STATE OF MAINE

BUREAU OF

INSURANCE

Docket No. MCINS 99-13

In re: UNITED HEALTHCARE INSURANCE COMPANY	))))	CONSENT AGREEMENT

This document is a Consent Agreement, authorized by 5 M.R.S.A. § 9053(2) entered into by and among United HealthCare Insurance Company , (hereafter also United HealthCare and the Superintendent of Insurance (hereafter "the Superintendent"). It's purpose is to resolve, without resort to an adjudicatory proceeding, violations of Bureau of Insurance Rule Chapter 850, hereafter also "Rule 850," as described below.

FACTS

1. The Superintendent of Insurance is the official charged with administering and enforcing Maine's insurance laws and regulations.
2. United HealthCare Insurance Company, license # LHF 700 has been licensed as a Life and Health Insurer in Maine since 1972.
3. United Healthcare employed HealthPlan Services, Inc., formerly known as Consolidated Group Inc., to administer claims from at least March of 1998, until at least July of 1998. HealthPlan Services is a licensed Third Party Administrator, license # TAF32930. United HealthCare is responsible for the acts of HealthPlan Services.
4. Consumer, whose true name has been omitted for protection of privacy, was insured, at all times relevant to this Consent Agreement, under a health insurance policy issued by United HealthCare.
5. Benefits under Consumer's policy are subject to Utilization Review. The policy provides that services and supplies proposed by the patient's Physician can be pre-approved as medically necessary by the Patient Advocate. The policy states, *"if you call the Patient Advocate before charges are incurred you will know which charges are Medically Necessary."* Charges determined not to be medically necessary are not covered expenses. Consumer's policy includes the following instruction for obtaining pre-authorization for medical services (emphasis added):

   - You must notify the Patient Advocate for any of the services shown below:
     - Confinement in any of the following facilities: A Hospital.
   - How to notify the Patient Advocate: The Patient Advocate is notified by call the toll-free number shown on your health insurance ID card.
   - The patient Advocate will ask for all of the following:
     - Medical information concerning the confinement, surgical procedure, diagnostic procedure or treatment plan.
     - Physician's name, phone number and address.
   - **The Patient Advocate will then complete the Utilization Review. You, your**

physician and the Hospital will be sent a letter confirming the results of the Review within 5 days of the date the Patient Advocate is notified.

6. Consumer's policy covers the following medically necessary transportation services.

   - By professional ambulance, other than air ambulance, to and from a hospital or medical facility.
   - By regularly scheduled airline, railroad or air ambulance, to the nearest hospital qualified to give the required treatment.

7. On **March 30, 1998** Consumer called HealthPlan Services to obtain authorization for transportation to a non local sleep disorder clinic recommended by her doctor. This phone call was required by, and in compliance with, her policy. Under the terms of the policy, set forth in paragraph 5, United HealthCare, through its representative, should have:

   a.) asked for information concerning the treatment plan;
   b.) requested the physicians name, phone number and address, and
   c.) completed a Utilization Review regarding the requested services.
   d.) The policy requires that the Consumer and the Hospital "will be sent a letter confirming the results of the Review within 5 days of the date the Patient Advocate is notified. Timely notice of Utilization Review decisions is also mandated by provisions of Rule 850, set forth below.

   > Rule 850(D)(3)(a). "A health carrier or the carrier's designated URE shall issue utilization review decisions in a timely manner pursuant to the requirements of subsection F,G and H.
   > (a) A health carrier or the carrier's designated URE shall obtain all information require to make a utilization review decision, including pertinent clinical information."
   >
   > Rule 850(8)(E)(2). "For initial determinations, a health carrier or the carrier's designated URE shall make the determination and so notify the covered person and their provider within 2 working days of obtaining all necessary information regarding a proposed procedure or service requiring a review determination. A carrier or the carrier's URE shall make a good faith effort to obtain all necessary information expeditiously, and is responsible for expeditious retrieval of necessary information in the possession of a person with whom the health carrier contracts."

