[IN ACCORDANCE WITH CALIFORNIA INSURANCE CODE (CIC) SECTION 12938, THIS REPORT WILL BE MADE PUBLIC AND PUBLISHED ON THE CALIFORNIA DEPARTMENT OF INSURANCE (CDI) WEBSITE]

WEBSITE PUBLISHED REPORT OF THE MARKET CONDUCT EXAMINATION OF THE CLAIMS PRACTICES OF

DENTISTS INSURANCE COMPANY (THE)
NAIC # 40975 CDI # 2361-4

AS OF JULY 31, 2013

ADOPTED DECEMBER 22, 2014

STATE OF CALIFORNIA

CALIFORNIA DEPARTMENT OF INSURANCE

MARKET CONDUCT DIVISION

FIELD CLAIMS BUREAU

NOTICE

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code (CIC) describe the Commissioner's authority and exercise of discretion in the use and/or publication of any final or preliminary examination report or other associated documents. The following examination report is a report that is made public pursuant to California Insurance Code Section 12938(b)(1) which requires the publication of every adopted report on an examination of unfair or deceptive practices in the business of insurance as defined in Section 790.03 that is adopted as filed, or as modified or corrected, by the Commissioner pursuant to Section 734.1.

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DEPARTMENT OF INSURANCE
Consumer Services and Market Conduct Branch
Field Claims Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013

December 22, 2014

The Honorable Dave Jones
Insurance Commissioner
State of California
300 Capitol Mall
Sacramento, California 95814

Honorable Commissioner:

Pursuant to instructions, and under the authority granted under Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claims handling practices and procedures in California of:

Dentists Insurance Company (The)
NAIC # 40975

Hereinafter, the Company listed above also will be referred to as TDIC or the Company.

This report is made available for public inspection and is published on the California Department of Insurance website (www.insurance.ca.gov) pursuant to California Insurance Code section 12938(b)(1).

FOREWORD

The examination covered the claims handling practices of the aforementioned Company on commercial property, professional liability and workers' compensation claims closed during the period from August 1, 2012 through July 31, 2013, and on a subset of workers' compensation claims that remained open as of August 1, 2011.

The examination was made to discover, in general, if these and other operating procedures of the Company conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law.

The report is written in a "report by exception" format. The report does not present a comprehensive overview of the subject insurer's practices. The report contains a summary of pertinent information about the lines of business examined, details of the non-compliant or problematic activities that were discovered during the course of the examination and the insurer's proposals for correcting the deficiencies. When a violation that reflects an underpayment to the claimant is discovered and the insurer corrects the underpayment, the additional amount paid is identified as a recovery in this report. While this report contains violations of law that were cited by the examiner, additional violations of CIC § 790.03, or other laws, not cited in this report may also apply to any or all of the non-compliant or problematic activities that are described herein.

All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or in other jurisdictions does not constitute acceptance of such practices.

Alleged violations identified in this report, any criticisms of practices and the Company's responses, if any, have not undergone a formal administrative or judicial process.

SCOPE OF THE EXAMINATION

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Company for use in California including any documentation maintained by the Company in support of positions or interpretations of the California Insurance Code, Fair Claims Settlement Practices Regulations, and other related statutes, regulations and case law used by the Company to ensure fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual claims files and related records.

3. A review of the California Department of Insurance's (CDI) market analysis results; a review of consumer complaints and inquiries about this Company closed by the CDI during the period August 1, 2012 through July 31, 2013; a review of previous CDI market conduct claims examination reports on this Company; and a review of prior CDI enforcement actions.

The review of the sample of individual claims files was conducted at the offices of the Company in Sacramento, California.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The commercial property, professional liability and workers' compensation claims reviewed were closed from August 1, 2012 through July, 2013, referred to as the "review period". The examiner randomly selected 145 TDIC claims files for examination. In the workers' compensation claims category, the examiner randomly selected 50 closed claims and 20 open claims which remained open as of August 1, 2011. The Company delegates the adjustment of its workers' compensation claims to Sedgwick Claims Management Services, a third party administrator referred to in this report as the TPA. The examiner cited 41 alleged claims handling violations of the California Insurance Code and the California Code of Regulations from this sample file review.

