

**[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**

**PREFERRED EMPLOYERS INSURANCE COMPANY
NAIC # 10900 CDI # 4525-2**

AS OF SEPTEMBER 30, 2014

ADOPTED OCTOBER 22, 2015

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



October 22, 2015

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:

**Preferred Employers Insurance Company
NAIC # 10900**

Group NAIC # 0098

Hereinafter, the Company listed above also will be referred to as PEIC 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 Workers' Compensation claims closed during the period from October 1, 2013 through September 30, 2014, and claims open as of September 30, 2014. 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 in this report by the examiners, 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 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 October 1, 2013 through September 30, 2014; a review of previous CDI market conduct claims examination reports on the 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 Walnut Creek, California.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The Workers' Compensation claims reviewed were both open and closed claims with the date of injury no earlier than October 1, 2012. The closed claims reviewed were closed from October 1, 2013 through September 30, 2014. The open claims reviewed were open as of September 30, 2014. The examiners randomly selected 70 claim files for examination, 39 of which contained utilization review referrals. The examiners cited 48 alleged claims handling violations of the California Insurance Code and the California Code of Regulations from this sample file review.

Findings of this examination included the failure to correctly pay or object to medical treatment expenses; failure to include statutory self-imposed penalty and interest due to delayed processing of medical bills; and failure to process medical bills correctly. Details are provided in the Summary of Examination Results section of this report.

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 with respect to alleged violations pertaining to utilization review are also provided in the Summary of Examination Results.

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

The review of market analysis and consumer complaint information identified no specific areas of concern.

The previous claims examination reviewed a period from July 1, 1998 through June 30, 1999. There was no specific area of concern identified in the previous claims examination.

DETAILS OF THE CURRENT EXAMINATION

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

PEIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED VIOLATIONS
Workers Compensation / Medical Only [Closed]	1,392	20	8
Workers Compensation / Medical Only [Open]	240	10	3
Workers Compensation / Indemnity [Closed]	505	20	14
Workers Compensation / Indemnity [Open]	1,065	10	23
Workers Compensation / Denied	216	10	0
TOTALS	3,418	70	48

TABLE OF TOTAL ALLEGED VIOLATIONS

Citation	Description of Allegation	PEIC Number of Alleged Violations
*CIC §790.03(h)(5)	The Company failed to correctly pay or object to medical treatment expenses.	17
*CIC §790.03(h)(5)	The Company failed to include statutory self-imposed penalty and interest due to delayed processing of medical bills.	13
*CIC §790.03(h)(5)	The Company failed to process medical bills correctly.	8
*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.	5
*CIC §790.03(h)(2)	The Company failed to issue timely benefit notices.	3
*CIC §790.03(h)(2)	The Company failed to timely respond to a request to provide or authorize medical treatment.	1
*CIC §790.03(h)(5)	The Company failed to calculate and reimburse mileage expenses correctly.	1
Total Number of Alleged Violations		48

***DESCRIPTONS OF APPLICABLE
UNFAIR CLAIMS SETTLEMENT PRACTICES**

- | | |
|-------------------|--|
| CIC §790.03(h)(2) | The Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies. |
| 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. |
| CIC §790.03(h)(5) | The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear. |

TABLE OF ALLEGED VIOLATIONS BY LINE OF BUSINESS

<p align="center">WORKERS COMPENSATION 2014 Written Premium: \$132,781,198</p> <p>AMOUNT OF RECOVERIES \$7,768.40</p>	<p align="center">NUMBER OF ALLEGED VIOLATIONS</p>
CIC §790.03(h)(5)	39
CIC §790.03(h)(2)	4
CIC §790.03(h)(3)	4
CIC §790.06(g)(2)(B) [CIC §790.03(h)(3)]	1
SUBTOTAL	48
TOTAL	48

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.

As a result of the examination, money recovered for claimants totaled \$7,768.40 as described in section number one below.

WORKERS COMPENSATION

1. **In 39 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 (LC) §4600 and §4603.2. The Department alleges these acts are in violation of CIC §790.03(h)(05).

