STATE OF MAINE BUREAU OF INSURANCE

MARKET CONDUCT EXAMINATION REPORT

For the Period January 1, 2005 through December 31, 2008

Anthem Health Plans of Maine
2 Gannett Drive
South Portland, ME 04106-6911

NAIC Number: 52618

February 15, 2011

EXAMINATION REPORT PREPARED BY INDEPENDENT CONTRACTORS FOR THE MAINE BUREAU OF INSURANCE

Pursuant to Title 24-A M.R.S.A. § 221, I have caused a Targeted Market Conduct Examination to be conducted of Anthem Health Plans of Maine. I hereby accept this Report of Examination and make it an official record of the Bureau of Insurance.

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Mila Kofman
Superintendent of Insurance
Maine Bureau of Insurance

April 4, 2011
Date

Contents

March 30, 2011

Mila Kofman
Superintendent of Insurance
State of Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333

Dear Superintendent Kofman:

Pursuant to Title 24-A M.R.S.A. § 221(5), a targeted Market Conduct Examination (the Examination) of selected focus areas including complaint handling, appeals, policyholder services, provider network, utilization review and pre-authorization practices, company operations and claims practices has been conducted of:

Anthem Health Plans of Maine (the Company)

The Company's records were examined at the Company's offices located in South Portland, Maine as well as through remote systems access provided by the Company.

The Examination covered the period from January 1, 2005 to December 31, 2008.

A Report of the Examination of Anthem Health Plans of Maine is, herewith, respectfully submitted.

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RSM McGladrey
Independent Market Conduct Examiner

SECTION I - EXECUTIVE SUMMARY

Background and Examination Objectives

The Maine Bureau of Insurance (the Bureau) is conducting a targeted market conduct Examination of Anthem Health Plans of Maine (Anthem or the Company) to assess the behavioral health services provided by the Company. The Bureau's primary objective in conducting the Examination is to evaluate whether mental health and substance abuse benefits are at least equal to those received by a person receiving medical treatment. More specifically, the Bureau's goals and objectives in conducting the Examination includes but is not limited to the following:

1. Test the Company's processes to ensure that the Company is providing accurate and timely information to both enrollees and health care providers.
2. Evaluate the insurer's compliance with applicable statutes and regulations as well as timeliness and accuracy of claim payments.
3. Determine the Company's compliance with applicable statutes and regulations concerning complaint handling, appeals and grievance procedures, policyholder service, claims handling, and pre-authorization and utilization review procedures.
4. Determine the timeliness of the Company's pre-authorization process, and the appropriateness of the decisions. Determine the reasonableness of the Company's process for obtaining and documenting receipt and disposition of treatment plans from providers, including both participating and non-participating providers.
5. Determine the accuracy and completeness of the Company's provider directory.

Examination Approach

RSM McGladrey, Inc. (the Examiners) relied primarily on the review and testing of records and information maintained by the Company concerning certain of their operations included within the scope of the Examination. Where appropriate, the Examiners tendered follow-up inquiries to the Company for response. Interviews with the Company's representatives and key personnel were also conducted. Targeted attribute testing was performed consistent with examination processes and sampling methodologies of the Bureau in concert with the applicable State of Maine insurance statutes, rules and regulations and the NAIC Market Regulation Handbook (the Handbook), which was used as a guide. The Examiners reviewed and tested, where applicable, the following areas:

1. Company Operations and Management
2. Claims Handling and Settlement
3. Utilization Review and Pre-Authorization
4. Complaints, Appeals and Grievance Handling
5. Policyholder Services and Provider Network

The Examination scope, workplan and testing was developed consistent with the requirements of the Bureau's Rider A - Specification of Work to Be Performed, of the Agreement to Purchase

Services (the Agreement). Rider A also establishes the Company's operational areas to be tested. In consultation with the Bureau, certain tests conducted during the Examination may have been modified from that set out in Rider A to meet the needs of the Bureau and to reflect statutes, rules and regulations referenced herein.

