IN RE : UNITED BEHAVIORAL HEALTH	)))))	**CONSENT AGREEMENT** **Docket No. 00-3005**

This document is a Consent Agreement, authorized by 5 M.R.S.A. § 9053(2), entered into by United Behavioral Health (hereafter also "*UBH*") 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) and (9) as set forth below.

FACTS

1. UBH has been a Maine licensed utilization review entity (URE), License # URF38961, since April 1, 1994.

2. The Superintendent of Insurance is the official charged with administering and enforcing Maine's insurance laws and regulations.

3. On December 14, 1998, the Bureau received complaint #1998504468 from Consumer, an enrollee under a United HealthCare (United) managed health care plan. Consumer complained because UBH, as United's designated utilization review entity (URE), denied coverage for requested psychotherapy on the ground that it is medically unnecessary for two or more family members to seek individual therapy exclusively from a single provider.

4. The United plan went into effect on June 11, 1998, replacing another carrier's plan under which Consumer and her minor son received benefits during concurrent treatment exclusively from the same psychotherapist. In contrast to the replaced plan, a UBH clinical guideline conditioned coverage for multiple family members on receiving treatment from different therapists.

5. On February 17, 1999, the Bureau received a second complaint on behalf of Consumer from her psychologist, Dr. K, who treated Consumer and her child under the previous plan. Dr. K complained that: it was medically necessary for him to continue treating Consumer and her child without participation by another mental health provider; UBH's

requirement for separate therapists is based on obsolete criteria; and UBH's utilization review procedures impaired his treatment of Consumer and her son.

6. On June 12, 1998, UBH orally denied Consumer's request to authorize Dr. K's continued dual therapy for her son and herself. The denial was based on UBH's written guideline, excerpted below, that it is not medically necessary for one psychotherapist to provide simultaneous and exclusive individual therapy to two or more members of the same family. The guideline provides in substance that it is generally necessary for each family member to be concurrently treated by different therapists:

   Despite the importance of family involvement in treatment, we do not consider it either appropriate or effective for one therapist to provide ongoing individual psychotherapy to multiple family members. When such situations are already established prior to UBH's management, the Care Manager will need to review the appropriateness and effectiveness of the care being provided. When a family member requests individual therapy with the current individual therapist of another family member, the patient's individual needs and available treatment resources must be considered. Nonetheless, it is recommended that the family member be referred to another individual therapist.

7. When it issued its June 1998 denial of concurrent, exclusive therapy from Dr. K, UBH directed him to have Consumer and her family decide whether Consumer *or* her son would see only him. The choice was made that Dr. K continue solely treating the child.

8. Consumer reluctantly accepted UBH's "separate therapists" condition. During June through December 1998, UBH authorized treatment whereby Consumer and her son saw Dr. K, while she also received treatment from another network mental health provider.

9. On November 3, 1998, Dr K notified UBH that beginning January 1, 1999 he was going to resume exclusive treatment of Consumer and continue his therapy of the child. He requested UBH to authorize this treatment plan.

10. On December 9, 1998, UBH orally denied Dr. K's request for authorization of the proposed change of therapy.

11. <u>Deadline for Making Initial Utilization Review Determination:</u> Rule 850(8)(E)(2) requires a URE to make an initial determination and notify the insured or insured's

provider in writing of the decision. The determination and notice must be made within two working days of the URE obtaining all necessary treatment information.

12. UBH did not timely determine Dr. K's November 3, 1998 request for authorization of his proposed therapy of Consumer and her child.

13. On December 9, 1998, UBH gave Consumer timely written notice of its adverse UR determination denying Dr. K's request to resume the proposed therapy. The denial was made on the ground that there was no medical necessity for the therapy.

14. On December 10th, Dr. K appealed UBH's adverse UR determination. By letter dated December 14 to Consumer and Dr. K, UBH denied the appeal on medical necessity grounds.

15. Dr. K immediately requested second level grievance review of the adverse UR determination.

16. On December 16th, UBH again wrote to Consumer and Dr. K., denying the second level grievance of the adverse UR determination.

17. The substance of the two UBH adverse UR determination notices (December 14 and 16, 1998) is the same. Each notice refers to unspecified "clinical information" and other "available information" on which UBH relied in making the adverse UR determinations:

    Benefit coverage is denied, based on the clinical information provided and the following employer group contract language:

    Medical Necessity – health care services and supplies that are determined by the Plan to be medically appropriate, and;

    1. *necessary to meet the basic health needs of the covered person;*
    2. *rendered in the type of setting appropriate for the delivery of the health service;*
    3. *consistent in type, frequency and duration of treatment with United Behavioral Health guidelines;*

4. *consistent with the diagnosis of the condition;*
5. *required for reasons other than the comfort or convenience of the covered person or his or her physician; and*
6. *of demonstrated medical value.*

   The employer group benefit plan will not cover expenses incurred for outpatient treatment because of lack of medical necessity, lack of risk, the patient has achieved maximum gains of treatment and resolution of acute symptoms.

18. During its investigation, the Bureau asked UBH to further explain the reasons for its December 14 and 16, 1998 adverse UR appeal and grievance determinations. UBH wrote to the Bureau on March 25, 1999, providing details of the "clinical and available" information on which it relied. The "clinical" information came from a review conducted on December 8, 1998 by UBH Medical Director Martin Held, M.D., and Milam Freitag, Ph. D. They decided that UBH correctly refused to certify the requested psychotherapy from Dr. K, because Consumer "was noted to be functioning well at home, school and work and the symptoms that were noted, were not acute." They concluded that there "was lack of medical necessity, lack of risk, as the patient had achieved maximum gains of treatment, as there was a noted resolution of acute symptoms." UBH supplied no clarification under the "available" information heading.

