IN RE : CIGNA HEALTHCARE OF MAINE, INC., formerly HEALTHSOURCE MAINE, INC.	)))))	CONSENT AGREEMENT Docket No. 00-3002

This document is a Consent Agreement, authorized by 5 M.R.S.A. § 9053(2), entered into by CIGNA HealthCare of Maine, Inc. (hereafter also "*CIGNA*") and the Superintendent of the Maine Bureau of Insurance (hereafter also the "*Superintendent*"). Its purpose is to resolve, without resort to an adjudicatory proceeding, violations of Bureau of Insurance Rule Chapter 850(8) as set forth below.

FACTS

1. CIGNA (formerly known as Healthsource Maine, Inc.) has been a Maine licensed health maintenance organization (HMO), License # HMD4, since January 30, 1987.
2. The Superintendent of Insurance is the official charged with administering and enforcing Maine's insurance laws and regulations.
3. On June 3, 1999, the Bureau received complaint #1999505566 from Consumer, an enrollee under a CIGNA managed health care plan. Consumer complained because CIGNA denied benefits for her minor daughter's inpatient hospitalization in July 1998. The ground for denial was that inpatient care was not medically necessary for the last three days of the five-day hospitalization, because the child ostensibly could have been transferred to a psychiatric facility after the first 48 hours.
4. On July 22, 1998, Consumer's child was admitted as an inpatient to Eastern Maine Medical Center (EMMC), located in Bangor. Earlier on that day the child was screened and stabilized in the EMMC emergency room, where she received psychiatric evaluation following a suicidal gesture (cutting her wrist) and her threat of suicide if she were to leave the hospital. She received inpatient treatment at EMMC until her transfer five days later to Acadia Hospital (Acadia), a psychiatric facility in Bangor.
5. Throughout the child's EMMC stay, CIGNA Behavioral Health, Inc. (CBH), CIGNA's designated utilization review entity (URE), communicated with EMMC about the child's condition and medical needs.
6. Rule 850(8)(A) provides in part that decisions, errors and omissions by a URE are attributable to and binding on the health care carrier on whose behalf such events occur:

   A health carrier shall be responsible for monitoring all utilization review activities carried out by or on its behalf, and for compliance with the requirements of [§ 8 of the Rule].

7. CBH did not challenge the medical necessity of the child's emergency room treatment or her first two days of inpatient care at EMMC, which included drugs, restraints and a suicide watch.
8. On Friday, July 24th, with CBH's active assistance, EMMC attempted to transfer the child to an inpatient psychiatric facility. CIGNA did not have a network contract with any

psychiatric clinic or hospital in the Bangor area. EMMC called Maine General Medical Center in Waterville, the nearest contracted facility. Maine General refused to admit the patient. EMMC next telephoned Acadia, a non-contracted facility. Acadia was unable to accept the patient because it had no vacant bed that day. On Monday, July 27th, the first day Acadia was willing to accept the child for admission, she was transferred there from EMMC. As of July 27th, there were no other transfer options in or out of CIGNA's network within 60 minutes of automobile travel time from the child's home, as required by Rule 850(7)(C)(2).

9. EMMC's clinical record reflects that, on July 24th , a psychiatric consultant from Acadia met with the child. The consultant's notes of the visit state: "[patient is] continuing to be suicidal—states if she leaves here she will kill herself using a razor again—She states she did not do this for attention but just wants to die."
10. Concurrent Utilization Review Determination: Under Rule 850(8)(E)(3), CBH had one working day after "receiving all necessary information" within which to make a concurrent utilization review (UR) determination whether to authorize inpatient status for Consumer's child while at EMMC. During her stay at EMMC, CBH conducted concurrent review of the needed level of care, but made no UR determination.
11. CBH's stated reason for failing to provide a concurrent UR determination during the child's inpatient treatment at EMMC is that it does not make such determinations with non-contracted providers.
12. CBH did not make *any* written UR determination regarding *any* of the inpatient hospitalization, including the three days at issue, until March 3, 1999, *seven months* after the patient's discharge from EMMC.
13. In its March 3, 1999 UR determination, CBH authorized the first two days of inpatient treatment but denied benefits for July 25, 26 and 27. CBH's ground for the denial was that the treatment was not medically necessary because:

    "[t]he patient's condition does not require the requested level of care or service[;] the requested level of care or service is not appropriate based on the information provided to [CBH] about the patient [in that] "the patient could have been transferred to a psychiatric unit after 48hrs."