In testing the above referenced areas, the Examiners were directed to evaluate whether mental health and substance abuse benefits were at least equal to those for physical illnesses for a person receiving medical treatment. In so doing, the Examiners used random samples where appropriate for the areas tested. Also, where applicable and consistent with the requirements of the Bureau, the Examiners utilized qualified clinical professionals, approved by the Bureau, to conduct peer reviews to perform the following:

- Review medical records to determine whether an adverse decision was appropriately rendered.
- Determine whether the Company conducted a fair review of medical necessity before issuing a denial; for example, they determined that medical records were reviewed or there was a substantive collection of medical information (written or verbal) before determining the lack of medical necessity.
- Review the Company's utilization review peer reviewers' qualifications for appropriateness.
- Review that the Company's reviewer had the appropriate expertise (personally or through a qualified consultant) in cases involving experimental/investigational treatment denials; for example, they determined that denials were appropriate and based upon scientific evidence or lack thereof.
- Determine that the Company's reviewer had knowledge or familiarity with neuropsychological testing and other cognitive-related issues, if applicable.

Findings

The Examiners noted observations regarding the Company's claims and appeals handling practices, which are listed below in order of priority:

Finding # 1

The Examiners identified one (1) of 43 complaints and one (1) of 43 appeals involving instances in which the Company failed to pay claims within 30 days, thus representing violations of Title 24-A § 2436 (1) of the Maine Insurance Code. When the examiners identified the errors the company paid the claim and interest.

Finding # 2

The Examiners identified one (1) of 130 denied and zero-paid claims tested representing a potential violation of Title 24-A §2436 (1) of the Maine Insurance Code, wherein the Company incorrectly denied a behavioral health claim for which benefits were available on the member's policy. Specifically, the maximum allowable visits for the plan year had not been met.

Finding # 3

The Examiners identified three (3) potential violations of Chapter 850, Section 9 A (1) of the Maine Insurance Rule, wherein the Company's appeal logs did not include the required information.

The details for each of the above referenced findings are discussed in Section V of this Report. Additionally, where applicable, the Examiners have included Additional Observations in each relevant area of the Examination.

SECTION II -SCOPE OF EXAMINATION

The scope of the Bureau's Examination was to determine the Company's compliance with applicable mental health parity provisions of the Maine Insurance Code, Title 24-A M.R.S.A §§ 2842-2844, 4234-A and 4303 as well as Maine's Health Plan Improvement Act and Bureau of Insurance Rule Chapters 191 and 850 for the period of the Examination (the Period), January 1, 2005 through December 31, 2008. The Examination was conducted under the supervision of the Bureau's Director of Consumer Health Care Division and the Director of Financial Analysis.

The Report of Examination (the Report) is a report by exception with modification, as references to practices, procedures or files that did not contain exceptions are limited. All unacceptable or non-complying practices may not have been identified. The failure to identify specific Company practices does not constitute acceptance of these practices.

RSM McGladrey, Inc. personnel participated in this Examination in their capacity as market conduct examiners. RSM McGladrey, Inc. provides no representations regarding questions of legal interpretation or opinion. Determination of findings constituting violations or potential violations is the sole responsibility of the Bureau.

SECTION III - COMPANY PROFILE

Anthem is a Maine domiciled stock insurance company and a wholly-owned subsidiary of ATH Holding Company, LLC ("ATH Holding"). ATH Holding is a direct, wholly-owned subsidiary of WellPoint, Inc. ("WellPoint"), a publically traded company in the United States. Anthem is Maine's largest domestic health benefits company serving approximately 211,450 enrollees, or 57% of the fully insured market, during the Period based on statistics reported by the Bureau in its brochure titled, "*2008 Financial Results for Health Insurance Companies in Maine.*"

Anthem Behavioral Health (Anthem Behavioral), a division of the Anthem Specialty Business unit, offers behavioral health benefit management services as well as employee assistance programs (EAP).

Anthem Behavioral holds accreditation from URAC in Health Utilization Management, Case Management and Provider Credentialing. Anthem's Behavioral provider network includes psychiatrists, psychologists, social workers, psychiatric nurses and other mental health and

employee assistance providers. The facility network includes hospital inpatient units, residential treatment centers, partial hospitalization programs and outpatient programs.