Of the 41 alleged violations cited, the examiner alleges 12 violations related to the utilization review process in workers' compensation claims. Utilization review is a process whereby the Company evaluates the medical treatment services recommended by the physician to determine if the services are medically necessary to cure or relieve the claimant's condition. Details regarding these allegations are provided in the Summary of Examination Results, section number 12(a).

Other findings of this examination included the failure to process medical bills correctly, failure to include statutorily mandated self-imposed penalties owed as a result of delays and failure to fully explain the basis for depreciation applied to property.

RESULTS OF REVIEWS OF MARKET ANALYSIS, CONSUMER COMPLAINTS AND INQUIRIES, PREVIOUS EXAMINATIONS, AND PRIOR ENFORCEMENT ACTIONS

The Company was the subject of four California consumer complaints and inquiries closed from August 1, 2012 through July 31, 2013, in regard to the commercial property and professional liability lines of business. Workers' compensation complaints are filed with the California Division of Workers' Compensation (DWC) are not included in this report. Of the complaints and inquiries, the CDI determined that no complaints were justified.

The previous claims examination reviewed a period from September 1, 2000 through August 31, 2001. The most significant non-compliant issues identified in the previous examination report were the Company's failure to provide written notice of the need for additional time every 30 calendar days and the failure to accept or deny the claim within 40 calendar days. These issues were not identified as problematic in the current examination.

There has been no prior enforcement action on the Company by the California Department of Insurance.

DETAILS OF THE CURRENT EXAMINATION

Further details with respect to the examination and alleged violations are provided in the following tables and summaries:

TDIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	**CLAIMS IN REVIEW PERIOD**	**SAMPLE FILES REVIEWED**	**NUMBER OF ALLEGED VIOLATIONS**
Commercial Property	1,119	50	21
Professional Liability	522	25	0
Workers' Compensation / Medical Only / Closed	304	20	7
Workers' Compensation / Medical Only / Open	115	10	0
Workers' Compensation / Indemnity / Closed	43	20	6
Workers' Compensation / Indemnity / Open	166	10	7
Workers' Compensation / Denied	36	10	0
TOTALS	**2,305**	**145**	**41**

TABLE OF TOTAL ALLEGED VIOLATIONS

Citation	Description of Allegation	TDIC Number of Alleged Violations
CIC §790.03(h)(2)	The Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.	13
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	8
CCR §2695.9(f) *[CIC §790.03(h)(3)]	The Company failed to fully explain the basis for any adjustment to the claimant in writing.	7
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation.	4
CCR §2695.9(f)(1) *[CIC §790.03(h)(3)]	The Company improperly applied depreciation or betterment to the expense of labor necessary to repair, rebuild or replace covered property.	3
CCR §2695.3(a) *[CIC §790.03(h)(3)]	The Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed.	1
CCR §2695.4(a) *[CIC §790.03(h)(1)]	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	1
CCR §2695.7(b)(3) *[CIC §790.03(h)(3)]	The Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance.	1
CCR §2695.7(c)(1) *[CIC §790.03(h)(3)]	The Company failed to specify, in the written notice, any additional information the insurer requires to make a claim determination and to state any continuing reasons for the Company's inability to make a determination.	1
CCR §2695.7(p) *[CIC §790.03(h)(3)]	The Company failed to provide written notification to a first party claimant as to whether the insurer intends to pursue subrogation.	1
CCR §2695.7(p) *[CIC §790.03(h)(3)]	The Company failed to provide written notification to a first party claimant of its decision to discontinue pursuit of subrogation.	1
Total		**41**

