



**DEPARTMENT OF INSURANCE**

FIELD CLAIMS BUREAU  
300 SOUTH SPRING STREET 11<sup>TH</sup> FLOOR  
LOS ANGELES, CA 90013  
(213) 346-6510  
(213) 897-9551 (FAX)  
dixonc@insurance.ca.gov

November 9, 2007

Joy Higa, Vice President Government Affairs  
PacifiCare Life and Health Insurance Company  
5995 Plaza Drive, MS CA112-0267  
Cypress, CA 90630

By Certified Mail # 70022030000139388378

RE: Field Claims Examination Reports  
PACIFICARE LIFE AND HEALTH INSURANCE COMPANY, NAIC # 70785

Dear Ms. Higa:

We have enclosed a copy of the verified written Field Claims Examination Reports made as of June 30, 2006 and May 31, 2007 on the referenced company.

Please review the reports and provide a response to me within the next thirty (30) calendar days, whether or not amendments are requested. E-mail responses are welcomed.

In addition, we request that you provide a response to any open items and exceptions that have not been resolved. We have also enclosed the working paper individual claim file data tables that serve as documentation to support findings in the reports. Any response received from the Company will be considered, and the reports will be either adopted as is, with corrections, or reopened for the purpose of conducting additional review.

If you have any questions, please do not hesitate to call or e-mail me at the addresses above.

Very Truly Yours,

*Craig Dixon,*  
Bureau Chief

RE:cf

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**From:** Dixon, Craig  
**Sent:** Saturday, November 10, 2007 12:14 AM  
**To:** 'shuntel.jackson@phs.com'; 'Joy.Higa@phs.com'  
**Cc:** Laucher, Joel; Rosen, Andrea  
**Subject:** Attached Files  
**Attachments:** PACIFICARE Life & Health Ins. Co I&II 30 Day .doc; DOCS\_MC-#24481-v3-PACIFICARE\_LIFE\_AND\_HEALTH\_INSURANCE\_COMPANY\_PART\_2.DOC; DOCS\_MC-#24482-v4-PACIFICARE\_LIFE\_AND\_HEALTH\_INSURANCE\_COMPANY\_PART\_2.DOC; DOCS\_MC-#24484-v1-PACIFICARE\_LIFE\_AND\_HEALTH\_INSURANCE\_COMPANY\_PART\_2.DOC; DOCS\_MC-#24485-v2-PACIFICARE\_LIFE\_AND\_HEALTH\_INSURANCE\_COMPANY\_PART\_1.DOC; DOCS\_MC-#24486-v3-PACIFICARE\_LIFE\_AND\_HEALTH\_INSURANCE\_COMPANY\_PART\_1.DOC; DOCS\_MC-#24487-v1-PACIFICARE\_LIFE\_AND\_HEALTH\_INSURANCE\_COMPANY\_\_PART\_1.DOC

Ms. Jackson: The following documents are being forwarded as a courtesy electronically per your request. The documents will also follow by regular certified mail.

CIC SECTION 12938 REPORT OF THE MARKET CONDUCT EXAMINATION  
OF THE CLAIMS PRACTICES OF THE  
**PACIFICARE LIFE AND HEALTH INSURANCE COMPANY**  
**NAIC # 70785 CDI # 3086-6**

AS OF MAY 31, 2007

**STATE OF CALIFORNIA**



**DEPARTMENT OF INSURANCE**  
**MARKET CONDUCT DIVISION**  
**FIELD CLAIMS BUREAU**

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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



November 9, 2007

The Honorable Steve Poizner  
Insurance Commissioner  
State of California  
45 Fremont Street  
San Francisco, California 94105

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 practices and procedures in California of:

**PacifiCare Life and Health Insurance Company**

**NAIC # 70785**

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

This report is made available for public inspection and is published on the California Department of Insurance web site ([www.insurance.ca.gov](http://www.insurance.ca.gov)) pursuant to California Insurance Code section 12938.

## **FOREWORD**

The examination covered the claims handling practices of the aforementioned Company during the period June 23, 2006, through May 31, 2007. The examination was made to discover, in general, if these and other operating procedures of the Company conform with the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al.

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, if any. When a violation that resulted in 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. 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**

The targeted examination focused on the Company claims processing operations including network management and provider contract uploading as a result of complaints received by the Department from consumers and healthcare providers with respect to individual and group health insurance coverage.

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 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 claims files, member appeals, provider disputes, and related records.
3. A review of consumer complaints and inquiries about the Company handled by the CDI during the same time period and a review of prior CDI market conduct examination reports on the Company.
4. A review of electronic paid claims data. The analysis however, was limited to a review of timely acknowledgement of claims and timely payment of claims.

The sample of claim files, provider disputes, member appeals and related records were reviewed at the office of the Company in Cypress, California. The review of electronic paid claims data was conducted primarily within the office of the Department of Insurance in Los Angeles, California.

## **EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED**

The examination targeted network operations for contract loading and claims processing, provider disputes and member appeals as a result of numerous complaints received by the Department from consumers and healthcare providers. The principal areas of concern noted in the examination report are: failure to adopt and implement reasonable standards for the prompt investigation and processing of claims, failure to file and record documentation and failure to effectuate prompt, fair and equitable settlements of claims.

The claims reviewed were closed between January 23, 2006 and May 31, 2007, commonly referred to as the “review period”. Using a computer analysis program, the examiners reviewed 1,125,707 paid claims (1,077,024 group and 48,683 individual). The electronic review resulted in 1,125,707 claims handling violations of the Fair Claims Settlement Practices Regulations as a result of failing to document acknowledgement of claim. For the on-site review, the examiners randomly selected 289 denied claims files, provider disputes and member appeals. The examiners cited 95 alleged claim handling violations of the Fair Claims Settlement Practices Regulations and/or California Insurance Code Section 790.03 from this sample file review detailed in the report tables and summaries.

