STATE OF ARIZONA
DEPARTMENT OF INSURANCE

In the Matter of: **AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY (NAIC No. 60305),** Respondent.	Docket No. 01A-104-INS CONSENT ORDER

A health care appeals audit was made of American Community Mutual Insurance Company, hereinafter referred to as "American Community", by the Health Care Appeals Supervisor and an Analyst ("Examiners") for the Arizona Department of Insurance (the "Department"), covering the time period from July 1, 1998 through October 8, 1999. The desk audit was completed on March 30, 2000. Based upon the audit results, it is alleged that American Community has violated the provisions of A.R.S. §§ 20-461, 20-2533, 20-2535, 20-2536 and 20-2537.

The Examiners reviewed American Community's health care appeals procedures, informal and formal appeals filed with American Community and external appeals filed with the Department.

American Community 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. American Community is Michigan-domiciled life and disability insurer authorized to transact health insurance pursuant to a Certificate of Authority issued by the Director.

2. The Examiners were authorized by the Director to conduct a health care appeals audit of American Community and have prepared a Report of Examination of the Health Care Appeals of American Community ("the Report").

3. The Examiners reviewed American Community's health care appeals information packet and found the following:

a. American Community, according to its survey response to the Department's appeals survey of May 1999, did not distribute appeals information packets to all new and in-force business until March 29, 1999.

b. American Community's information packet states that denied claims may not be processed at the informal reconsideration level, and instead must begin the appeals process at the formal appeal level. However, American Community's processing of such appeals indicates that some files were treated as informal reconsideration appeals. Thus, American Community's appeals packet does not accurately reflect how American Community, in fact, processes appeals involving denied claims.

4. The Examiners reviewed five informal reconsideration appeals, and found that all five files contained at least three deficiencies. The deficiencies are as follows:

a. American Community failed to send an acknowledgment letter to one member upon receiving the member's request for informal reconsideration.

b. American Community failed to send health care appeals information packets to three members.

c. American Community failed to send acknowledgment letters to treating providers in three informal reconsideration files.

d. American Community failed to send health care appeals information packets to three treating providers along with the informal reconsideration acknowledgment letters.

e. American Community failed to send two acknowledgment letters within five business days upon receiving the original appeal requests.

f. American Community failed to include the clinical reasons and criteria it used in rendering decisions in two informal reconsideration appeals.

g. American Community failed to render two informal reconsideration

decisions within 30 days.

h. American Community failed to send written notice of the informal reconsideration decision to the treating provider in two cases.

i. American Community failed to send a written notice of an informal reconsideration decision to one member.

5. The Examiners reviewed 70 formal appeals, and found that 59 files contained at least one deficiency. The deficiencies are as follows:

a. American Community failed to include the criteria used and the clinical reasons for its determinations in 18 formal appeals.

b. American Community failed to complete seven formal appeals for denied claims within 60 days of receiving the appeal requests.

c. American Community failed to complete one formal appeal for a denied service within 30 days of receiving the appeal request.

d. American Community failed to send acknowledgement letters to treating providers in 38 formal appeals.

e. American Community failed to send acknowledgment letters to 13 members upon receiving the requests for formal appeal.

f. American Community failed to send health care appeals information packets to 56 members along with formal appeal acknowledgment letters.

g. American Community failed to send health care appeal information packets to 58 treating providers along with the formal appeal acknowledgment letters.

h. American Community failed to send 15 formal appeal acknowledgment letters within five business days upon receiving the formal appeal requests.

i. American Community failed to inform eight members in original denial letters of the correct timeframes within which one may start the appeals process.

j. American Community failed to inform a member in the explanation of benefits form of the correct timeframe within which one may appeal a denied claim.

k. American Community failed to properly notify 31 members of the right to request external independent review in letters upholding American Community's earlier denials.

l. American Community failed to send eight members notice of its decision following the completion of the formal appeals.

m. American Community inaccurately described the next level of the appeals process in a formal appeal decision letter sent to one member.

n. American Community incorrectly informed two members in their decision letters that they could request another formal appeal following the completion of the formal appeal process.

o. American Community incorrectly forced seven members to go through the formal appeal level twice before the cases were sent to external independent review.