*DESCRIPTONS OF APPLICABLE UNFAIR CLAIMS SETTLEMENT PRACTICES

CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

TABLE OF ALLEGED VIOLATIONS BY LINE OF BUSINESS

COMMERCIAL PROPERTY **2012 Written Premium: $11,244,560** **AMOUNT OF RECOVERIES $4,034.87**	**NUMBER OF ALELGED VIOLATIONS**
CCR §2695.9(f) [CIC §790.03(h)(3)]	7
CCR §2695.7(d) [CIC §790.03(h)(3)]	4
CCR §2695.9(f)(1) [CIC §790.03(h)(3)]	3
CIC §790.03(h)(5)	1
CCR §2695.3(a) [CIC §790.03(h)(3)]	1
CCR §2695.4(a) [CIC §790.03(h)(1)]	1
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	1
CCR §2695.7(c)(1) [CIC §790.03(h)(3)]	1
CCR §2695.7(p) [CIC §790.03(h)(3)]	1
CCR §2695.7(p) [CIC §790.03(h)(3)]	1
SUBTOTAL	**21**

PROFESSIONAL LIABILITY **2012 Written Premium: $26,597,182** **AMOUNT OF RECOVERIES $0**	**NUMBER OF ALLEGED VIOLATIONS**
SUBTOTAL	**0**

WORKERS' COMPENSATION 2012 Written Premium: $10,559,987 AMOUNT OF RECOVERIES $302.05	NUMBER OF ALLEGED VIOLATIONS
CIC §790.03(h)(2)	13
CIC §790.03(h)(5)	7
SUBTOTAL	**20**

TOTAL	41

SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report.

In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. The Company is obligated to ensure that compliance is achieved.

Any noncompliant practices identified in this report may extend to other jurisdictions. The Company was asked if it intends to take appropriate corrective action in all jurisdictions where applicable. The Company intends to implement corrective actions in all jurisdictions.

Money recovered within the scope of this report was $4,336.92 as described in sections number 4 and 12 below.

COMMERCIAL PROPERTY

1. In seven instances, the Company failed to fully explain the basis for any adjustment to the claimant in writing. The Department alleges these acts are in violation of CCR §2695.9(f) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: In the noted instances, the Company agrees it failed to fully explain the basis for depreciation to the policyholder in writing. As a result of this examination, the Company incorporated procedures to provide written explanations of depreciation to policyholders. The Company has informed the independent adjusters handling property losses to incorporate the procedures immediately. Additionally, the Company provided training to the claims staff in how to communicate depreciation to the policyholder that is explicit, complete and in writing. This was also included as part of procedures in the Claims Service Manual as of July 1, 2014. Formal training for the claims staff on the entire subject of depreciation was completed by September 1, 2014. These changes were announced to the claims staff and were implemented immediately, as a result of the examination.

2. <u>In four instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation.</u> The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

a) In two instances, the Company instructed the insured to have the malfunctioning equipment inspected by a repair company to determine the cause of the failure. The insured was to bear the cost of the inspection but would be reimbursed if the Company determined the loss was covered. Additionally, the insured was to submit a statement from the repair company explaining the actual physical damage to each piece of equipment. The onus of the investigation was placed on the insured along with the cost of determining the cause of loss.

b) In one instance, the file was void of any investigative activity for a period of six weeks.

c) In the remaining instance, the insured was advised that the Company could not proceed with its investigation and evaluation of the claim until the insured provided a copy of the police report.

<u>Summary of the Company's Response:</u> The Company provided the following responses concerning these issues.

a) Instructing the insured to obtain their own inspection at their expense is not consistent with the investigative procedures of the Company. Currently, the coverage for Equipment Breakdown is through Hartford Steam Boiler (HSB) and the representation was made by its representative. However, the claims are reported to TDIC and the TDIC claims representative should have intervened with HSB. Beginning July 1, 2014, TDIC will begin direct-writing Equipment Breakdown coverage in order to have total control over the adjustment of these losses. In the interim, the Company will work with HSB to prevent further issues.

