IN RE: WASHINGTON NATIONAL INSURANCE COMPANY	**)**	**CONSENT AGREEMENT**
	)	**BUREAU OF INSURANCE**
	)	**DOC NO. MCINS 99-11**

This document is a Consent Agreement, authorized by 5 M.R.S.A. § 9053(2) entered into by and among Washington National Insurance Company (hereafter "Washington National") and the Superintendent of the Maine Bureau of Insurance (hereafter also "the Superintendent"). Its purpose is to resolve, without resort to an adjudicatory proceeding, a violations of the Maine Insurance Code as set forth below.

FACTS

1. The Superintendent is the official charged with administering and enforcing Maine's insurance laws and regulations.
2. Washington National has been a Maine licensed life and health insurance company, License # LHF294, since 1925.
3. Consumer, whose true name has been omitted for protection of privacy, was insured, at all time relevant to this Consent Agreement, under a health insurance policy issued by Washington National.
4. On February 23, 1999, Consumer filed a formal complaint, complaint # 1999504911, with the Bureau of Insurance objecting to a denial of her claim by Washington National. The complaint stated in relevant part:

   I had major foot surgery in July 1997 – repaired tendons (torn) and removal of an evulsion FX – by Dr. Gregory Pomeroy. I had many problems [with] this surgery. Dr. Pomeroy thought it was medically necessary to unload the tendons to see if they would heal – he ordered orthotics 12-31-97. I went to purchase these via prescription (from Dr. Pomeroy) and before I saw the guy that was going to custom fit me for the orthotics I called Washington Nat. for the "OK". Brian Bystrom – a Washington National representative said yes to ahead your covered – so I did I paid $300.00 on 12/31/97 (my deductible was zero) I submitted the claim. I was refused. They said we and our medical staff feel you didn't need these – provide us [with] a note from your doctor saying it was medically necessary – which I did they said we still feel you didn't need these – so they refuse to pay me.!

5. Washington National phone records document a telephone call from provider to Washington National on December 30, 1997. In a telephone call from the Bureau of Insurance to Washington National on June 29, 1999, Washington National's representative explained that this telephone record indicates that benefits for orthotics were approved during the provider's phone call of December 30, 1997. If the benefits had been approved or verified subject to medical necessity, there would have been a notation on the phone record indicating that a determination of medical necessity was required. Washington National has advised that this phone record indicates that benefits for orthotics were approved and that the consumer and provider were entitled to rely on that approval.

6. On April 22, 1998, Washington National sent Consumer an Explanation of Benefits denying the claim, with the remark:

   "information requested has not been received."

7. On May 6, 1998, Washington National sent Consumer an Explanation of Benefits again denying the claim, with the remark:

   "Please submit itemized doctor bill which includes diagnosis."

8. On November 6, 1998 Consumer's provider wrote Washington National a letter of medical necessity for orthotics following surgery for the repair of a torn tendon, stating:

   "Please note that [Consumer] is a patient of mine who has peroneal tendinitis of the left foot. She requires custom orthotics with a lateral wedge to unload the tendon. This will unload the tendon and provide pain relief while the tendon heals. In an attempt to treat her conservatively, I ordered custom inserts for her. I would greatly appreciate you considering covering the cost of the orthotics and custom shoes. If there is anything further you need, please contact me.

9. On December 7, 1998 Washington National sent Consumer an Explanation of Benefits denying the claim, and stating as grounds:

   "Claim does not support molded supports for the treatment of tendonitis."

   "*Charges not covered. Refer to policy exclusions/limitations."*

10. On January 14, 1999 Consumer's provider wrote a letter of Medical Necessity to Washington National, essentially identical to the medical necessity letter of November 6, 1998.
11. On February 16, 1999, Washington National wrote Consumer, advising:

    "We are in receipt of your correspondence requesting review of claim… for orthotics. After a medical review, by our medical review department, we have determined that the orthotics were not medically necessary. Therefore we are unable to reconsider claim…for benefits. If you have any questions please contact our Customer Service Department."