The Company indicated that a spike in processing errors occurred as a result of provider contracting efforts due to a network transition effective June 23, 2006. The Company’s administrative capacity was affected as follows: a) inaccurate loading of provider contracts; b) inaccurate control over documents for processing of claims and provider disputes; and c) insufficient staffing and training. The Company states that it is committed to correcting the deficiencies cited in the report.

**RESULTS OF REVIEWS OF  
CONSUMER COMPLAINTS AND INQUIRIES  
PREVIOUS EXAMINATIONS**

Between June 23, 2006 and May 31, 2007, the Company was the subject of 237 consumer complaints and inquiries which includes 68 provider disputes between June 23, 2006 and May 31, 2007. The review of these complaints and inquiries indicate the following trend allegations: wrongful denials of covered claims; undue delay in claims processing; multiple requests for documentation that was previously provided, including, but not limited to, certification of creditable coverage and improper contract uploads.

The most recent prior examination reviewed a period between July 1, 2005 and June 30, 2006. The most significant noncompliance issues identified in the prior examination report were failure to maintain all documents, notes and work papers in the claim file, failure to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue and failure to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.

## DETAILS OF THE CURRENT EXAMINATION

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

<b>PLHIC SAMPLE FILES REVIEWED ON SITE</b>			
<b>LINE OF BUSINESS / CATEGORY</b>	<b>CLAIMS FOR REVIEW PERIOD</b>	<b>SAMPLE FILES REVIEWED</b>	<b>CITATIONS</b>
Accident and Disability / Group Health Denied	428,126	68	2
Accident and Disability / Group Health Provider Disputes	12,367	55	36
Accident and Disability / Group Health Member Appeal	688	47	33
Accident and Disability / Individual Health Denied	2957	46	3
Accident and Disability / Individual Health Provider Disputes	159	41	21
Accident and Disability / Individual Health Member Appeals	68	32	0
<b>TOTALS</b>	454,931	289	95

## TABLE OF TOTAL CITATIONS

Citation	Description	PLHIC
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.	19
CCR §2695.3(a)	The Company's claim file failed to contain all documents, notes and work papers that pertain to the claim.	17
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	15
CCR §2695.3(b)(3)	The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years.	14
CCR §2695.5(b)	The Company failed to respond to communications within 15 calendar days or with a complete response based on the facts as then known by the licensee.	11
CCR §2695.11(b)	The Company failed to provide an explanation of benefits or a clear explanation of benefits.	8
CCR §2695.3(b)(2)	The Company failed to record in the file the date the Company received, date the Company processed and date the Company transmitted or mailed every relevant document in the file.	4
CCR §2695.5(a)	The Company failed to respond to a Department of Insurance inquiry within 21 calendar days.	3
CCR §2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	2
CIC §790.03(h)(1)	The Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue.	2
<b>Total Citations</b>		<b>95</b>

**TABLE OF CITATIONS BY LINE OF BUSINESS**

<b>ACCIDENT AND DISABILITY 2006 Written Premium: \$843,721,575</b>	<b>NUMBER OF CITATIONS</b>
<b>AMOUNT OF RECOVERIES</b> <span style="float:right"><b>\$560.29</b></span>	Sample Review
CIC §790.03(h)(3)	19
CCR §2695.3(a)	17
CIC §790.03(h)(5)	15
CCR §2695.3(b)(3)	14
CCR §2695.5(b)	11
CCR §2695.11(b)	8
CCR §2695.3(b)(2)	4
CCR §2695.5(a)	3
CCR §2695.7(g)	2
CIC §790.03(h)(1)	2
<b>SUBTOTAL</b>	<b>95</b>
<b>TOTAL</b>	<b>95</b>

## 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. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. 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 to take appropriate corrective action in all jurisdictions where applicable.

Money recovered within the scope of this report was \$560.29 as described in section number 3 below. As a result of the examination, the total amount of money returned to claimants within the scope of this report was \$560.29.

### **ACCIDENT AND DISABILITY**

1. **In 19 instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.** The Company did not follow its own guidelines for processing member appeals and provider disputes. The Department alleges these acts are in violation of CIC §790.03(h)(3).

**Summary of Company Response:** The Company acknowledges the deficiencies cited. The Company will reinforce its processing procedures with claims staff to ensure future compliance and provide feedback to the Department.

2. **In 17 instances, the Company failed to maintain all documents, notes and work papers in the claim file.** The Department alleges these acts are in violation of CCR §2695.3(a).

**Summary of Company Response:** The Company acknowledges that the claim files did not include documents pertinent to each claim file cited in such detail that pertinent events and the dates of the events could be reconstructed so that its actions pertaining to the claim file could be determined.

This is an unresolved issue and may result in administrative action.

3. **In 15 instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.** Claims were reimbursed using an incorrect fee schedule or claims were denied for payment with no documentation to support billed services were not covered. The Department alleges these acts are in violation of CIC §790.03(h)(5).

**Summary of Company Response:** The Company acknowledges that in two of the instances, it failed to adjudicate the claims properly. As result of the findings, the Company issued payments totaling \$560.29 to claimants. In one instance an incorrect remark code was

used resulting in an incorrect payment. In the remaining 12 instances the Company states the denials were proper and/or the processing of the claims was based on the recommendation of their software program utilized to adjudicate the claim.

This is an unresolved issue and may result in administrative action.

4. **In 14 instances, the Company failed to maintain hard copy files or claim files that are accessible, legible and capable of duplication to hard copy for five years.** The Department alleges these acts are in violation of CCR §2695.3(b)(3).

**Summary of Company Response:** The Company states that the data was archived on a server and a project was in progress to access the archived data when the acquisition with United Health Care occurred. The project was placed on hold and the files are not currently accessible.

This is an unresolved issue and may result in administrative action.

5. **In 11 instances, the Company failed to respond to communications within 15 calendar days.** The Company failed to respond to member appeals within the 15 calendar days. The Department alleges these acts are in violation of CCR §2695.5(b).