14. On March 10, 1999, Consumer submitted a first level appeal of CBH's March 3 adverse determination, setting forth the reasons for her appeal.
15. On April 16, 1999, CBH denied the appeal and issued an adverse utilization review appeal determination notice. The notice failed to state any reason for the denial.
16. Required Contents of Adverse UR Determination Notice on First Level Appeal: Rule 850(8)(G)(1)(c) requires an adverse UR appeal determination notice to include:

    i) The names, titles and qualifying credentials of the person or persons evaluating the appeal;

    ii) A statement of the reviewers' understanding of the reason for the covered person's request for the appeal;

iii) The reviewers' decision in clear terms and the clinical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

iv) A reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination. The decision shall include instructions for requesting copies of any referenced evidence, documentation or clinical review criteria not previously provided to the covered person. Where a covered person had previously submitted a written request for the clinical review criteria relied upon by the health carrier or the carrier's designated URE in rendering its initial adverse determination, the decision shall include copies of any additional clinical review criteria utilized in arriving at the decision.

v) A description of the process for submitting a written request for second level grievance review pursuant to section 9(D), the procedures and time frames governing a second level grievance review, and the rights specified in section 9(D)(3)(c).

17. CBH's April 16, 1999 adverse UR appeal determination notice did not include: a statement of its understanding of Consumer's reason for appeal; a clearly articulated basis for the decision; references to evidence or documents used to reach the decision, including clinical review criteria; a statement of the insured's procedural rights and duties for second level grievance review.
18. When Consumer requested a copy of the clinical rationale and criteria CBH used to make the April 16 adverse determination, CBH's April 29 response quoted findings of its psychiatric reviewer:

    Chart notes reflect that patient's clinical status is such that the patient is at no imminent risk of danger to self or others so that further intervention can be continued safely with the patient as an outpatient. Alternative level of care is intensive outpatient and residential school program at Hinckley. Certification is appropriate for ER assessment only.

19. On June 9, 1999, the Bureau forwarded a copy of Consumer's complaint to CBH and requested its response.
20. During the Bureau's subsequent investigation of Consumer's complaint, CBH revealed that the psychiatrist's conclusions excerpted in paragraph 18 above did not involve the child's July 1998 hospitalization at EMMC. CBH conceded in its January 14, 2000 letter to the Bureau that the quoted remarks concern the child's <u>February 1999</u> admission to <u>another</u> psychiatric facility.
21. By letter dated July 1, 1999, CBH, "after further review of the file," reversed its previous denials and authorized benefits for the hospitalization on July 25, 26 and 27, 1998. In a July 9, 1999 follow-up letter, CBH explained its reversal:

    Upon administrative review of the denial, it was determined that the authorization to transfer [Consumer's child] to Acadia Hospital occurred toward the end of the business day on Friday, July 24, 1998, and that Eastern Maine Medical Center was unable to

facilitate her transfer due to the timing of the authorization. [CBH] therefore made the determination to authorize the dates in question.

22. On July 24, 1998, EMMC informed CBH of the patient's mental condition and her need for inpatient treatment until transfer from EMMC could take place.
23. By reversing its denial of benefits, CBH acknowledged the need for holding Consumer's child on an inpatient basis until her move to Acadia. Participation by CBH in the unsuccessful effort on July 24th for an immediate transfer establishes it then knew or should have known that: 1) until the transfer could be effected, it was medically necessary for the child to continue receiving inpatient care at EMMC; 2) CBH's guideline for transfer to a psychiatric facility within 48 hours of admission to an acute care hospital could not be met where, as here, through no fault of Consumer there was no psychiatric facility reasonably available to accept her daughter prior to July 27th.