19. <u>Contents of Adverse UR Determination Appeal Notice:</u> Rule 850(8)(G)(1)(c) requires an adverse UR determination appeal 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 an 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 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).*
20. UBH's December 14, 1998 adverse UR determination appeal notice does not contain the following information required by Rule 850(8)(G)(1)(c): the qualifying credentials of the reviewer, Andrew Mebane, MD; a statement of the reviewer's understanding of

Consumer's reasons for appeal; the decision in clear terms and the clinical rationale in sufficient detail to enable Consumer to respond further to the denial; a reference to the evidence or documentation used for the adverse UR determination, together with instructions for requesting writings not previously given to Consumer; and a description of the process, procedures, time frames and Consumer's rights for second level grievance review.

21. <u>Description of Grievance Procedure</u>: Rule 850(9)(B)(2) requires written notice to the insured of the procedure for filing grievances, including second level adverse UR determination grievances:

    A description of the grievance procedure shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to covered persons. The grievance procedure description shall include a statement of the covered person's right to contact the Superintendent's office for assistance at any time. The statement shall include the toll free telephone number and address for the Bureau of Insurance.

22. The United master policy, certificate and other evidence of coverage do not contain a description of the procedure for filing grievances.

23. <u>Contents of Adverse UR Determination Grievance Notice:</u> Rule 850(9)(D)(3)(f) requires that an adverse UR determination grievance notice include all of the following information, incorporated from § 9(C)(1)(b):
    . *The names, titles and qualifying credentials of [the reviewers;]*
    i. *A statement of the reviewers' understanding of the…grievance and all pertinent facts;*
    ii. *The reviewers' decision in clear terms and the basis for the decision;*
    iii. *A reference to the evidence or documentation used as the basis for the decision;*
    iv. *Notice of the covered person's right to contact the Superintendent's office. The notice shall contain the toll free telephone number and address of the Bureau of Insurance.*
24. UBH's December 16, 1998 adverse UR determination second level grievance notice does not contain the following information required by Rule 850(9)(D)(3)(f): the qualifying credentials of the reviewer, Penny Randall, MD; a statement of the reviewer's understanding of the grievance and all pertinent facts; a clear articulation of the decision or its bases; a reference to specific evidence or a particular document to support the decision; and a notice of the right to contact the Bureau of Insurance.

CONCLUSIONS OF LAW

25. As described in paragraphs 11 and 12 above, UBH violated Rule 850(8)(E)(2) by failing to make an initial UR determination within two working days of receiving all necessary information.

26. As described in paragraphs 14, 17, 18, 19 and 20 above, UBH violated Rule 850(8)(G)(1)(c) by failing to include in its December 14, 1998 adverse UR determination appeal notice a statement of the reviewer's qualifying credentials.

27. As described in paragraphs 14, 17, 18, 19 and 20 above, UBH violated Rule 850(8)(G)(1)(c) by failing to include in its December 14, 1998 adverse UR determination appeal notice a statement of the reviewer's understanding of the reasons for the appeal.

28. As described in paragraphs 14, 17, 18, 19 and 20 above, UBH violated Rule 850(8)(G)(1)(c) by failing to include in its December 14, 1998 adverse UR determination appeal notice a clear statement of the decision and the rationale in sufficient detail to enable Consumer to respond further to UBH's position.

29. As described in paragraphs 14, 17, 18, 19 and 20 above, UBH violated Rule 850(8)(G)(1)(c) by failing to include in its December 14, 1998 adverse UR determination appeal notice any reference to the evidence or documentation used for its decision, and instructions to Consumer for requesting documentation.

30. As described in paragraphs 14, 17, 18, 19 and 20 above, UBH violated Rule 850(8)(G)(1)(c) by failing to include in its December 14, 1998 adverse UR determination appeal notice a description of the process, procedures, time frames and insured's rights for second level grievance review.

31. As described in paragraphs 21 and 22 above, UBH violated Rule 850(9)(B)(2) by failing to inform Consumer in writing of the procedure for filing grievances.

32. As described in paragraphs 16, 17, 18, 23 and 24 above, UBH violated Rule 850(9)(D)(3)(f) by failing to include in its December 16, 1998 adverse UR determination grievance notice the qualifying credentials of its reviewer.

33. As described in paragraphs 16, 17, 18, 23 and 24 above, UBH violated Rule 850(9)(D)(3)(f) by failing to include in its December 16, 1998 adverse UR determination grievance notice a clear statement of the decision and the bases for the decision.

34. As described in paragraphs 16, 17, 18, 23 and 24 above, UBH violated Rule 850(9)(D)(3)(f) by failing to include in its December 16, 1998 adverse UR determination of Consumer's grievance a notice of her right to contact the Bureau of Insurance.

COVENANTS

35. 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.

36. At the time of executing this Agreement, UBH shall pay to the Maine Bureau of Insurance a penalty in the amount of $10,000 payable to the Treasurer of the State of Maine.

37. In consideration of UBH'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 herein.

MISCELLANEOUS

38. UBH understands and acknowledges that this Agreement will constitute a public record within the meaning of 1 M.R.S.A. § 402, 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.

39. The parties understand that nothing herein shall affect any right or interest of any person who is not a party to this Agreement.

40. This Agreement may be modified only by the written consent of the parties.

41. UBH was informed of its right to consult with counsel of its own choice, and, in fact, has done so before executing this Agreement.

42. Nothing herein shall prohibit the Bureau of Insurance from seeking an order to enforce this Consent Agreement, or from seeking additional sanctions in the event UBH 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 UNITED BEHAVORIAL HEALTH

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

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Alessandro A. Iuppa
Superintendent of Insurance

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

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Notary Public/Attorney at Law