**Summary of Company Response:** No Company Response to Criticism

6. **In eight instances, the Company failed to provide to the claimant an explanation of benefits including the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.** The Department alleges these acts are in violation of CCR §2695.11(b).

**Summary of Company Response:** No Company Response to Criticism

7. **In four instances, the Company failed to record the date the Company received, date the Company processed and date the Company transmitted or mailed every relevant document in the file.** The Department alleges these acts are in violation of CCR §2695.3(b)(2).

**Summary of Company Response:** No Company Response to Criticism

8. **In three instances, the Company failed to respond to a Department of Insurance inquiry within 21 calendar days.** The Department alleges these acts are in violation of CCR §2695.5(a).

**Summary of Company Response:** No Company Response to Criticism

9. **In two instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low.** The participating provider was paid at a rate that was less than the contracted rate. The Department alleges these acts are in violation of CCR §2695.7(g).

**Summary of Company Response:** As a result of the findings of the examination, the Company is in the process of identifying claims submitted by this provider to determine whether there was an underpayment.

10. **In two instances, the Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue.** The Company referenced a one year pre-existing illness limitation time period on the EOB when the exclusionary period for pre-existing conditions is six months. The Department alleges these acts are in violation of CIC §790.03(h)(1).

**Summary of Company Response:** The Company acknowledges the finding and states their policy and procedures have been changed to state the exclusionary period for pre-existing conditions is six month.

## **ELECTRONIC ANALYSIS**

The examiners received a listing of 1,077,024 group paid claims and 48,683 individual paid claims. The results of the computerized data analysis revealed that the Company does not maintain documentation of acknowledgement of their claim receipt. This is in non-compliance with CCR § 2695.3(a). The Company has acknowledged this deficiency. The Company states that their vendor did not print system generated acknowledgement letters from July 2006 until January 2007. The Company was able to provide dates claims were allegedly acknowledged beginning in January 2007, however, the Company could not provide supporting documentation. As a result of the examination finding, the Company contacted the vendor on 10/17/07 and obtained a commitment to receive a weekly generated report that links acknowledgment letter dates to claim numbers to monitor timely and appropriate issuance of these letters. Further, the Company will ensure that acknowledgement letters will be retrievable and available for review pursuant to regulation requirements.

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

**PACIFICARE LIFE AND HEALTH INSURANCE COMPANY**  
**NAIC # 70785 CDI # 3086-6**

AS OF May 31, 2007

**STATE OF CALIFORNIA**



**DEPARTMENT OF INSURANCE**  
**MARKET CONDUCT DIVISION**  
**FIELD CLAIMS BUREAU**

## **NOTICE REGARDING CONFIDENTIALITY**

**The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code 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. Section 12938 of the California Insurance Code requires the publication of certain legal documents and examination reports.**

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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



November 8, 2007

The Honorable Steve Poizner  
Insurance Commissioner  
State of California  
45 Fremont Street  
San Francisco, California 94105

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 practices and procedures in California of:

**PacifiCare Life and Health Insurance Company**

**NAIC # 70785**

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

## **FOREWORD**

The examination covered the claims handling practices of the aforementioned Company during the period June 23, 2006, through May 31, 2007. The examination was made to discover, in general, if these and other operating procedures of the Company conform with the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains alleged violations of laws other than Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. A report of violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. will be made available for public inspection and published on the Department's web site pursuant to Section 12938 of the California Insurance Code.

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, if any. When a violation that resulted in 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. 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**

The targeted examination focused on the Company's claims processing operations including network management and provider contract uploading as a result of complaints received by the Department from consumers and healthcare providers with respect to individual and group health insurance coverage.

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 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 claims files, member appeals, provider disputes, provider contracts and related records.
3. A review of consumer complaints and inquiries about the Company handled by the CDI during the same time period and a review of prior CDI market conduct examination reports on the Company.
4. A review of electronic paid claims data. This analysis however, was limited to a review of timely acknowledgement of claims and timeliness of payment of claims pursuant to the California Insurance Code (CIC).

The sample of claim files, provider disputes, member appeals and related records were reviewed at the office of the Company in Cypress, California. The review of electronic paid claims data was conducted primarily within the office of the Department of Insurance in Los Angeles, California.

## **EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED**

The examination targeted network operations for contract loading and claims processing, provider disputes and member appeals as these areas have been the subject of numerous complaints received by the Department from consumers and healthcare providers. The principal areas of concern noted in the examination report are: excessive delays in uploading provider contracts, incorrect payment of claims, lost mail and/or imaged documents such as certificates of creditable coverage and medical records, failure to timely acknowledge receipt of claims, failure to address all issues and respond timely to member appeals and provider disputes.

The claims reviewed were closed between January 23, 2006 and May 31, 2007, which shall be referred to as the “review period”. Using a computer analysis program, the examiners reviewed 1,125,707 paid claims (1,077,024 group and 48,683 individual). The electronic review resulted in 1,176,657 alleged violations of the California Insurance Code for failure to reimburse claims no later than 30 working days after receipt, failure to pay interest on an uncontested claim after 30 working days and failure to timely acknowledge receipt of claims. For the on-site review, the examiners randomly selected 339 denied claims files, provider disputes, member appeals and contract agreement uploads. The examiners cited 312 alleged claim handling violations of the California Insurance Code from this sample file review which are detailed in the report tables and summaries.

The Company indicated that a spike in processing errors occurred as a result of provider contracting efforts due to a network transition effective June 23, 2006. The Company’s administrative capacity was affected as follows: a) inaccurate and untimely loading of provider contracts; b) insufficient control over documents for processing claims and provider disputes; and c) inadequate staffing and training and d) inability to control and correct fee schedules. The Company states that it is committed to correcting the deficiencies cited in the report.