SECTION IV - EXAMINERS METHODOLOGY

In accordance with the Bureau's requirements, the Examiners developed random samples, where applicable, to review and test specific attributes associated with policies that were marketed and sold to state of Maine residents. These populations included large group policies, small group policies with more than 20 covered employees, and State of Maine employee plan and city and local governmental plans. Also, where applicable, the samples included individual policies and groups with 20 or fewer employees for which the policyholders had elected mental health parity. Administrative services business, with the exception of the State of Maine employee plan, was excluded from the sample testing. The Examiner's sampling methodology was reviewed and approved by the Bureau. The Examiners' testing of each focus area was designed to evaluate whether mental health and substance abuse benefits are at least equal to those for physical illnesses for a person receiving medical treatment for any of the categories of mental illness as defined by Maine Insurance Code, Title 24-A M.R.S.A §§2843 (5-C) and 4234-A (6) and (7).

The categories of mental illness were identified in the Bureau's Rider A as defined in the Diagnostic and Statistical Manual (DSM), except for those that are designated as "V" codes by the DSM. The categories include the following.

1. Psychotic disorders, including schizophrenia;
2. Dissociative disorders;
3. Mood disorders;
4. Anxiety disorders;
5. Personality disorders;
6. Paraphilias;
7. Attention deficit and disruptive behavior disorders;
8. Pervasive developmental disorders;
9. Tic disorders,
10. Eating disorders, including bulimia and anorexia; and
11. Substance abuse-related disorders

Company Operations and Management

Testing of this focus area included the Examiners requesting certain operational data along with policies and procedures from the Company in effect during the Period. The requested information included:

- An overview of relevant Company systems.
- The Company's corporate legal entity and functional organization charts.
- The Company's policies and procedures for oversight of behavioral health vendors, service providers, and other companies that provide insurance-related services.

- Functional organizational charts for all areas responsible for handling and overseeing behavioral health claims, complaints, appeals and grievances, utilization reviews, preauthorizations, enrollee inquiries and policyholder services.

Upon receipt of the above requested information, the Examiners evaluated the Company's responses for compliance with Maine's mental health parity laws as may be applicable and other related rules and regulations. The results are summarized in Section V.

Claims Handling and Settlement

Testing of this focus area included requesting a population of mental health claim data and the supporting policies and procedures for the Period. The information requested included:

- A schematic process flow for processing behavioral health claims.
- The population of denied and zero-paid claim lines, which had a primary, secondary or tertiary behavioral health diagnosis. Zero-paid claims are defined as those matters involving instances where the service is covered, however, co-insurance applies or the member's deductible has not yet been met and therefore no payment was due by the Company.
- The Company's claim manual.

In response to the Examiners' requests, the Company provided a population of 367,110 denied and zero-paid claim lines which had a behavioral health diagnosis as outlined above. The Examiners developed samples approved in consultation with the Bureau and utilized Audit Control Language (ACL) to select a random sample of 130 denied and zero-paid claims using a 95% confidence level. The Examiners' methodology regarding the Company's claim adjudication practices included reviewing sampled claims as well as any prior or subsequent adjudication of the sample claim. The prior or subsequent claims may have included a payment or denial of the sampled claims. The claims were reviewed to ensure compliance with Maine Mental Health Parity Laws as outlined in Rider A. The Examiners also reviewed the member's insurance policy for each sampled claim to determine if mental health coverages and limits were at least equal to the member's medical benefits.

The Examiners also conducted interviews with Company representatives and received training from the Company related to the Company's systems to which the Examiners would need access. The results of the claims review are summarized in Section V.

Utilization Review and Pre-Authorization

Testing of this focus area involved requesting a population of utilization reviews (UR) and pre-authorization denials and the policies and procedures the Company had in place during the Period. The information requested included:

Utilization Review

- The Company's policies and procedures related to the Company's UR program in effect during the Period.
- A listing of all behavioral health-related claims having had a UR performed as well as the disposition of the claim as a result of the UR.
- A listing of all behavioral health utilization review peer reviewers, including authorization areas or limitations, as well as documentation to support each reviewer's qualifications.
- An overview of the process utilized to determine whether a reviewer's qualifications are appropriate, including any written policies or procedures for evaluating qualifications.