8. The telephone logs from Consumer's **March 30, 1998**, call to HealthPlan Services documented that Consumer was initially informed on that date that transportation would only be covered for emergency purposes. In fact, as HealthPlan Services acknowledged by letter of May 13, 1998, "Consumer was correct in stating that the benefit booklet does not indicate that the ambulance service must be for 'emergency services' only."

9. The telephone logs from Consumer's **March 30, 1998**, call to HealthPlan Services also documented that Consumer was advised that "*if you can get a letter from your doctor of medical necessity……you need to send the letter to me and I can send this information to the carrier for a priority review*."
10. On or about **April 6, 1998**, Consumer filed a complaint with the Bureau of Insurance. The relevant portion of the complaint is set forth below.

    "I spoke with Louise at Health Plan Services on 3/30/98 re: the insurance company paying for transportation to a medical ctr. in another state (NH). She said it had to be "an emergency" to have the ins. co pay for trans. However, on pg. 54 of the manual, only "medically necessary trans. Services" is mentioned, & it falls under Comprehensive medical coverage. Clearly emergency services is not even indicated!"

11. The Bureau of Insurance forwarded the complaint to United HealthCare for a response on **April 10, 1998**.
12. On **April 23, 1998**, Consolidated Group Inc. (now HealthPlan Services) wrote to the Bureau of Insurance. This letter incorrectly stated that the Consumer had made a request for round trip ambulance service, when that had not in fact been requested. HealthPlan Services also improperly indicated the responsibility lay with the Consumer to obtain documentation that was the carrier's obligation to obtain under Rule 850(E)(2). Consumer's policy states the Patient Advocate will complete the Utilization Review and notify the patient the results within 5 days. Relevant excerpts of the April 23, 1998, letter are set forth below. (Emphasis added.)

    "Our records indicate that Consumer contacted our office on March 30, 1998, in an attempt to obtain pre-authorization for round trip ambulance transportation from her residence in Maine to a facility located in Vermont where she would undergo diagnostic sleep studies.
    The Comprehensive Medical Benefit section of the booklet indicates that this plan pays for medically necessary transportation services by professional Ambulance, other than air ambulance, to and from a hospital or medical facility; or by regularly scheduled airline, railroad or air ambulance, to the nearest hospital qualified to give the required treatment…
    Medical necessity was questioned by the customer service representative at the time of the inquiry. ***Consumer was advised that a letter of medical necessity from her physician should be submitted for further review by the carrier****. As of the date of this letter, we have not received any documentation related to this service. A letter of medical necessity for the sleep study should also include information as to why the nearest facility equipped to perform a sleep study is out of state and five hours away from [Consumer's] home.*

13. On **May 6, 1998**, the Bureau of Insurance wrote to Consolidated Group, requesting a copy of Consumer's health plan booklet along with all amendments and riders. Pursuant to 24-A § 220-A the carrier was required to respond to this request within 14 days.
14. On **May 12, 1998**, Consumer's provider sent a letter to Consolidated Group Inc. (now HealthPlan Services) addressing the need for sleep disorder treatment. An excerpt from this letter is set forth below.

"[Consumer] presented to [provider] stating a long standing history of sleep disorders…She states that she had previously been evaluated by two Maine physicians who have expertise in sleep disorders; however, all treatments thus far have apparently been unsuccessful. Because of the significant effect that [Consumer's] disorders have on the quality of her life, it has been deemed medically necessary for Consumer to be evaluated and treated at the [Sleep Disorder Clinic] as they have medical equipment that can provide adequate testing for Consumer–equipment that is not available to her in this state."

15. Rule 850(E)(2) requires a carrier conducting Utilization Review to expeditiously obtain any additional information it considers necessary, and respond to the consumer and provider within two days of receiving all necessary information. Neither Consumer nor provider received any response within two days to provider's May 12, 1998, letter.
16. On **May 13, 1998**, HealthPlan Services wrote to the Bureau of Insurance.

    "Consumer is correct in stating that the benefit booklet does not indicate that the ambulance service must be for "emergency" services only. However, the benefit booklet does state that benefits are available for Medically Necessary Transportation Services. For this reason we request a letter of medical necessity [for] any transportation services."