**RESULTS OF REVIEWS OF  
CONSUMER COMPLAINTS AND INQUIRIES  
PREVIOUS EXAMINATIONS**

The Company was the subject of 237 consumer complaints and inquiries which includes 68 provider disputes between June 23, 2006 and May 31, 2007. The review of these complaints and inquiries indicate the following trend allegations: wrongful denials of covered claims; undue delay in claims processing; multiple requests for documentation that was previously provided, including, but not limited to, certification of creditable coverage and improper contract uploads.

The most recent prior examination reviewed a period between July 1, 2005 and June 30, 2006. The most significant noncompliance issues identified in the prior examination report were failure to maintain all documents, notes and work papers in the claim file, failure to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue and failure to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.

## DETAILS OF THE CURRENT EXAMINATION

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

<b>PLHIC SAMPLE FILES REVIEW</b>			
<b>LINE OF BUSINESS / CATEGORY</b>	<b>CLAIMS FOR REVIEW PERIOD</b>	<b>SAMPLE FILES REVIEWED</b>	<b>CITATIONS</b>
Accident and Disability / Group Health Denied	428,126	68	49
Accident and Disability / Group Health Provider Disputes	12,367	55	67
Accident and Disability / Group Health Member Appeal	688	47	55
Accident and Disability / Individual Health Denied	2957	46	21
Accident and Disability / Individual Health Provider Disputes	159	41	21
Accident and Disability / Individual Health Member Appeals	68	32	7
Provider Contract Agreements Effective dates 1/1/06-3/31/07	10,566	50	90
General Category	-	-	2
<b>TOTALS</b>	454,931	339	312

## TABLE OF TOTAL CITATIONS

Citation	Description	PLHIC
CIC §10123.13(a)	<ul style="list-style-type: none"> <li>• The Company failed to reimburse a health care claim no later than 30 working days after receipt</li> <li>• The Company failed to refer to specific policy provisions in the claim denial.</li> <li>• 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.</li> <li>• The Company failed to include all required information on the Explanation of Benefit or denial; the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</li> </ul>	139
CIC §790.02	The Company engaged in an unfair or deceptive act or practice.	47
CIC §734	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company failed to maintain all documents, notes and work papers in the claim file.	45
CIC §10169(i)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.	27
CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days.	22
CIC §10123.137(c)	The Company failed to issue a written determination within 45 working days after the date of receipt of the provider dispute.	14

**TABLE OF TOTAL CITATIONS**

Citation	Description	PLHIC
CIC §10123.147(a) <i>Emergency Services only.</i>	<ul style="list-style-type: none"> <li>• The Company failed to refer to specific policy provisions in the claim denial.</li> <li>• 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.</li> <li>• The Company failed to include all required information on the Explanation of Benefit or denial; the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</li> <li>• The Company failed to reimburse a health care claim no later than 30 working days after receipt.</li> </ul>	6
CIC §10133.66(c)	The Company failed to acknowledge receipt of the health claim within 15 days.	6
CIC §10123.13(c)	The Company failed to pay interest on a contested claim after 30 working days.	3
CIC §10198.7(a)	The Company failed to provide coverage for any individual on the basis of a pre-existing condition provision for a period greater than 6 months following the individual's effective date of coverage. No health benefit plan that covers 3 or more persons (Group or Individual Coverage) that is issued, renewed or written by any insurer shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than 6 months following the individual's effective date of coverage.	3
<b>Total Citations</b>		<b>312</b>

## TABLE OF CITATIONS BY LINE OF BUSINESS

<b>ACCIDENT AND DISABILITY 2006 Written Premium: \$843,721,575</b>	<b>NUMBER OF CITATIONS</b>		
<b>AMOUNT OF RECOVERIES</b> <span style="float: right;"><b>\$16,993.87</b></span>	Electronic Review	Sample Review	Total
CIC §10123.13(a)	42,137	139	42,276
CIC §734	0	45	45
CIC §790.02	0	47	47
CIC §10169(i)	0	27	27
CIC §10123.13(b)	8813	22	8835
CIC §10123.137(c)	0	14	14
CIC §10123.147(a)	0	6	6
CIC §10133.66(c)	1,125,707	6	1,125,713
CIC §10123.13(c)	0	3	3
CIC §10198.7(a)	0	3	3
<b>SUBTOTAL</b>	<b>1,176,657</b>	<b>312</b>	<b>1,176,969</b>
<b>TOTAL</b>	<b>1,176,657</b>	<b>312</b>	<b>1,176,969</b>

## 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 to take appropriate corrective action in all jurisdictions where applicable.

Money recovered within the scope of this report was \$16,993.87 as described in sections one, three and seven below.

### ACCIDENT AND DISABILITY

1. **In 139 instances, The Company failed to reimburse a health care claim no later than 30 working days after receipt ,or The Company failed to refer to specific policy provisions in the claim denial or 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 or The Company failed to include all required information on the Explanation of Benefit or denial; the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.** The Department alleges these acts are in violation of CIC §10123.13(a).

**Summary of Company Response:** The Company agrees that in three of the 139 instances cited, it failed to reimburse health claims within 30 working days after receipt. The Company acknowledges that these claims were improperly denied since information was in the file to reimburse the health claims. As a result of the findings, three group denied claims were processed for payments totaling \$16,351.61. In the remaining instances cited, the Company agrees that the Explanation of Benefits (EOB), Explanation of Payments (EOP) and Dispute Uphold correspondence did not include required wording. The Company further states that they were advised of the deficiencies in the EOB/EOP documents prior to the examination by the staff of the Consumer Services Division at the CDI and initiated a Corrective Action Plan (CAP) on 3/27/07. The final versions were approved and subsequently implemented on 6/15/07. The uphold letter template has been updated and the reference to the Department of Managed Health Care (DMHC) has been deleted. An updated template was provided to staff on 9/13/07. Additionally, staff will be provided training bulletins to be reviewed in team meetings.