b) In this instance, there was no additional information needed from the insured. However, the letter should have given the insured a status on the investigation, why it was continuing and an approximate resolution date. Currently, the coverage for Equipment Breakdown is through HSB and the investigation was made by its representative. However, the claims are reported to TDIC and the TDIC claims representative should have been insistent that HSB provide TDIC with a status of the investigation to relate to the insured. Beginning July 1 2014, TDIC will begin direct-writing Equipment Breakdown coverage in order to have total control over the adjustment of these losses. In the interim, the Company will work with HSB to prevent further issues.

c) It is Company procedure to obtain a report directly from the relevant law enforcement agency. In the event that this information may only be released to the victim, i.e., the insured, the Company will reimburse the insured for the cost to obtain this report. If the insured already possesses a copy of the report, the Company

provides reimbursement of the cost incurred by the insured, if any. The Company communicated the appropriate process with the claims staff at the most recent claims staff meeting (October 10, 2013). In addition, the Company will add this item to the property claim review process for manager review of property claim files.

3. In three instances, the Company improperly applied depreciation or betterment to the expense of labor necessary to repair, rebuild or replace covered property. The Department alleges these acts are in violation of CCR §2695.9(f)(1) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: Depreciation was improperly taken on labor costs which is not consistent with Company adjustment policy. In the identified instances, the Company paid recoverable depreciation which included the amount that was depreciated for labor. The Company will ensure that this does not occur in the future by evaluating this issue and directing the vendors as well as educating internal staff on what constitutes appropriate depreciation. The Company claims manual has a section on what constitutes "actual cash value" and it is not specific enough on the actual depreciation calculation. This section will be revised by July 1, 2014, to be more specific to this issue. The claims staff has been made aware of this issue through regular staff meetings where the results of the audit were discussed in December 2013. Formal training on appropriate depreciation practices and communications with insureds will take place by September 1, 2014.

4. In one instance, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. Specifically, in a commercial property claim, the Company failed to pay for the repairs to the building. The Department alleges this act is in violation of CIC §790.03(h)(5).

Summary of the Company's Response: As a result of the examination, the Company has issued a payment to the insured in the amount of $4,034.87. This amount represents the cost to repair the damaged property subject to the insured's $1,000 deductible.

5. In one instance, the Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed. The Department alleges this act is in violation of CCR §2695.3(a) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The file does lack documentation from HSB on the investigation process and its outcome. While HSB was conducting the investigation it does not absolve TDIC of the responsibility to be insistent with the HSB representative in providing those details. Currently, the coverage for Equipment Breakdown is through HSB and the investigation was made by its representative. However, the claims are reported to TDIC and the TDIC claims representative should have been insistent that HSB provide TDIC with a status of the investigation to relate to

the insured. Beginning July 1 2014, TDIC will begin direct-writing Equipment Breakdown coverage in order to have total control over the adjustment of these losses. In the interim, the Company will work with HSB to prevent further issues.

6. In one instance, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. Specifically, the Company failed to inform the insured of the time limit in which to recover depreciation. The Department alleges this act is in violation of CCR §2695.4(a) and is an unfair practice under CIC §790.03(h)(1).

Summary of the Company's Response: The Company has provided training to the claims staff in appropriate depreciation determination and communication. This included communicating to the policyholder the time limitation in which additional documentation can be provided to obtain full replacement value. Formal training for the claims staff on the entire subject of depreciation will take place no later than September 1, 2014.

7. In one instance, the Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance. The Department alleges this act is in violation of CCR §2695.7(b)(3) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with the Department's criticism in this isolated instance. The failure to include the required statement in the denial letter was an oversight by the handling adjuster. It is the Company's policy to always include a statement in the claim denial that the claimant may have the matter reviewed by the California Department of Insurance including the contact information for the department. Proper procedure has been reviewed with pertinent claims staff.