12. Rule 850(8)(E)(5) requires carriers to notify their insureds in writing of any adverse utilization review determination. The notice must include:
    a. *The principal reason or reasons for the determination.*
    b. *The instructions for initiating an appeal for reconsideration of the determination.*
    c. *The instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination.*

d. *A phone number the covered person may call for information on and assistance with initiating an appeal for reconsideration and/or requesting clinical rational and review criteria.*

13. Washington National's February 16th, 1999 adverse determination notice does not include:
    a. The principal reasons for the determination.
    b. The instructions for initiating an appeal for reconsideration of the determination.
    c. The instructions for requesting a written statement of the clinical rational, including the clinical review criteria used to make the determination.
    d. A phone number the covered person may call for information on and assistance with initiating an appeal for reconsideration and/or requesting clinical rational and review criteria.
14. On March 1, 1999, the Bureau of Insurance forwarded Consumer's complaint to Washington National, advising (emphasis added):

    "*Please review the complaint and provide a detailed, substantive response to all issues raised. Your response must be supplemented by documentation in support of all representations, including, as applicable, all relevant notices, internal memos, file notes, phone logs or correspondence. In addition, please provide a copy of the policy at issue along with all relevant policy amendments and riders. Pursuant to Title 24-A M.R.S.A. §220(2), you must respond within 14 days after your receipt of this letter. Failure to provide a timely response that both meaningfully addresses all issues raised in the complaint and provides supporting documentation may result in disciplinary action."*

15. On March 18, 1999 Washington National wrote the Bureau of Insurance. They advised that the policy:

    "*is a Major Medical Expense plan, issued effective June 1, 1997.*
    Policy page 6 (copy enclosed) lists the definition of Medical Necessity. [Consumers'] claim for custom orthotics in the amount of $300.00 and [Provider's] letter of January 14, 1999, was reviewed by our Medical Unit. In accordance to their review, custom orthotics is not appropriate nor medically necessary for the treatment of tendinitis. Based on this information, the claim was denied. If [Consumer] wishes for us to review this claim again, she will need to submit medical records from Dr. Pomeroy.

    Please be advised that we have reviewed our Customer Service records and find no record of [Consumer] calling our office regarding custom orthotics.

16. Rule 850(8)(D)(2) provides:

    "A clinical peer shall evaluate the clinical appropriateness of adverse determinations."

17. Rule 850 (5)(H) defines "Clinical peer" to mean:

    "a physician or other health care professional who holds a non-restricted license in a state of the United States in the same or similar specialty as typically manages the

medical condition, procedure or treatment under review, or other physician or health care professional with demonstrable expertise to review a case, whether or not the reviewing professional is in the same or similar specialty as the health care professional who made the initial decision."

18. The "medical unit" which Washington National referenced in its letter of March 18, 1999, and the "medical review department" referenced in its letter of February 16, 1999, do not qualify as clinical peers under Rule 850(5)(H) for the purpose of determining the medical necessity of Consumer's treatment. As documented by Washington National's Nurse Review Routing Sheet, dated December 1, 1998, the medical necessity determination was made solely by a Nurse Reviewer. Under the heading RECOMMENDATIONS, the nurse reviewer wrote, *"Unable to locate benefit for orthotics per policy provisions. Claim does support molded supports for the treatment of tendonitis."*
19. On March 19, 1999, the Bureau of Insurance wrote to Washington National:

    "Thank you for your response of March 18, 1999 with attachments. As previously requested, please provide a complete copy of the claim file for the claim numbered above. The file should include al relevant notices, internal memos, file notes, telephone logs and all correspondence."

20. In its March 19, 1999 letter, the Bureau of Insurance advised Washington National that the company was not in compliance with the requirements of Rule 850, and requested that, *"Washington National Life Insurance Co. reconsider the decision to deny Ms. Gross' claim and take immediate steps to implement the standard under Chapter 850 in future handling of all claims falling under Maine jurisdiction."*
21. On April 8, 1999, Washington National wrote to the Bureau of Insurance, and included the following enclosures.
    a. Record of telephone encounter dated December 30, 1997 which documents that Washington National verified benefits for orthotics on that date. As set forth in paragraph 5 above, Washington National has confirmed to the Bureau of Insurance that Washington National agrees that based on the December, 30, 1997 telephone record the consumer and provider had a right to expect that the claim would be paid.
    b. Letter of Medical Necessity dated November 6, 1998 from patient's provider, requesting coverage for orthotics. This letter included a hand written note from consumer, stating: "*Dear MMIU, I've given you all the information you asked for regarding this claim – I've been trying to collect since 1997 Dec. Please pay me the $300.00 I've got coming to me."*
    c. *Nurse Review Routing Sheet dated December 1, 1998. Under the heading RECOMMENDATIONS, the nurse reviewer wrote, "Unable to locate benefit for orthotics per policy provisions. Claim does support molded supports for the treatment of tendonitis."*
22. In its April 8, 1999 letter, Washington National stated (emphasis added):