2. **In 27 instances, the Company issued denial letters and other written responses to grievances which failed to provide the insured information regarding their right to request an independent medical review.** In the cited instances, the Company failed to provide information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or

delayed by the insurer, or by one of its contracting providers. The Department alleges these acts are in violation of CIC §10169(i).

**Summary of Company Response:** The Company agrees that it failed to provide information concerning the right of the insured to request an independent medical review in the instances cited. The Company states they were advised of this deficiency prior to the examination by the staff of the Consumer Services Division at the CDI and initiated a Corrective Action Plan (CAP) on 3/27/07. The final versions were approved and subsequently implemented on 6/15/07.

**3. In 22 instances, The Company failed to pay interest on an uncontested claim after 30 working days.** The Department alleges these acts are in violation of CIC §10123.13(b).

**Summary of Company Response:** The Company agrees that it did not pay interest on an uncontested claim after 30 working days. As a result, interest was paid on 19 of the cited instances (\$78.87 Individual Provider Appeals, \$49.44 Group Provider Appeals, \$262.73 Group Member Appeals). In the remaining four instances no interest was paid following the reprocessing of a claim or interest was calculated improperly due to the use of incorrect dates.

In three instances this remains an unresolved issue and may result in administrative action.

**4. In 14 instances, The Company failed to issue a written determination within 45 working days after the date of receipt of the provider dispute.** According to the Company there were 16,563 Provider Disputes during the exam window period of which, 15,053 were responded to within requirements. Per Company reporting 1,510 disputes during the window period did not receive a written determination within 45 working days after the dispute was received. The Department alleges these acts are in violation of CIC §10123.137(c).

**Summary of Company Response:** The Company acknowledges the deficiencies cited. As a result of these findings, the Company will conduct training with its staff emphasizing regulatory requirements to ensure prompt responses to provider disputes and resolution of each provider dispute consistent with applicable law. Additionally, the Company states the primary reason for the delay in provider dispute resolution was due to issues with the correspondence tracking system known as “docDNA”. Due to these issues, certain correspondence needed to resolve the disputes such as medical records were delayed within the tracking queues and thus were not reviewed timely. The Company is in process of remediating this issue. As a result of the Company’s efforts to date, the docDNA inventory has decreased by approximately 78% since February 28, 2007.

**5. In six instances, the Company failed to refer to specific policy provisions in the claim denial or 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 or The Company failed to include all required information on the Explanation of Benefit or denial; the notice shall include the address, the Internet Web site address, and telephone number of the unit**

**within the Department that performs this review function or The Company failed to reimburse a health care claim no later than 30 working days after receipt.** The Department alleges this act is in violation of CIC §10123.147(a).

**Summary of Company Response:** The Company agrees that the Explanation of Benefits (EOB), Explanation of Payments (EOP) and Dispute Uphold correspondence did not include required wording. The Company further states that they were advised of the deficiencies in the EOB/EOP documents prior to the examination by the staff of the Consumer Services Division at the CDI and initiated a Corrective Action Plan (CAP) on 3/27/07. The final versions were approved and subsequently implemented on 6/15/07. The uphold letter template has been updated and the reference to the Department of Managed Health Care (DMHC) has been deleted. An updated template was provided to staff on 9/13/07. Additionally, staff will be provided training bulletins to be reviewed in team meetings.

**6. In six instances, The Company failed to acknowledge receipt of the claim within 15 days.** The Department alleges these acts are in violation of CIC §10133.66(c).

**Summary of Company Response:** The Company acknowledges this finding and states their vendor did not print system generated acknowledgement letters from July 2006 until January 2007. The Company was able to provide dates claims were allegedly acknowledged beginning in January 2007, however, the Company could not provide supporting documentation. As a result of the examination finding, the Company contacted the vendor on 10/17/07 and obtained a commitment to receive a weekly generated report that links acknowledgment letter dates to claim numbers to monitor timely and appropriate issuance of these letters. Further, the Company will ensure that acknowledgement letters will be retrievable and available for review pursuant to statutory requirements. Additionally, the DOC DNA project team was implemented to identify timely processing of mail to the correct recipients.

**7. In three instances, The Company failed to pay interest on a contested claim after 30 working days.** In one instance, the claim was denied inappropriately for pre-existing condition. As a result of the examination, an additional claim was located from the member that was inappropriately denied and reprocessed. In one instance it was noted that the Company did not pay the correct interest rate. In one instance, the Company failed to include interest on this claim that was reimbursed after 30 working days. The Department alleges this act is in violation of CIC §10123.13(c).

**Summary of Company Response:** The Company acknowledges claims were paid incorrectly in two instances. As a result, interest was paid on 2 of the cited instances (\$251.22 Group Provider Appeals) and issued payments to the claimants.

In one instance this remains an unresolved issue and may result in administrative action.

**8. In two instances, The Company failed to provide coverage for any individual on the basis of a pre-existing condition provision for a period greater than 6 months following the individual's effective date of coverage. No health benefit plan that covers 3 or more persons (Group or Individual Coverage) that is issued, renewed or written by any insurer shall**

**exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than 6 months following the individual's effective date of coverage.** The Company began applying a 12 month pre-existing period on group policies effective January 1, 2004 and continued thru December 2006. The Department alleges these acts are in violation of CIC §10198.7(a).

**Summary of Company Response:** The Company states that the Company's training materials were updated to reflect a 6 month pre-existing review period and subsequent training of staff was completed in December 2006 team meetings. An automated update of the claims system was made in December 2006 and the pre-existing field is set for 6 months for California Plans. In March 2007, the Company issued Large Group plan amendments changing the exclusionary period to 6 months and communications were sent to the affected groups advising them of the changes.