17. On **June 18, 1998**, the Bureau wrote to HealthPlan Services, again requesting a copy of the Consumer's health plan. A copy of Consumer's health plan which was first requested on May 6, 1998.
18. On **July 9, 1998**, over two months after it was requested, HealthPlan Services wrote to the Bureau of Insurance, enclosing a copy of Consumer's policy. The letter states, (emphasis added): *"I have reviewed the letter of medical necessity you included from [provider], however, this letter does not indicate the medical necessity <u>for an ambulance</u>. Therefore, we cannot authorize an ambulance for this service."* As discussed at paragraph 6, Consumer did not request authorization for an ambulance.
19. On **July 23, 1998**, HealthPlan Services wrote to the Bureau of Insurance stating, in relevant part:

    "In order to review Consumer's file we will need a letter explaining the medical necessity for transportation. We need to know why Consumer cannot transport herself from Maine to New Hampshire in order to perform the services she is in need of. Please indicate what form of transportation Consumer is requesting."
    Once this information is received, I will forward her file to the insurance carrier for review."

20. On or about **July 24, 1998**, the Bureau of Insurance wrote to HealthPlan Services, stating:

    "As I explained to you in our phone conversation of July 22, 1998, Consumer is not making a request for ambulance service. In accordance with her plan she is requesting coverage for the expense of transportation by either a regularly scheduled airline,

railroad or air ambulance…I am once again providing you with a copy of the letter from Consumer's doctor's office indicating the need for treatment at [Sleep Disorder Clinic]. Also, I am enclosing a copy of the message I received form her doctor's office, pursuant to your July 23rd letter, indicating that there are potential risks. Her ability to concentrate while driving such a long distance should be a concern. The mode of travel to New Hampshire can be determined fairly, I trust, by the plan's Patient Advocate…"

21. On or about **July 24, 1998**, the Bureau of Insurance forwarded [Provider's] July 23, 1998, letter regarding medical necessity for transportation to HealthPlan Services. [Provider's] letter stated:

    "Consumer has stated that she does not feel that she can safely transport herself to her out of state appointment for evaluation of her sleep disorders. I agree that there is a possible risk associated with her driving for such a distance for not only herself but for others on the road as well."

22. On **July 30, 1998**, HealthPlan Services wrote to the Bureau of Insurance, and acknowledged "*receipt of your letter and supporting documentation concerning the proposed transportation services for Consumer. All submitted material has been forwarded to the insurance carrier for review."*
23. On **August 21,1999**, HealthPlan Services notified Consumer of its adverse determination, stating:

    "The transportation is not required for diagnostic testing. The proposed transportation provides no medical services. It is also not the least intensive means of transportation. In addition, [Sleep Disorder Clinic] is not the nearest facility qualified to provide services related to sleep disorders. It has been determined that the benefits for transportation to the [Sleep Disorder Clinic] are not available under the plan."

    United HealthCare failed to acknowledge and address the May 12, 1998, letter from Consumer's provider, which clearly stated that the [Sleep Disorder Clinic] in New Hampshire has **"medical equipment that can provide adequate testing for Consumer– equipment that is not available to her in this state."**

24. In its letter of **August 21, 1998,** HealthPlan Services advised that the Consumer's policy clearly states, *"services and supplies proposed by your Physician can be pre-approved as Medically Necessary by the Patient Advocate. If you call the Patient Advocate before charges are incurred you will know which charges are Medically Necessary."* This is what Consumer attempted to do on March 30, 1998, when she called HealthPlan Services and spoke with customer representatives. At that time she was told transportation was not covered because it was not a life threatening emergency, a reason inconsistent with her policy.
25. In its **August 21, 1998** letter, after over four months of effort on the part of Consumer and the Bureau, HealthPlan Services denied the consumer's request on the ground of lack of medical necessity. The same letter states, *"the consumer has not initiated any formal request for a determination of benefits in regard to either the transportation or the*

testing/treatment to be rendered." As set forth below, this letter once again indicated that the request for coverage was not accompanied by certain listed information which had never been previously requested, and which the carrier was responsible for obtaining.