In response to the Examiners' data requests, the Company provided the requested documentation and a population of 37,082 URs performed. Of the 37,082 URs, 1,688 were for behavioral health services that had a partial or a full denial of coverage. The Examiners developed samples approved in consultation with the Bureau and utilized ACL to select a random sample of 43 denied requests using a 95% confidence level.

Anthem's UR files were reviewed to ensure compliance with Maine Mental Health Parity Laws as outlined in Rider A. Additionally, the Examiners reviewed Anthem's mental health UR processes in order to determine if the processes were equivalent to Anthem's UR medical processes.

Pre-Authorization

- The Company's policies and procedures for obtaining and documenting the receipt and disposition of treatment plans from providers (both participating and non-participating) in a timely manner.
- Written policies and procedures used by specialists in the review and documentation of pre-authorization requests, including denied pre-authorizations.
- A listing of all pre-authorization requests that were denied during the Period.
- A listing of all provider relations specialists in the Company and their authorization levels for approving behavioral health-related services.

In response to the Examiners' data requests, the Company provided the requested documentation and a population of 1,037 denied pre-authorization requests. The Examiners developed samples approved in consultation with the Bureau and utilized Audit Command Language (ACL) to select a random sample of 43 requests using a 95% confidence level.

Anthem's pre-authorization files were reviewed to test compliance with Maine's Mental Health Parity Laws as outlined in Rider A. Additionally, the Examiners reviewed the Company's mental health pre-authorization processes in order to determine if the processes were equivalent to Anthem's medical pre-authorization processes.

The Examiners also conducted interviews with Company representatives and reviewed the Company's responses. In addition, all requests denied for medical necessity were reviewed by an independent clinical peer reviewer. The results are summarized in Section V below.

Complaints, Appeals and Grievances

Testing of this focus area commenced with the Examiners requesting separate populations of complaints, appeals and grievances from the records or logs maintained by the Company and which only involved behavioral health matters. The terms appeals and grievances are used interchangeably throughout this Report. The Examiners also requested the related policies and procedures the Company had in place for the Period. Information requested from the Company to conduct the review of these areas included:

Complaints

- A copy of the written policy and procedures for processing complaints relating to residents of the State of Maine.
- A listing of training to educate the specialists on the Company's policies and procedures.
- The Company's general complaint log which included both complaints received from the Bureau and complaints from members and/or providers related to behavioral health.
- A listing of behavioral health pharmacy-related complaints received from the Bureau, members or providers.
- Complaint management reports.
- The Company's definition of a complaint as applied to complaints relating to residents of the state of Maine.
- A detailed explanation of the escalation/tiering process for complaints established by the Company.
- The description and composition of an established formal committee, which reviewed complaints specific to behavioral health services on a routine basis.

In response to the Examiners' data request, the Company provided the requested documentation and a listing of 658 complaints received during the Period. Of the 658 complaints, 87 were related to behavioral health issues. The Examiners developed samples approved in consultation with the Bureau and utilized ACL to select a random sample of 43 complaints using a 95% confidence level.

Also included in the scope of the Examination was testing of complaints to identify any matters related to pharmacy benefits. The Examiners confirmed that the Company maintained a complaint log for the Period and identified 51 pharmacy-related complaints. Of the 51 pharmacy-related complaints, five were identified as behavioral health. The Examiners tested all five (5) pharmacy complaints related to behavioral health for compliance with the state of Maine's mental health parity laws and other applicable rules and regulations. The results are summarized in Section V.

Appeals and Grievances

- Written policy and procedures for processing first and second level appeals and grievances for residents of the state of Maine.
- A complete log of all appeals and grievances related to behavioral health received from members and providers.
- The Company's definition of appeals and grievances as applied to those received in connection with residents of the state of Maine.
- A detailed explanation of the escalation/tiering process for appeals and grievances established by the Company.
- The description and composition of an established formal committee, which reviewed appeals and grievances specific to behavioral health services on a routine basis.

In response to the Examiners' data requests, the Company provided the requested documentation and a listing of 1,463 appeals (including administrative and clinical levels I and II).
The Examiners developed samples approved in consultation with the Bureau and utilized ACL to select a random sample of 43 appeals using a 95% confidence level.