## **PROVIDER CONTRACT AGREEMENTS**

9. **In 45 instances, the Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company failed to maintain all documents, notes and work papers.** Specifically, the Company failed to maintain all documents, notes, computer data and work papers pertaining to the provider contract file. The Company cannot provide proof of the dates that provider contracts were uploaded into the RIMS claims system. The Company asserts that contracts were tracked manually but the information provided to the examiners has numerous gaps in date capture and tracking. Further there was no proof presented that any of the provider contracts received were deficient. The examiners received no documentation to support the return of unsatisfactory contracts to the providers, for example letters sent to the providers regarding essential contract information or documentation of phone calls made to providers concerning contracting issues. The Department alleges these acts are in violation of CIC §734.

**Summary of Company Response:** The Company states the date upon which a contract is received in the organization is tracked manually. During the CTN Transition, the receipt date was tracked in an excel spreadsheet, and we ultimately transitioned to a more robust database in January 2007. The Plan is not aware of any regulation which requires it to track the dates contracts are loaded in to its various databases. The system has always tracked the last time a record was touched; this has been sufficient to track who and when updates are made. It is important to note that nearly 40% of contracts received from physicians are deficient in critical ways that prevent us from executing and loading the agreements – missing tax identification number, missing or incomplete roster, missing or incomplete locations, etc. These are elements that are necessary to be completely and correctly provided by a physician or medical group in order to ensure that a contract is executed and results in correct/timely claims payment as well as correct demographics for on-line directories.

Noting that a contract is received does not necessarily mean that the contract is complete and ready for full execution – whether noted in a log or on a contract itself.

This remains an unresolved issue and may result in administrative action.

**10. In 45 instances, the Company engaged in an unfair or deceptive act or practice.** The Company failed to institute provider contract upload mechanisms, required as the result of provider contracting efforts, to ensure timely initiation of contract terms. Consequently, provider claims were not processed correctly as the result of delayed uploading. Additionally, providers were not listed as participating in the PacifiCare Network therefore compromising insured's access to contracted providers. The Department alleges these acts are in violation of CIC §790.02.

**Summary of Company Response:** The Company states these were unforeseen circumstances resulting from the termination, with 180 days notice, of the CareTrust Network of physicians in December 2005. The CTN network migration and network recruitment activity was an isolated and unprecedented migration in our industry, and a migration of such a scale is not expected to occur. Our August 6, 2007 presentation to the Department clearly documents our business-as-usual contract negotiation system load process.

This remains an unresolved issue and may result in administrative action.

## **GENERAL BUSINESS PRACTICE**

**11. The Company engaged in an unfair or deceptive act or practice.** PacifiCare has admitted it did not consistently address problems in claims adjudication when provider contract uploading was delayed or contracts were back dated. Additionally, PacifiCare can not verify that all claims submitted prior to contract uploading or contract back date were reviewed for correct payment and interest where applicable. The Department alleges these acts are in violation of CIC §790.02.

**Summary of Company Response:** The plan acknowledges that it may not have consistently implemented rework projects for PLHIC claims impacted by retro-effective contracts during the CTN network transition. The Company is finalizing a corrective action plan which is intended to mitigate this problem, and we propose to share that corrective action plan with the CDI when finalized.

**12. The Company engaged in an unfair or deceptive act or practice.** PacifiCare does not have a procedure in place to accurately document the proper application of a health policy pre-existing condition exclusion. The Company indicates, “When an employer group determines their own eligibility, the date of hire becomes a null and void element because it is assumed that the employer group has validated that the employee has met all their respective waiting periods,

if any, to be enrolled in the plan. If the claims examiner does not have the hire date of the insured, we apply the exclusionary provision based on the effective date the employer group has provided.” None of the claims files reviewed documented how the pre-existing period was determined by the Company. There is no documentation in the claims file confirming member date of hire- a necessary element to apply the pre-existing period -as the pre-existing exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six month period ending on the day before the date of hire. There is no documentation that employer waiting periods were reviewed and included in the six month exclusionary period applied to the members who did not have creditable coverage. There is no documentation that the benefit effective date supplied by the employer has been correctly entered or verified by the Company. There is no documentation to support Company requirement for a Certificate of Creditable Coverage (COCC) when a possible pre-existing diagnosis claim has been received. The Company fails to adequately document their basis for determining a condition is pre-existing when medical records have been provided and they do not support prior medical advice, diagnosis, care or treatment. Company fails to document why they would uphold a pre-existing determination when an insured does not respond to a request for a COCC or names of physicians who have treated the member in the past six months. If the Company requires notice from a member affirming that no treatment, advice, diagnosis or care was received or no COCC is available, correspondence should state member response requirements. The Department alleges these acts are in violation of CIC §790.02.

**Summary of Company Response:** The Company did not acknowledge the alleged deficiency. This is an unresolved issue and may result in administrative action.

## **ELECTRONIC ANALYSIS**

The examiners received a listing of 1,077,024 group paid claims and 48,683 individual paid claims. The results of the computerized data analysis revealed that 40,808 group paid claims and 1329 individual paid claims were not reimbursed as soon as practical, but no later than 30 working days of receipt of the claim by the company. The Department alleges these acts are in violation of CIC § 10123.13(a).

The data analysis identified 8369 of the group paid claims and 444 of the individual paid claims did not include interest with the reimbursement paid over 30 working days of receipt of the claim. The Department alleges these acts are in violation of CIC § 10123.13(b).

The electronic data analysis also detected that the company did not comply with acknowledgement of claim receipt. This violation occurred in the entire 1,125,707 paid claims population (group and individual). The Department alleges these acts are in violation of CIC § 10133.66(c).