6. The Examiners reviewed 21 external independent reviews and found that 18 files contained deficiencies. The deficiencies are as follows:

a. American Community failed to send acknowledgment letters to three members' treating providers notifying them of the Department's request for external independent review.

b. American Community failed to send acknowledgment letters to four members' treating providers notifying them of the request for external independent medical review.

c. American Community failed to send acknowledgment letters to two members regarding requests for external independent review of coverage issues.

d. American Community failed to send an acknowledgment letter to a member regarding the request for external independent medical review.

e. American Community failed to forward to the Department one appeal file within five business days of receiving the request for external independent review.

f. American Community failed to notify the Department within five business

days of the external reviewer it selected in two cases.

g. American Community failed to send acknowledgment letters to five members and their treating providers within five business days of the request for an external independent medical review.

h. American Community failed to send a case summary and supporting documentation to the Department in three external independent reviews of coverage issues.

i. American Community failed to send decision letters to the treating providers following the completion of two external independent medical reviews.

j. American Community failed to send decision letters to two treating providers following the completion of external independent reviews of coverage issues.

k. American Community failed to complete seven external independent reviews within 30 days of receiving the requests.

l. American Community disclosed the names of the insureds and the treating providers in 12 appeals sent for external independent medical review.

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

CONCLUSIONS OF LAW

1. American Community violated A.R.S. §20-2533(C) by failing to distribute health care appeals information packets with newly issued policies.

2. American Community violated A.R.S. §20-2533(C) by failing to reflect in its health care appeals information packets the manner in which it processed appeals.

3. American Community violated A.R.S. §20-2535(B) by failing to send written acknowledgment letters to members and treating providers within 5 business days of receiving the original requests for informal reconsideration appeals.

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

letters.

5. American Community violated A.R.S. §20-2535(D) by failing to render all informal reconsideration decisions within 30 days of receiving the appeal requests.

6. American Community violated A.R.S. §20-2535(D) by failing to send members and treating providers written notices of its decisions following informal reconsideration appeals.

7. American Community 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.

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

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

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

11. American Community violated A.R.S. §20-2536(G) by failing to properly notify all members of upheld decisions of the option to proceed to an external independent review.

12. American Community violated A.R.S. §20-2536(E) by failing to provide written notices of its decisions following the completion of all formal appeals.

13. American Community violated A.R.S. §20-2536(G) by inaccurately describing the next step in the appeals process in its formal appeal decision letters.

14. American Community violated A.R.S. §20-2533(B) and A.R.S. §20-2536(G) by failing to send cases for external independent review following upheld formal appeals.

15. American Community violated A.R.S. §20-2537(C)(1)(a) by failing to send acknowledgment letters of external independent medical reviews to the members and treating providers.

16. American Community violated A.R.S. §20-2537(C)(2)(a) by failing to send

acknowledgment letters to the members and treating providers following requests by members or the Department for external independent reviews of coverage issues.

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

18. American Community violated A.R.S. §20-2537(C)(1)(c) by failing to notify the Department within five business days of receiving a request for external independent review of the external reviewer it selected.

19. American Community violated A.R.S. §20-2537(C)(1)(a) by failing to send acknowledgment letters to members and treating providers within five business days of receiving a request for external independent medical review.

20. American Community violated A.R.S. §20-2537(C)(2)(b) by failing to send case summaries and supporting documentation to the Department with external independent reviews of coverage issues.

21. American Community violated A.R.S. §20-2537(D)(1)(b) and, after August 6, 2000, A.R.S. §20-2537(E), by failing to send decision letters to all treating providers following external independent medical review.

22. American Community violated A.R.S. §20-2537(D)(2) by failing to send decision letters to all treating providers following the completion of the external independent reviews of coverage issues.

23. American Community violated A.R.S. §20-2537(D)(1)(b) in cases completed prior to August 6, 1999, by failing to complete all external independent medical reviews within 30 days of receiving the appeal requests

24. American Community violated A.R.S. §20-2537(H)(3) and, after August 6, 1999, A.R.S. §20-2537(I)(3), by disclosing the names of the insureds and the treating providers in appeals sent for external independent medical reviews.

25. American Community violated A.R.S. §20-461(A)(17) by failing to comply with

the health care appeals laws with such a frequency as to indicate a general business practice.

ORDER

IT IS HEREBY ORDERED THAT:

1. Within 90 days of the filed date of this Order, Respondent shall do the following:

a. amend and re-file its appeals information packet with the Department if the information provided in the packet remains inconsistent with the Respondent's internal procedures.

b. amend its written internal procedures to ensure compliance with A.R.S. §§20-2533 through 2538 and provide the Department with a copy of the revised procedures.