The Examiners reviewed Anthem's mental health appeal procedures and related notices to determine whether they comply with Maine's requirements and whether the Company's procedures and notices for behavioral health appeals are equivalent to medical appeals procedures and notices.

The Examiners also conducted interviews with Company representatives and reviewed the Company's responses. In addition, complaints and appeals relating to claims or requests for authorizations for services denied for medical necessity were reviewed by an independent clinical peer reviewer. The results are summarized in Section V below.

Policyholder Services and Provider Network

Testing of this focus area involved requesting information related to policyholder services and provider network and the policies and procedures applicable during the Period. The information requested included:

Policyholder Services

- Written policies and procedures in place to ensure compliance with the new mental health parity requirements (Federal and state of Maine).
- Written policies and procedures provided to and used by the policyholder service representatives when responding to and documenting instances when an enrollee contacts the Company (verbally or in writing) for information on behavioral health matters.
- The Company's process, including the levels of review or escalation, for handling behavioral health inquiries (verbal or written).
- The number of inquiries (verbal or written) received per year related to behavioral health.
- A listing of all insurance policies (and certificates of coverage, where applicable) that were marketed to Maine residents.

Provider Network

- Copies of the provider directories (hard copy and electronic) for each year of the Examination.
- A description of the process used by the Company to ensure that the provider directory is accurate and up-to-date, including timelines for updating, adding and deleting providers from the directory.
- A listing of all provider contracts in effect during the Period.
- Policies and procedures for claims filing and any additional requirements applicable to providers filing behavioral health claims.
- A description of the methodology used by the Company (or an external vendor) to ascertain the Maximum Allowable Charges ("the Charges").
- A description of any differences in the determination of the Charges (in the calculation factors or percentages) for behavioral health services compared to those for general medical services and the rationale for differences, if any.
- Policies and procedures in place to verify whether the methodology for determining the Charges considered relevant information specific to the state of Maine such as whether there was sufficient data to constitute a representative sample of Charges for the same or comparable service.
- The process for updating the Charges in the Company's claims system and the frequency of the updates.
- The process used by the Company to audit whether the appropriate Charges were loaded into the system.

To review and test the accuracy of a provider's network status on the date of service, the Examiners utilized the random sample of 43 Pre-Authorization denials and requested that the Company supply a listing of providers contracted at any time during the Period.

The Examiners also determined the Company's compliance with the state of Maine's mental health parity laws and other applicable rules and regulations. The results are summarized in Section V.

As previously noted, in addition to reviewing the documentation and performing the testing discussed above, the Examiners also conducted interviews with Company representatives responsible for certain Anthem functional areas, including claims, complaints, appeals, pre-authorizations, UR, policyholder services and provider network.

SECTION V - RESULTS OF THE EXAMINATION

The Examination identified six (6) potential violations of Maine insurance laws. In addition, other findings were noted regarding inconsistencies in the Company's policies and procedures or represent the Examiners' observations for possible improvements in the Company's practices. The following summarizes the results of the Examination:

Company Operations and Management

No exceptions were noted.

Claims Handling and Settlement

The testing of a sample of 130 denied and zero-paid claims included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's general claim processing. Based on the review of the claim sample, the Examiners determined that during the Period, the Company did not impose any more restrictive filing requirements on providers who filed behavioral health related claims when compared to medical claim submissions.

Testing identified a potential violation regarding one (1) Maine statute. The Maine statute and the exception noted are as follows:

1. Title 24-A, Chapter 27, Section 2436 (1) reads in part:

1. A claim for payment of benefits under a policy or certificate of insurance delivered or issued for delivery in this State is payable within 30 days after proof of loss is received by the insurer and ascertainment of the loss is made either by written agreement between the insurer and the insured or beneficiary or by filing with the insured or beneficiary of an award by arbitrators as provided for in the policy. For purposes of this section, "insured or beneficiary" includes a person to whom benefits have been assigned. A claim that is neither disputed nor paid within 30 days is overdue.