- a. In 25 instances, the Company failed to correctly pay or object to medical treatment expenses as required by required by LC §4603.2(b)(2). The exceptions are noted below:
 - In eight instances, the Company failed to pay the billed medical services.
 - In seven instances involving preauthorization of services, the Company failed to correctly process and pay for qualified medical services.
 - In three instances involving medical report billings, the Company failed to correctly process and pay for eligible medical services.
 - In two instances involving the down-coding of pre-authorized services, the Company failed to correctly process and pay for eligible medical services.
 - In two instances involving a revision of pre-authorized services, the Company failed to correctly process and pay for eligible medical services.

- In one instance involving a medical report previously submitted, the Company failed to correctly process billed medical services.
 - In one instance involving different charges on a CPT code, the Company failed to correctly process and pay for eligible medical services
 - In one instance, the Company failed to correctly process billed medical services when the date of service (DOS) preceded the date of claim denial.
- b. In 13 instances, the Company failed to include statutory self-imposed penalty and interest when owed as require by LC §4603.2(b)(2).
- In nine instances involving provider appeals, the Company failed to include self-imposed penalty and interest in the reprocessing of the invoices.
 - In four instances, the Company failed to include self-imposed penalty and interest when the billed medical services were not processed within 45 days.
- c. In one instance, the Company failed to pay the mileage reimbursement rate as required by LC §4600(e)(2).

Summary of the Company's Response: The Company acknowledges and agrees with the findings.

As a result of the findings on the 38 instances under sections 1(a) and 1(b), the Company paid \$4,087.63 for additional medical services owed, and \$3,669.57 for self-imposed penalty and interest owed.

The Company acknowledges that its bill reviewers and/or adjusters erred in the processing of medical billing, and of its failure to include statutory self-imposed penalty and interest owed. The Company identified errors with regard to invoices received by facsimile mail, and on utilization review authorizations. As a result of this examination, the Company revised its procedures and communication processes for its claims examiners and third party vendors in these areas of review.

The Company also identified errors with its mailroom processes and the Company has completed staff remedial training.

With regard to the instance in section 1(c), the request for mileage reimbursement was not processed due to an oversight by the individual adjuster. The

Company reopened the claim and the mileage reimbursement amount of \$11.20 was paid.

The Company informed the Department that it has completed refresher staff training for compliance reinforcement on June 15, 2015 for its Walnut Creek staff and on June 18, 2015 for its San Diego staff.

2. In four instances, the Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies. The Department alleges the Company failed to comply with 8 California Code of Regulations (CCR) §9792.9.1 and §9812.

- a. In 3 instances, the Company failed to provide timely benefit notices as required by 8CCR §§9812(a)(1), 9812(a)(2) and 9812(j).
- b. In one instance, the Company failed to provide a timely Utilization Review determination as required by 8CCR §9792.9.1.

The Department alleges these acts are in violation of CIC §790.03(h)(2).

Summary of the Company's Response: The Company acknowledges and agrees with the findings. The Company states that in one instance described under 2(a) above, the submitted medical report was mislabeled in its mailroom operations. The Company has now instituted screening of its mail by its nursing staff to eliminate this type of error.

The Company also informed the Department that it has completed refresher staff training for compliance reinforcement on June 15, 2015 for its Walnut Creek staff and on June 18, 2015 for its San Diego staff.

3. In four instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. The Department alleges the Company failed to conduct a reasonable investigation as required by 8CCR §10101 and §10109. The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges and agrees with the findings. The Company states that its claims handling revealed an improper documentation on mileage reimbursement; and the failure to follow-up and secure complete and accurate documentation needed to conclude the claims or determine benefits.

The Company informed the Department that it has completed refresher staff training for compliance reinforcement on June 15, 2015 for its Walnut Creek staff and on June 18, 2015 for its San Diego staff.

4. In one instance, the Company utilized a disclosure authorization form that failed to specify the length of time the authorization would remain valid. The length of time for the disclosure authorization form to remain valid exceeded the duration of the claim. The Department alleges this act is in violation of CIC §791.06(g)(2)(B) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with the finding. As a result of the examination, the Company revised the template language on its medical authorization form to comply with the statute as of April 2015.

The Company informed the Department that it has completed refresher staff training for compliance reinforcement on June 15, 2015 for its Walnut Creek staff and on June 18, 2015 for its San Diego staff.