The Company acknowledged these deficiencies. The Company will reinforce timely reimbursement of claims and has emphasized with managers the importance of continued daily use of inventory reports to monitor the age of claims. In the instances where interest was not

included, the company will conduct a self survey of the claims identified in the data analysis review period (6/23/06 – 5/31/07) and manually adjust the claims to include interest. The Company will provide evidence of the completion of the survey, including supporting data and proof of payments to the Department on or before January 2, 2008. With respect to acknowledgement of claims, the Company states that their vendor did not print system generated acknowledgement letters from July 2006 until January 2007. The Company was able to provide dates claims were allegedly acknowledged beginning in January 2007, however, the Company could not provide supporting documentation. As a result of the examination finding, the Company contacted the vendor on 10/17/07 and obtained a commitment to receive a weekly generated report that links acknowledgment letter dates to claim numbers to monitor timely and appropriate issuance of these letters. Further, the Company will ensure that acknowledgement letters will be retrievable and available for review pursuant to statutory requirements.

**TABLES OF SPECIFIC FINDINGS**

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Provider Contract Verification</b>			
<b>Provider</b>	<b>Provider ID Number</b>	<b>Citation</b>	<b>Description</b>
Chow, U.	330433535	CIC §734	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company failed to maintain all documents, notes, computer data and work papers pertaining to the provider contract file. The Company was unable to provide proof the welcome letter sent to the provider.
Frintner, M.	202357769	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded into the RIMS claims system.</p> <p>The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 5/3/06 to 8/8/06 totals 97 days).</p>
Jacoby, G.	334404260	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded into the RIMS claims system.</p> <p>The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 6/8/06 to 8/16/06 totals 69 days).</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Provider Contract Verification</b>			
<b>Provider</b>	<b>Provider ID Number</b>	<b>Citation</b>	<b>Description</b>
Pratt, S.	330621255	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded into the RIMS claims system.</p> <p>The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 5/19/06 to 8/16/06 totals 89 days).</p>
Watts, H. D.	455626717	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.</p> <p>The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 6/29/06 to 9/14/06 totals 77 days).</p>
Turpin, I.	953651729	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.</p> <p>The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 8/24/06 to 10/18/06 totals 55 days).</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Provider Contract Verification</b>			
<b>Provider</b>	<b>Provider ID Number</b>	<b>Citation</b>	<b>Description</b>
Angfonte, G.	770106534	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.</p> <p>The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 6/5/06 to 8/22/06 totals 78 days).</p>
Sano, T.	953567720	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.</p> <p>The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 6/13/06 to 8/2/06 totals 50 days).</p>
Mok, D.	953350882	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.</p> <p>The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 6/21/06 to 8/17/06 totals 57 days).</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Provider Contract Verification</b>			
<b>Provider</b>	<b>Provider ID Number</b>	<b>Citation</b>	<b>Description</b>
Remington, R.	770440644	CIC §734	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.
		CIC §790.02	The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 6/27/06 to 8/17/06 totals 51 days).
Vitality Healthcare	431977414	CIC §734	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.
		CIC §790.02	The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 5/3/06 to 8/8/06 totals 97 days).
Kathleen J. Denniszarate MD a Medical Corp.	954787293	CIC §734	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.
		CIC §790.02	The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 6/14/06 to 12/19/06 totals 188 days).

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Provider Contract Verification</b>			
<b>Provider</b>	<b>Provider ID Number</b>	<b>Citation</b>	<b>Description</b>
Kenneth E. Schemmer MD Inc.	953786831	CIC §734  CIC §790.02	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.  The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 5/31/06 to 8/22/06 totals 83 days).
Gooding, J.	952699939	CIC §734  CIC §790.02	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.  The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 2/27/06 to 5/24/06 totals 86 days).
Soleimanpour, M.	330952805	CIC §734  CIC §790.02	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.  The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 9/8/06 to 2/19/07 totals 164 days).

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Provider Contract Verification</b>			
<b>Provider</b>	<b>Provider ID Number</b>	<b>Citation</b>	<b>Description</b>
Chronis, C.	770564197	CIC §734  CIC §790.02	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.  The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 8/15/06 to 10/18/06 totals 64 days).
Rahman, H.	753019928	CIC §734  CIC §790.02	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.  The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 9/6/06 to 12/8/06 totals 93 days).
Sevel, G.	770525262	CIC §734  CIC §790.02	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.  The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 9/10/06 to 11/14/06 totals 65 days).

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Provider Contract Verification</b>			
<b>Provider</b>	<b>Provider ID Number</b>	<b>Citation</b>	<b>Description</b>
Nishimoto, W.	954400055	CIC §734  CIC §790.02	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.  The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 9/18/06 to 11/14/06 totals 57 days).
Logiudice, P.	330017583	CIC §734  CIC §790.02	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.  The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 10/23/06 to 1/29/07 totals 98 days).
Halaburka, C.	202626923	CIC §734  CIC §790.02	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.  The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 10/25/06 to 12/20/06 totals 56 days).

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Provider Contract Verification</b>			
<b>Provider</b>	<b>Provider ID Number</b>	<b>Citation</b>	<b>Description</b>
Roseville Cardiology Med Associates	421586623	CIC §734  CIC §790.02	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.  The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 10/9/06 to 12/20/06 totals 56 days).
Raab, E.	953777340	CIC §734  CIC §790.02	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.  The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 12/5/06 to 2/20/07 totals 77 days).
Usborne, P.	223922241	CIC §734  CIC §790.02	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.  The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 11/16/06 to 2/8/07 totals 84 days).

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Provider Contract Verification</b>			
<b>Provider</b>	<b>Provider ID Number</b>	<b>Citation</b>	<b>Description</b>
San Diego Digestive Disease Conservatory	330213846	CIC §734  CIC §790.02	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.  The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 11/27/06 to 2/5/07 totals 70 days).
Mission Care Pediatrics	205829716	CIC §734  CIC §790.02	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.  The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 12/4/06 to 3/6/07 totals 92 days).
King, J.	205459324	CIC §734  CIC §790.02	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.  The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 12/11/06 to 3/13/07 totals 92 days).