One (1) of the 130 denied and zero-paid claims, or 0.8%, involved a potential violation of Title 24-A Chapter 27 §2436 (1). The error is explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Title 24-A, §2436 (1)	The Company incorrectly denied a behavioral health claim, in which it was determined the maximum allowable visits had been met. Upon review it was confirmed the benefit had not been met.	1	0.8%
TOTAL		**1**	**0.8%**

The Examiners investigated the above noted error and identified an additional ten (10) errors associated with the same member's claims, which were submitted in 2006. In these instances the Company incorrectly denied a behavioral health claim for which benefits were available for the member's policy. Please note these claims were not part of the Examiners' sample but were indentified in concert with the review of the claims from the sample, which were identified as an error. The Company provided documentation to the Examiners to confirm the claims had been reprocessed, however; the processing did not occur until 2010. Further, when the claims were reprocessed the payment amounts were appropriately applied to the member's deductible, which had not been met for the relevant timeframe.

Utilization Review and Pre-Authorization

Utilization Review

The testing of a sample of 43 UR claims that were denied included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's general processing. Based upon the results of the Examiners' testing of the sample UR population, it was determined that Anthem's UR processes for managing mental health benefits were equivalent to the Company's UR processes for managing medical benefits. No exceptions were noted.

Additional Observations

As part of the Examiners' review and at the request of the Bureau, the Examiners referred certain files that the Company denied for medical necessity to an Independent Peer Reviewer. The Examiners identified 34 UR files that were denied by the Company due to not meeting the medical necessity criteria as defined by the Company, and not overturned through the Company's appeal process. The complete files provided by the Company were reviewed and referred for peer-to-peer review.

In one (1) of the 34 UR files referred for Peer Review, or 2.9%, the Independent Peer Reviewer did not concur with the Company's decision to deny benefits, based on the medical information in the file. The Bureau has reviewed and evaluated the results of the Peer Review and will address the findings with the Company to determine any appropriate corrective actions which may be deemed necessary.

Pre-Authorization

The testing of a sample of 43 Pre-Authorization requests that were denied included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's policies and procedures. Based upon the results of the Examiner's testing of the sample of pre-authorizations, it was determined that Anthem's processes for pre-approval of mental health benefits were equivalent to Anthem's pre-authorization process for pre-approval of medical benefits. No exceptions were noted.

Additional Observations

The Examiners confirmed that the Company had policies and procedures in place requiring that Pre-Authorization denials be made by a qualified peer. With respect to behavioral health issues, a qualified peer, depending upon the situation, is described by the Bureau in Rider A as one that is in the provider's discipline and is equally qualified as the provider ordering the treatment or service. This would include but not be limited to a mental health professional (e.g., psychologist, psychiatrist or psychiatric nurse practitioner) or physician (e.g., M.D., D.O.).

As part of the Examiner's review and at the request of the Bureau, the Examiners referred certain files that the Company denied for medical necessity to an Independent Peer Reviewer. The Examiners identified 39 Pre-Authorizations that were denied by the Company for not meeting the medical necessity criteria as defined by the Company, and not overturned through the Company's appeal process. The complete files provided by the Company were reviewed and referred for peer-to-peer review.

In one (1) instance or 2.7%, of the Pre-Authorizations referred for Peer-to-Peer Review, the Independent Peer Reviewer was not able to conclude as to the appropriateness of the denial regarding the request for treatment based on the medical information in the file. The Bureau has reviewed and evaluated the results of the Peer Review and will address the findings with the Company and discuss any appropriate corrective action which may be necessary.

Complaints, Appeals and Grievance Handling

Complaints

The testing of a sample of 43 complaints included assessing the Company's compliance with applicable Maine statutes and testing the Company's complaint handling procedures. Testing identified one (1) potential violation of one (1) Maine statute. The error is explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Title 24-A § 2436 (1)	The Company overturned a decision related to the denial of a claim however; the claim was not paid within 30 days.	1	2.3%
TOTAL		**1**	**2.3%**

Pharmacy Complaints

No exceptions were noted.