2. The Respondent shall cease and desist from the following acts, as required by the statutes shown:

a. processing informal reconsiderations and formal appeals of denied claims for services already provided in a way that is inconsistent with American Community's appeals packet (A.R.S. §§20-2533, 20-2535 and 20-2536).

b. failing to include a copy of the health care appeals information packet in newly-issued policies (A.R.S. §20-2533(C)).

c. failing to send written acknowledgment letters of requests for informal reconsideration to all members and treating providers (A.R.S. §20-2535(B)).

d. failing to include health care appeals information packets with acknowledgment letters of informal reconsideration and formal appeals (A.R.S. §§20-2535(B) and 20-2536(B)).

e. failing to send written acknowledgment letters in all informal reconsideration within five business days of receiving the requests for appeal (A.R.S. §20-2535(B)).

f. failing to include the criteria used and the clinical reasons for the decision in all decision letters of informal reconsideration appeals (A.R.S. §§20-2535(D) and 20-2535(F)).

g. failing to complete all informal reconsideration appeals within 30 days of receiving the appeal requests (A.R.S. §20-2535(D)).

h. failing to send written decision letters to members and treating providers in all informal reconsideration appeals (A.R.S. §20-2535(D)).

i. failing to include the criteria used and the clinical reasons for the decision in all decision letters of formal appeals (A.R.S. §20-2536(E)).

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

k. failing to complete all formal appeals for denied services not yet provided within 30 days of receiving the appeal requests (A.R.S. §20-2536(E)(1)).

l. failing to send written acknowledgment letters of formal appeal to members and their treating providers within five days of receiving the appeal requests (A.R.S. §20-2536(B)).

m. failing to reference the correct timeframes in which members may request appeals in all original denial letters and explanation of benefits forms (A.R.S. §§20-2535(A) and 20-2536(A)).

n. failing to inform members and treating providers of the option to proceed to an external independent review following an upheld formal appeal (A.R.S. §20- 2536(G)).

o. failing to send all members written decision letters following the completion of all formal appeals (A.R.S. §20-2536(E)).

p. informing members in decision letters upholding formal appeals that the member may file a complaint with the Department (A.R.S. §20-2536(G)).

q. informing members in decision letters upholding formal appeals that the members may request another formal appeal (A.R.S. §20-2536(G)).

r. forcing members to go through the formal appeals process twice before sending appeals for external independent review (A.R.S. §20-2533(B) and A.R.S. §20-2536(G)).

s. failing to send acknowledgment letters of requests for external independent review of coverage issues to members and treating providers (A.R.S. §20-2537(C)(2)(a)).

t. failing to send acknowledgment letters of requests for external independent medical reviews to members and treating providers (A.R.S. §20- 2537(C)(1)(a)).

u. failing to send all external independent reviews of coverage issues to the Department within five business days of receiving the requests (A.R.S. §20- 2537(C)(2)(b)).

v. failing to send members and treating providers acknowledgment letters within five business days of receiving the requests for external independent review (A.R.S. §20-2537(C)(1)(a)).

w. failing to send case summaries and supporting documentation to the Department in all external independent reviews of coverage issues (A.R.S. §20-2537(C)(2)(b)).

x. failing to send decision letters to all treating providers following external independent medical reviews (A.R.S. §20-2537(E)).

y. failing to send written decision letters to all treating providers following all external independent reviews of coverage issues (A.R.S. §20-2537(D)(2)).

z. failing to complete all external independent medical reviews within 30 days (Circular Letter 1999-3).

3. American Community shall pay a civil penalty of $15,000.00 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 March 30, 2000, and any objections to the Report submitted by American Community, shall be filed with the Department upon the filing of this Order.

DATED this 10th day of April, 2001.

Charles R. Cohen
Director of Insurance

CONSENT TO ORDER

1. Respondent, American Community Mutual Insurance Company, has reviewed the foregoing Order.

2. Respondent admits the jurisdiction of the Director of Insurance, State of Arizona, admits the foregoing Findings of Fact 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. Frances P. Dempsey, who holds the office of VP + General Counsel of Respondent, is authorized to enter into this Order for it and on its behalf.

AMERICAN COMMUNITY MUTUAL INSURANCE CO.

3/31/01
(date)

By _____

COPY of the foregoing mailed/delivered this 11th **day of** April**, 2001 to:**

Sara Begley
Deputy Director

Vista Brown
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