CONCLUSIONS OF LAW

24. As described in paragraphs 10 and 11 above, CBH violated Rule 850(8)(E)(3) by failing to make a concurrent utilization review determination regarding the child's continuing need for inpatient care at EMMC prior to her transfer to Acadia. Pursuant to Rule 850(8)(A), CIGNA

    is responsible for the actions of its URE.

25. As described in paragraphs 16 and 17 above, CBH violated Rule 850(8)(G)(1)(c) by failing to include in its April 16, 1999 adverse UR appeal determination notice a statement of the reviewers' understanding of Consumer's reason for appealing the March 3, 1999 denial of benefits. Pursuant to Rule 850(8)(A), CIGNA is responsible for the actions of its URE.
26. As described in paragraphs 16, 17 and 18 above, CBH violated Rule 850(8)(G)(1)(c) by failing to announce in its April 16, 1999 adverse UR appeal determination notice and follow-up letter of April 29 a clear statement of the reasons for denying Consumer's appeal. Pursuant to Rule 850(8)(A), CIGNA is responsible for the actions of its URE.
27. As described in paragraphs 16 and 17 above, CBH violated Rule 850(8)(G)(1)(c) by failing to refer in its April 16, 1999 adverse UR appeal determination notice to evidence, documentation or clinical review criteria used as bases for its decision. Pursuant to Rule 850(8)(A), CIGNA is responsible for the actions of its URE.
28. As described in paragraphs 16 and 17 above, CBH violated Rule 850(8)(G)(1)(c) by failing to delineate in its April 16, 1999 adverse UR appeal determination notice the process for Consumer to submit a written request for second level grievance review, and the rights, procedures and deadlines governing such review, as established by Rule 850(9)(D). Pursuant to Rule 850(8)(A), CIGNA is responsible for the actions of its URE.

COVENANTS

29. A formal hearing in this complaint proceeding is waived, and no appeal will be taken. This Consent Agreement is an enforceable agency action within the meaning of the Maine Administrative Procedure Act.
30. At the time of executing this Agreement, CIGNA shall pay to the Maine Bureau of Insurance a penalty in the amount of $10,000, drawn to the Treasurer of the State of Maine.
31. In consideration of CIGNA's execution of and compliance with the terms of this Consent Agreement, the Superintendent agrees to forgo pursuing any disciplinary measure or other civil sanction for the violations described above other than those agreed to in this Agreement.

MISCELLANEOUS

32. CIGNA understands and acknowledges that this Agreement will constitute a public record within the meaning of 1 M.R.S.A. § 402, and will be available for public inspection and copying as provided by 1 M.R.S.A. § 408, and will be reported to the NAIC "RIRS" database.
33. The parties understand that nothing herein shall affect any right or interest of any person not a party to this Agreement.
34. This Agreement may be modified only by the written consent of the parties.
35. CIGNA was informed of its right to consult with counsel of its own choice, and, in fact, has done so before executing this Agreement.
36. Nothing herein shall prohibit the Bureau of Insurance from seeking an order to enforce this Consent Agreement or from seeking additional penalties in the event CIGNA does not comply with the above terms or in the event the Bureau receives evidence that further legal action is necessary for the protection of Maine consumers.

FOR CIGNA HEALTHCARE OF MAINE, INC.

Dated:___________, 2000

By: ____________________
Signature

____
Typed Name and Title

Subscribed and sworn to before me
this _______ day of ________, 2000.

____
Notary Public

FOR THE BUREAU OF INSURANCE

Dated: _________, 2000

____

Alessandro A. Iuppa
Superintendent of Insurance

STATE OF MAINE
KENNEBEC, ss.
Subscribed and sworn to before me
this _______ day of ______, 2000

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Notary Public/Attorney-at-Law

FOR THE MAINE
ATTORNEY GENERAL

Dated: ____________, 2000

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Judith Shaw Chamberlain
Assistant Attorney General

STATE OF MAINE
KENNEBEC, ss.

Subscribed and sworn to before me
this______day of___________2000