"In regards to the proposed treatment at [Sleep Disorder Clinic], there has been no request for a determination of the proposed services. No clinical documentation was submitted reflecting the specific testing/treatment to be rendered. Therefore, we cannot substantiate the medical necessity for the proposed services.
Consumer has not initiated any formal request for a determination of benefits in regards to either the transportation or the testing/treatment to be rendered.
- If Consumer wishes to do so, she may submit the following information:
Complete history/physical
- Prior evaluation and treatment for sleep disorder, diagnostic test results
- Specifics regarding what testing and treatment is proposed at [Sleep Disorder Clinic]
- Clinical documentation substantiating the proposed transportation meets *the above definition of medically necessary transportation services."*

26. The **August 21, 1998** letter from HealthPlan Services did not contain instructions for filing an appeal. This letter was an adverse determination notice and as such was required to comply with Rule 850(8)(E)(5), which provides:

    "A written notification of an adverse determination shall include the principal reasons or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rational, including the clinical review criteria used to make the determination. The notification must include a phone number the covered person may call for information on and assistance with initiating an appeal or reconsideration and/or requesting clinical rational and review criteria. The carrier or the carrier's designated URE shall respond expeditiously to such written requests."

27. On **September 10, 1998** the Bureau of Insurance wrote a detailed letter to United HealthCare explaining how, in the Bureau's view, Consumer's request for pre-authorization had been severely mishandled.
28. On **September 18, 1998** HealthPlan Services wrote: *"On July 30, 1998 I received all the information necessary in order to have this file reviewed. I sent you a letter stating all the information was sent to the carrier for review of medical necessity. I received a reply from the carrier and sent you a letter on August 21, 1998 stating that the carrier has reviewed the file and determined that the transportation was not medically necessary. They also indicated that in order to review the file to determine if the sleep study was medically necessary additional information was needed*."
29. This medical necessity determination took from 7/30/98 to 8/21/98. The adverse determination was sent 21 days after United HealthCare acknowledged it received "all information necessary in order to have this file reviewed."
30. Title 24-A M.S.R.A. § 4304(2) requires that, "requests by a provider for prior authorization of a non emergency service must be answered by the carrier within 2 business days. If the information submitted is insufficient to make a decision, the carrier

shall notify the provider within 2 business days of the additional information necessary to render a decision."

31. In response to an inquiry by the Bureau of Insurance concerning licensure, HealthPlan Services advised in its letter of **September 18, 1998** that, "HealthPlan Services is not a Utilization Review Entity therefore we cannot provide a license number. The Utilization Review Organization is Patient Advocate. However, this type of procedure does not require a review by Utilization review. Page 28 of Consumer's policy booklet lists all procedures which require a review by Patient Advocate…"
32. In its letter of **September 18, 1998**, HealthPlan Services stated in relevant part:

    "You state that Consumer did initiate a formal request for a determination of benefits. We have never received a written predetermination letter from her physician. A predetermination should include the procedure to be performed and any medial documentation to substantiate the proposed service. Therefore, we were not able to provide a written notification to Consumer, her physician or yourself."

33. United HealthCare sent the Bureau of Insurance a letter post-marked **October 7, 1998**, indicating that its relationship with HealthPlan Services had ended in June of 1998. Excerpts from this letter are set forth below.

    "Thank you for bringing this matter to United HealthCare's attention. I have reviewed this matter and have determined that Health Plan Services (HPS) no longer has a relationship with United HealthCare (UHC) as of approximately June 1998 in the state of Maine…In our relationship with HPS, all utilization review decisions were to be made by United HealthCare. My review indicates HPS sent the file to UHC for review. The resolution revealed more documentation was needed to make a benefit determination. Thus, we are very concerned about these charges.
    We would like to expedite this matter. UHC will request the documentation from the physician/member and obtain all the necessary information relative to determine benefit coverage. Medical necessity guidelines will be reviewed by Unite HealthCare upon receipt of Consumer's file."

