appeals for denied services within 30 days of receiving the appeal requests.

12. Central Benefits violated A.R.S. §20-2536(B) by failing to send acknowledgment letters of formal appeal requests to members and their treating providers within five business days of receiving the appeal requests.

13. Central Benefits violated A.R.S. §20-2536(B) by failing to provide health care appeals information packets with the acknowledgment letters to members upon receiving the formal appeal requests.

14. Central Benefits violated A.R.S. §20-2536(A) by rejecting an appeal of a denied claim that was properly appealed within two years following the denial.

15. Central Benefits violated A.R.S. §20-2536(G) by failing to notify members of the right to request external independent review after the formal appeal was upheld.

16. Central Benefits violated A.R.S. §20-2536(E) by failing to send notice of the decision to a member following the formal appeal.

17. Central Benefits violated A.R.S. §20-2536(D) by failing to have a physician or other appropriate health care professional as defined by law render formal appeal decisions.

18. Central Benefits violated A.R.S. §20-2537(C)(2)(b) by failing to forward an external independent review of a coverage issue to the Director within five business days of receiving the request.

19. Central Benefits violated A.R.S. §20-2537(C)(2)(b) by failing to send the Director a summary description of the applicable issues in an external independent review case involving an issue of coverage.

20. Central Benefits violated A.R.S. §20-2537(D)(2) by failing to send decision letters to a member and treating provider following the external review of a coverage issue within 30 days of receiving the external appeal request.

21. Central Benefits violated A.R.S. §20-2537(E) by failing to send a decision letter to a treating provider within three business days of receiving the external reviewer's notification.

22. Central Benefits violated A.R.S. §20-2537(I)(3) by disclosing the names of the members and treating providers in appeals sent for external independent medial reviews.

23. Central Benefits violated A.R.S. §20-461(A)(17) by failing to comply with the health care appeal laws with such a frequency as to indicate a general business practice.

ORDER

IT IS HEREBY ORDERED THAT:

1. At such time that Respondent either reenters the fully insured health market or issues any policies or products that would be subject to the Arizona health care appeal laws, Respondent shall do the following:

a. develop and implement procedures that are consistent with Arizona law.

b. amend and re-file its appeals packet with the Department so that the information in the packet is consistent with the Company's internal procedures.

2. At such time that a health care appeal is filed based on a claim that was denied prior to Respondent withdrawing from the health market, Respondent shall cease and desist from the following acts, as required by the statutes shown:

a. failing to include health care appeals information packets to members and their treating providers with the acknowledgment letters of informal reconsideration and formal appeal requests (A.R.S. §§20-2535(B) and 20-2536(B)).

b. failing to send written acknowledgement letters within five business days after receiving the original requests for informal reconsideration and formal appeals (A.R.S. §§20-2535(B) and 20-2536(B)).

c. failing to include the criteria and clinical reasons for its decisions in informal reconsideration and formal appeal decision letters (A.R.S. §§20-2535(D), (F) and 20-2536(E)).

d. failing to render informal reconsideration decisions within 30 days of receiving the appeal requests (A.R.S. §20-2535(D)).

e. failing to send members and treating providers written notices of decisions following informal reconsideration appeals (A.R.S. §20-2535(D)).

f. failing to inform members of the right to request a formal appeal following an informal reconsideration, and if the informal appeal is upheld, an external independent review (A.R.S. §20-2535(F)).

g. failing to complete formal appeals for denied claims within 60 days of receiving the appeal requests (A.R.S. §20-2536(E)(2)).

h. failing to complete formal appeals for denied services within 30 days of receiving the appeal requests (A.R.S. §20-2536(E)(1)).

i. failing to process appeals that are properly filed within the statutory timeframe (A.R.S. §20-2536(A)).

j. failing to notify members of the right to request external independent review after a formal appeal is upheld (A.R.S. §20-2536(G)).

k. failing to send decision notices to members following formal appeals (A.R.S. §20-2536(E)).

l. failing to forward external independent review appeals involving issues of coverage to the Director within five business days of receiving the request (A.R.S. §20-2537(C)(2)(b)).

m. failing to send decision letters to members and treating providers following the external review of coverage issues within 30 days of receiving the external appeal requests (A.R.S. §20-2537(D)(2)).

3. Central Benefits shall pay a civil penalty of $10,000.00 to the Director for remission to the State Treasurer for deposit in the State General Fund in accordance with A.R.S. §20-220(B). Said amount shall be provided to the Health Care Appeals Section of the Department prior to the filing of this Order.

4. The Report of Examination dated October 2, 2000, and any objections to the Report submitted by Central Benefits, shall be filed with the Department upon the filing of this Order.

DATED this 21rst day of March, 2001.

Charles R. Cohen
Director of Insurance

CONSENT TO ORDER

1. Respondent, Central Benefits National Life Insurance Company, has reviewed the foregoing Order.

2. Respondent admits the jurisdiction of the Director of Insurance, State of Arizona, admits the foregoing Finding of Facts are true, and consents to the entry of the Conclusions of Law and Order.

3. Respondent is aware of the right to a hearing, at which it may be represented by counsel, present evidence and cross-examine witnesses. Respondent irrevocably waives the right to such notice and hearing and to any court appeals related to this Order.

4. Respondent states that no promise of any kind or nature whatsoever was made to it to induce it to enter into this Consent Order and that it has entered into this Consent Order voluntarily.

5. Respondent acknowledges that the acceptance of this Order by the Director of the Arizona Department of Insurance is solely for the purpose of settling this matter and does not preclude any other agency or officer of this state or its subdivisions or any other person from instituting proceedings, whether civil, criminal, or administrative, as may be appropriate now or in the future.

6. WILLIAM C. MECHLING, who holds the office of SR. VICE PRESIDENT AND SECRETARY of Respondent, is authorized to enter into this Order for it and on its behalf.

CENTRAL BENEFITS NATIONAL LIFE INSURANCE COMPANY

3/7/01 (date) By [signature]

COPY of the foregoing mailed/delivered this 22nd day of March, 2001 to:

Sara Begley
Deputy Director
Vista Brown
Executive Assistant
Gerrie Marks
Executive Assistant
Catherine O'Neil
Consumer Legal Affairs Officer/Custodian of Records
Mary Butterfield
Assistant Director
Consumer Affairs Division
Alexandra Shafer
Assistant Director
Life and Health Division
Deloris E. Williamson
Assistant Director
Rates & Regulations Division
Steve Ferguson
Assistant Director
Financial Affairs Division
Nancy Howse
Chief Financial Examiner
Financial Affairs Division

DEPARTMENT OF INSURANCE
2910 North 44th Street, Suite 210
Phoenix, AZ 85018

Reba Jones, MHP, HIA
Senior Compliance Analyst
CENTRAL BENEFITS NATIONAL LIFE INSURANCE CO.
255 East Main Street
Columbus, OH 43216