8. In one instance, the Company failed to specify, in the written notice, any additional information the insurer requires to make a claim determination and to state any continuing reasons for the Company's inability to make a determination. The Department alleges this act is in violation of CCR §2695.7(c)(1) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: In this instance, there was no additional information needed from the insured. However, the letter should have given the insured a status on the investigation, why it was continuing and an approximate resolution date. Currently, the coverage for Equipment Breakdown is through HSB, and the investigation was made by its representative. However, the claims are reported to TDIC and the TDIC claims representative should have insisted that HSB provide TDIC with a status of the investigation to relate to the insured. Beginning July 1, 2014, TDIC will begin direct-writing Equipment Breakdown coverage in order to have total control

over the adjustment of these losses. In the interim, the Company will work with HSB to prevent further issues.

9. <u>In one instance, the Company failed to provide written notification to a first party claimant as to whether the insurer intends to pursue subrogation.</u> The Department alleges this act is in violation of CCR §2695.7(p) and is an unfair practice under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company acknowledges that it did not provide the proper notification with regard to subrogation. Training was conducted on December 12, 2013, to reinforce the importance of providing the insured with written confirmation of the Company's intent to pursue or not to pursue subrogation.

10. <u>In one instance, the Company failed to provide written notification to a first party claimant of its decision to discontinue pursuit of subrogation.</u> The Department alleges this act is in violation of CCR §2695.7(p) and is an unfair practice under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company acknowledges that it did not provide the proper notification with regard to subrogation. Training was conducted on December 12, 2013, to reinforce the importance of providing the insured with written confirmation of the Company's intent to pursue or not to pursue subrogation.

<u>PROFESSIONAL LIABILITY</u>

There were no violations alleged or criticisms of insurer practices made within the scope of this report with regard to this line of business.

<u>WORKERS' COMPENSATION</u>

11. <u>In 13 instances, the Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.</u> The Department alleges the Company failed to comply with LC §4610, 8CCR §§9792.9 and 9812. The Department alleges these acts are in violation of CIC §790.03(h)(2).

a) In 12 instances, the Company failed to provide a timely utilization review determination as required by LC §4610 and 8CCR §9792.9.

b) In one instance, the Company failed to issue timely a benefit notice advising the claimant no permanent disability exists, as required by 8CCR §9812(g)(3).

Summary of the Company's Response:

a) In nine of the 12 instances, the Company agrees that the TPA failed to comply with the requirement of the referenced Labor Code and California Code of Regulations. In August 2012, the Company's Utilization Review (UR) unit initiated a plan that would ensure the prompt rendering of UR decisions. The plan was implemented in 2013 and includes the following procedures:

1) In 2013, UR established an efficiency project with the oversight of Senior Management to address ways to increase UR efficiency and timeliness in determinations.
2) UR has a project team that meets weekly to address the processes and to walk through technology enhancements that have been made to reduce late URs. Multiple software enhancements have been rolled out in 2013 to facilitate the process.
3) UR increased staff by 13% to address the volume of incoming URs.
4) Since the implementation date of January 1, 2013, UR has been successful in decreasing late URs to less than .5%.

In the remaining three instances, the Company believes the requests for authorization were technically handled in accordance with the regulation/code. The Company acknowledges that the TPA could have taken a more pro-active approach to its claims handling rather than focus solely on regulatory compliance. The Company met with the TPA's management team on March 11, 2014, to review the findings of the examination. The TPA was instructed to use a common sense, service oriented approach and not to rely exclusively on technicalities. In these instances, the technical question of the validity of the authorization resulted in an unnecessary delay when the intent and surrounding factors were clear. The TPA responded positively to the Company's instruction and will act to handle claims accordingly.

b) The Company acknowledges the instance regarding the TPA's failure to provide a timely benefit notice that no permanent disability exists. The Company states this is an isolated error. As a corrective measure, the Company discussed benefit notice requirements directly with the TPA's adjuster who handled this claim and with the TPA's management personnel during a post-examination meeting on March 11, 2014.