Appeals

The testing of a sample of 43 appeals included assessing the Company's compliance with applicable Maine statutes and testing the Company's appeals processing procedures. Anthem's appeal process for mental health claim denials was determined to be equivalent to that related to medical claim denial appeals, based upon the results of the Examiner's review of the Company's processes. Testing identified four (4) potential violations of two (2) Maine statutes. The Maine Statutes and the exceptions noted are as follows:

In one (1) instance or 2.3% of the 43 appeals files reviewed, the Examiners identified a claim wherein the Company failed to pay the claim within 30 days.

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Title 24-A § 2436 (1)	The Company overturned a claim denial decision; however the claim was not paid within 30 days.	1	2.3%
TOTAL		**1**	**2.3%**

1. Testing of the Company's appeal logs identified three (3) potential violations of one Maine statute as follows:

Chapter 850, Section 9 A (1) reads:

"1) A health carrier shall maintain written records to document all grievances received during a calendar year (the register). Standard and expedited appeals pursuant to Section 8(G) of this rule shall not be considered a grievance for purposes of the grievance register. For each grievance the register shall contain, at a minimum, the following information:

a) A general description of the reason for the grievance;
b) Date received;
c) Date of each review or hearing;
d) Resolution at each level of the grievance;
e) Date of resolution at each level; and
f) Name of the covered person for whom the grievance was filed.

Violation #1:	The Administrative Appeal Logs for 2005 and 2006 do not contain the general description of the reason for the appeal as required by Chapter 850, Section 9A, 1(a). The log contained 315 appeals.
Violation #2:	The Clinical Second Level Appeal Logs for 2005-2008 do not contain the name of the covered person for whom the appeal was filed, as required by Chapter 850, Section 9A, l(f). The log contained 750 appeals.
Violation #3:	The Clinical Second Level Appeal Logs for 2005-2008 do not contain the date of each review or hearing, as required by Chapter 850, Section 9A 1(c). The log contained 398 appeals.

Additional Observations

1. The Company did not maintain a copy of the "further appeal rights through the independent external review process" notice in the appeal file in two (2) instances or 4.7% of the appeal files.
2. As part of the Examiners' review and at the request of the Bureau, the Examiners referred certain files that the Company denied for medical necessity to an Independent Peer Reviewer. The Examiners identified ten (10) appeals that were denied by the Company for not meeting the medical necessity criteria as defined by the Company, and not overturned through the Company's appeal process. The complete files provided by the Company were reviewed and then referred for peer-to-peer review.

Of the ten appeals sent for review, in one (1) instance, or 10%, the Independent Peer Reviewer disagreed with the Company's decision to uphold a claim denial without requesting additional information. The Bureau has reviewed and evaluated the results of the Peer Review and will address the findings with the Company and discuss any appropriate corrective action which may be necessary.

Policyholder Services and Provider Network

Policyholder Services

The testing of policyholder services involved assessing the Company's compliance with applicable Maine Statutes. The Company had separate policies, procedures and training on how to respond to behavioral health inquiries. No exceptions were noted.

Provider Network

The accuracy of a provider's network status on the date of service was tested through a review of the sample of 43 pre-authorization requests. The status of the provider as noted in the pre-authorization request file was compared to the network provider list for the date of request. No exceptions were noted.

Additional Observations

1. In addition to the testing performed, the Examiners identified a Maine Bureau of Insurance complaint from a member, which involved the Company's Provider Directory. Upon review, the Examiners confirmed that the Provider Directory was not updated in a timely manner for a second location where the physician practiced.

   Specifically, the physician, who had two office locations, provided the Company with a written notice to terminate from the network but the Company only updated the system for one of the two locations. As a result of the complaint, the Company processed a retroactive termination for the second location approximately one year later.

2. The Company's process for updating certain provider information was to rely on information submitted by providers, including submitting updated demographic information, which the Company used to make changes. The Company communicated this responsibility through provider contracts, periodic newsletters and the Behavioral Health Policy and Procedure Manual. In 2008, as part of a one-time project, the Company mailed letters to all participating providers to confirm that the demographic information on the Company's system was accurate and request any updates. Based upon information provided by the Company, approximately 60% of the providers submitted responses, some of which included updated information. The Company did not follow-up with those providers who did not respond.