34. On **October 12, 1998,** United HealthCare sent a letter to the Consumer again requesting more information from the Consumer. Excerpts from this letter are set forth below.

    "We have no clinical information to substantiate the medical indication for the proposed sleep study. There is an indication in the record that you have been evaluated and treated by two local physician. The clinical information form you previous providers is not available for review. Information that should be submitted to support the reason for the requested test should include a current history and physical examination, your physician's explanation of a rationale for the current proposed testing as well as a clarification of what specific testing is proposed to be performed at [Sleep Disorder Clinic] that can not be performed at a local facility."…..We would like the opportunity to proceed with the evaluation of your request. To do so, please submit the following medical information within sixty (60) days of receipt of this notice:
    - Complete history and physical

- Complete medical record form your previous providers to include medical evaluations And results of treatment for sleep disorders, diagnostic test results
- Specifics regarding what testing and treatment is proposed at [Sleep Disorder Clinic]
- Documentation to support that [Sleep Disorder Clinic], a facility located five hours from you, is the closest facility available to perform the specific required testing.

35. On **November 12, 1998** United HealthCare sent a letter to the Consumer, again advising the Consumer that they required additional information. The letter states:

"*We have received a response to the October 14, 1998 letter from the [provider]. The physician's office explained that there was no record of your previous sleep work up at the [provider's] practice as they had not performed any of the previous testing. They advised that you will have to provide that documentation from your other physicians to support the need for your requested testing."*

CONCLUSIONS

36. United HealthCare is responsible for the acts of its subcontractor, HealthPlan Services.
37. As set forth in paragraphs 8,10, and12, United HealthCare violated Title 24-A M.R.S.A. § 2153 by misrepresenting the terms of Consumer's policy.
38. As set forth in paragraphs 9,12, 16, 18, 19, 25, 31, and 32, United HealthCare and HealthPlan Services failed to correctly explain what Consumer was required to do to obtain pre-certification of benefits.
39. As set forth in paragraphs 9, 12, 16, 18, 19, 25, 28, 32, 34, and 35, United HealthCare violated Rule 850(8)(E)(2) and the terms of its own policy by repeatedly advising Consumer that it was her obligation , rather than United HealthCare's, to obtain medical documentation. United HealthCare did not make a good faith effort to obtain all necessary information expeditiously.
40. As set forth in paragraphs 23-26, United HealthCare violated Rule 850(8)(E)(2), by failing to provide a written notification of adverse determination that included the principal reasons for the determination, the instructions for initiating an appeal for reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination.
41. United HealthCare failed to communicate with Consumer and her provider in a timely manner. In particular, United HealthCare failed to comply with the requirements of 24-A M.S.R.A. § 4304(2), which requires that, "requests by a provider for prior authorization of a non emergency service must be answered by the carrier within 2 business days. If the information submitted is insufficient to make a decision, the carrier shall notify the provider within 2 business days of the additional information necessary to render a decision." See paragraphs 14 – 16, and 21-35.
42. United HealthCare failed to adequately or timely respond to the Bureau of Insurance, in violation of Title 24-A M.R.S.A. § 220(2). See paragraphs 13, 17, and 18.
43. As the facts set forth above chronicle, United HealthCare failed to fulfill its obligations under Rule 850 and under its policy. Despite extensive efforts by both the Consumer and the Bureau, the issue of pre-certification was not resolved for over six months.

COVENANTS

44. United HealthCare agrees to the imposition of a civil penalty of $20,000 for the violation recited above, pursuant to Title 24-A M.R.S.A. §§ 12-A(1), and shall submit a check for $20,000, payable to the Treasurer of the State of Maine, at the time of the execution of this Agreement.

MISCELLANEOUS

45. United HealthCare 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 for by 1 M.R.S.A. § 408.
46. 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.
47. United HealthCare has been advised of its right to consult with counsel and has, in fact, consulted with counsel before executing this agreement.

Dated: _____

For: United HealthCare

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