    "Pursuant to your request, enclosed are copies of all correspondence we have on file related to the orthotic that [Consumer] received on December, 30, 1997, in the amount of

*$300.00. As previously indicated [Consumer] does not have coverage for orthotics. However, **a review of our telephone records indicates that June White, of Picurro's Prosthetic Orthotic called our Customer service Department on December 30, 1997, and that a claim representative verified benefits for orthotics**." Based on this information, we have decided to reconsider the claim. Once the claim has been reconsidered, we will forward a copy of the Explanation of Benefit's form to your office."*

"Please be advised that our Utilization Review Entity was never contacted about orthotics. Therefore, we do not feel that Maine's Revised Rule, Chapter 850, is applicable to this case."

23. On April 9, 1999, over a year after the initial claim was submitted, Washington National paid the claim.
24. On April 16, 1999 the Bureau of Insurance wrote to Washington National, again requesting documentation previously requested.

    "Please provide a copy of the initial denial letter and subsequent letter &/or notice(s) sent to [Consumer] regarding your company's decision on this claim. The only letter, in our file, sent to [Consumer] regarding your company's decision on her claim, is dated February 16, 1999. This appears to be the decision by your company on her appeal."

25. On April *30, 1999, Washington National wrote:*

    "Please be advised that our correspondence to [Consumer] regarding her claim for orthotics were done on the Explanation of Benefits forms. Our original consideration was done on April 22, 1998, and the examiner utilized the incorrect remark code "A#" which states "information requested has not been received". The examiner should have utilized requested a copy of the bill which included the diagnosis. On December 7, 1998, the orthotic's claim was denied. We have enclosed copies of the Explanation of Benefits forms."

CONCLUSIONS

26. As set forth in paragraphs 11, 12, and 13, Washington National violated Rule 850(8)(E)(5) by sending Consumer an adverse determination notice which failed to include the principal reasons for the determination, the instructions for initiating an appeal for reconsideration of the determination, the instructions for requesting a written statement of the clinical rational for the determination, and a phone number to call for information on and assistance with initiating an appeal for reconsideration and/or requesting clinical rational and review criteria.
27. As set forth in paragraphs 14, 15, 19, 21, 22, 24, and 25, Washington National violated Title 24-A M.R.S.A. §220(2) by failing to fully and timely fulfill its legal obligation to provide the Bureau of Insurance with all documents related to Consumer's claim.
28. As set forth in paragraphs 15, 16, 17, and 18, Washington National violated Rule 850(8)(D)(2) by failing to by failing to have a clinical peer evaluate the clinical appropriateness of the adverse determination.

COVENANTS

29. A formal hearing in this matter is waived and no appeal will be made.

30. At the time of executing this Agreement, Washington National will pay to the Maine Bureau of Insurance a penalty in the amount of ten thousand dollars ($10.000), payable to the Treasurer of the State of Maine.

31. In consideration of Washington National's execution of and compliance with the terms of this Consent Agreement, the Superintendent agrees to forgo pursuing any disciplinary measures or other civil sanction for the specific violations described above other than those agreed to in this Consent Agreement.

MISCELLANEOUS

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

33. It is understood by the parties to this Agreement that nothing herein shall affect any rights or interests that any person not a party to this Agreement may possess.

34. Washington National acknowledges that this Consent Agreement is a public record within the meaning of 1 M.R.S.A. § 402 and will be available for public inspection and copying as provided for by 1 M.R.S.A. § 408.

35. Washington National has been advised of its right to consult with counsel and has, in fact, consulted with counsel before executing this Agreement.

Washington National Life Insurance Company

Dated: _____, 1999

By: _____
Signature

For: _____
Typed Name

_____
Typed Title

this _____ day of _____, 1999.

_____
Notary Public

FOR THE BUREAU OF INSURANCE

Dated: _____, 1999

_____
Alessandro A. Iuppa
Superintendent of Insurance

STATE OF MAINE
KENNEBEC, SS.

Subscribed and sworn to before me
this _____ day of _____, 1999.

_____
Notary Public/Attorney-at-Law

FOR THE MAINE ATTORNEY GENERAL

Dated: _____, 1999

_____
Judith Shaw Chamberlain
Assistant Attorney General