12. In seven instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The Department alleges the Company failed to comply with Labor Code §4603.2. The Department alleges these acts are in violation of CIC §790.03(h)(5).

a) In three instances, the TPA failed to process medical bills within 45 working days as required by LC §4603.2(b)(1). Specifically, in one instance the TPA incorrectly denied a bill as a duplicate. The bill was paid after the TPA received a

request for reconsideration from the provider. In another instance, the TPA received a medical bill but did not forward the bill to its medical review unit for approximately 135 days. In the final instance, the provider submitted a medical bill to the TPA for processing and the bill was paid 103 days later.

b) In the three instances referenced above, the Company failed to include statutory self-imposed penalty and interest when owed as required by LC §4603.2(b)(1).

c) In one instance, the TPA received a faxed medical report from the provider for services provided. The bill associated with this medical service was subsequently submitted for payment. The TPA contested the bill citing that a report was required in order to process the bill.

Summary of the Company's Response:

a) In the first instance, a medical bill was received and returned to the provider with an explanation that it was a duplicate bill. There is no information available to explain why the bill was flagged as a duplicate. The bill was resubmitted for payment and payment was issued 174 days from the date of the original submission. The TPA states that it did not violate the regulations in the handling of this medical bill. However, TDIC acknowledges that there was a delay in payment to the medical provider due to an error in processing by the TPA. As a remedial measure, the TPA has agreed to pay interest and penalties to the medical provider, as explained in subsection b) below.

In the second instance, the payment was not issued within the regulatory timeframe as it was not submitted to the bill review unit timely. The TPA has no explanation for the delay. The TPA acknowledges that this bill was not paid in a timely manner. In this particular instance, the TPA was unable to determine the reason the bill was not sent to bill review when it was initially received. As a remedial measure, the TPA has issued a check to the vendor for penalty and interest. In addition, the following steps were recently instituted by the TPA to ensure timely payment of medical bills:

1) New examiners, upon hire, receive thorough training on the imaging system and on the bill review process prior to being placed on an active desk.

2) The TPA's Assistant Vice-President of Claims receives a report each week listing every examiner and the number of documents outstanding with the age of the documents. The TPA's internal goal is to have no outstanding mail over 10 days old. This report allows the TPA to identify, on a weekly basis, that an examiner needs assistance in getting mail current and ensures that bills are being processed within the statutory timeframe. Recently generated reports have shown that the goals of the TPA have been met with regard to the objective of having mail handled within 10 days of receipt.

In the third instance, the provider sent the bill to the incorrect handling office of the TPA, who has multiple locations throughout California. It is the TPA's position that the delay in payment occurred due to provider error in submitting the bill. While the TPA was technically correct in the handling of this medical bill, TDIC acknowledges that the TPA could take a more pro-active approach to its claims handling rather than to focus solely on regulatory compliance. As a remedial measure, the TPA has agreed to pay interest and penalties to the medical provider.

b) In two of the three instances identified in subsection a) above, the TPA states that it believes it did not violate the referenced regulation/code in the handling of the medical bill. However, the Company acknowledges that there were delays in payment to the medical providers due to an error in processing by the TPA. The Company has instructed the TPA to pay interest and penalties to the medical provider. In the third and final instance identified in subsection a) above, the TPA acknowledges that penalty and interest should have been paid. As a remedial measure for all three instances, the TPA issued three payments for penalty and interest to the providers totaling $40.41

c) The bill from the provider was received with no report attached as required by LC §4603.2(b)(1), which states [quoted from the Company's response]:

> Any provider of services including but not limited to physicians, hospitals, pharmacies, interpreters, copy services, transportation services, and home health care services, SHALL [emphasis added] submit its request for payment with an itemization of services provided and the charge for each service, a copy of all reports showing the services performed...

In this particular case the bill was received without a report attached as required. The examiner objected timely to the bill advising the bill needed to be submitted with a report attached. To-date, the TPA has been unable to locate a resubmission or appeal from the provider in response to the objection. Therefore, the TPA believes this bill was managed appropriately. The TPA handled the medical bill technically in accordance with the regulations. However, TDIC acknowledges that the TPA could take a more pro-active approach to its claims handling rather than to focus solely on regulatory compliance. As a remedial measure, the TPA issued payment to the medical provider for the bill, plus interest and penalties, totaling $261.64.