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Provider Contract Verification</b>			
<b>Provider</b>	<b>Provider ID Number</b>	<b>Citation</b>	<b>Description</b>
Alomari, E.	952402760	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.</p> <p>The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 1/8/07 to 3/9/07 totals 60 days).</p>
Carter, M.	946325426	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.</p> <p>The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 1/16/07 to 3/9/07 totals 52 days).</p>
Zaid, A.	330851034	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.</p> <p>The Company engaged in an unfair or deceptive act or practice. The time delay between the contract signing date and the welcome letter send date exceeds 45 calendar days. (From 1/24/07 to 3/22/07 totals 57 days).</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Provider Contract Verification</b>			
<b>Provider</b>	<b>Provider ID Number</b>	<b>Citation</b>	<b>Description</b>
Sirott, L.	000857809	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.</p> <p>The Company engaged in an unfair or deceptive act or practice in the business of insurance. There is a gap of 89 days from the date the provider signed the agreement to the date the welcome letter was sent to the provider, which does not meet the Company guidelines for contract uploading.</p>
Zelman, G.	000644815	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined.</p> <ul style="list-style-type: none"> <li>• Proof of the date the contract was sent to Florida for uploading was not provided.</li> <li>• The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.</li> </ul> <p>The Company engaged in an unfair or deceptive act or practice in the business of insurance. There is a gap of 56 days from the date the provider signed the agreement to the date the welcome letter was sent to the provider, which does not meet the Company guidelines for contract uploading.</p>



<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Provider Contract Verification</b>			
<b>Provider</b>	<b>Provider ID Number</b>	<b>Citation</b>	<b>Description</b>
Oyer, R. A.	000223654	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.</p> <p>The Company engaged in an unfair or deceptive act or practice in the business of insurance. There is a gap of 58 days from the date the provider signed the agreement to the date the welcome letter was sent to the provider, which does not meet the Company guidelines for contract uploading.</p>
Hansen, D. R.	000756004	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined.</p> <ul style="list-style-type: none"> <li>• Copy of the welcome letter was not provided.</li> <li>• The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.</li> </ul> <p>The Company engaged in an unfair or deceptive act or practice in the business of insurance. There is a gap of 58 days from the date the provider signed the agreement to the date of the Emptoris/DiCarta/NDB downloads, which does not meet the Company guidelines for contract uploading.</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Provider Contract Verification</b>			
<b>Provider</b>	<b>Provider ID Number</b>	<b>Citation</b>	<b>Description</b>
Harper, G. C.	00806488	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined.</p> <ul style="list-style-type: none"> <li>• The date the contract was downloaded into Emptoris/DiCarta was not provided.</li> <li>• The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.</li> </ul> <p>The Company engaged in an unfair or deceptive act or practice in the business of insurance. There is a gap of 37 days from the date the provider signed the agreement to the date the welcome letter was sent to the provider, which does not meet the Company guidelines for contract uploading.</p>
Rosett, R. C.	001237093	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined.</p> <ul style="list-style-type: none"> <li>• The welcome letter to the provider does not appear to be in the file.</li> <li>• The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.</li> </ul> <p>The Company engaged in an unfair or deceptive act or practice in the business of insurance.</p> <ul style="list-style-type: none"> <li>• There is a gap of 262 days from the date the provider signed the agreement to the date a letter in file was sent to the provider, which does not meet the Company guidelines for contract uploading.</li> <li>• Additionally, this letter address the DMHC not the DOI.</li> </ul>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Provider Contract Verification</b>			
<b>Provider</b>	<b>Provider ID Number</b>	<b>Citation</b>	<b>Description</b>
Gokey, M.S.	001299313	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined.</p> <ul style="list-style-type: none"> <li>• The file does not document the date the provider contract was sent to Florida for entry into the Emptoris/DiCarta database.</li> <li>• The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.</li> </ul> <p>The Company engaged in an unfair or deceptive act or practice in the business of insurance. There is a gap of 183 days from the date the provider signed the agreement to the date the welcome letter was sent to the provider, which does not meet the Company guidelines for contract uploading.</p>
Cha, T. K.	001324296	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined.</p> <ul style="list-style-type: none"> <li>• The file does not document the date the provider contract was sent to Florida.</li> <li>• The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.</li> </ul> <p>The Company engaged in an unfair or deceptive act or practice in the business of insurance. There is a gap of 51 days from the date the provider signed the agreement to the date the welcome letter was sent to the provider, which does not meet the Company guidelines for contract uploading.</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Provider Contract Verification</b>			
<b>Provider</b>	<b>Provider ID Number</b>	<b>Citation</b>	<b>Description</b>
Duban, M. L.	002464597	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined.</p> <ul style="list-style-type: none"> <li>• The examiners were not provided with proof of contract download into the NDB system.</li> <li>• The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.</li> </ul> <p>The Company engaged in an unfair or deceptive act or practice in the business of insurance. There is a gap of 66 days from the date the provider signed the agreement to the date the welcome letter was sent to the provider, which does not meet the Company guidelines for contract uploading.</p>
Suesberry, W.	000406734	CIC §734  CIC §790.02	<p>The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.</p> <p>The Company engaged in an unfair or deceptive act or practice in the business of insurance. There is a gap of 118 days from the date the provider signed the agreement to the date the welcome letter was sent to the provider, which does not meet the Company guidelines for contract uploading.</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Provider Contract Verification</b>			
<b>Provider</b>	<b>Provider ID Number</b>	<b>Citation</b>	<b>Description</b>
Patel, M.N.	002369133	CIC §734	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.
		CIC §790.02	The Company engaged in an unfair or deceptive act or practice in the business of insurance. There is a gap of 97 days from the date the provider signed the agreement to the date the welcome letter was sent to the provider, which does not meet the Company guidelines for contract uploading.
Spayde, E. C.	002604280	CIC §734	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.
		CIC §790.02	The Company engaged in an unfair or deceptive act or practice in the business of insurance. There is a gap of 153 days from the date the provider signed the agreement to the date the welcome letter was sent to the provider, which does not meet the Company guidelines for contract uploading.

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Provider Contract Verification</b>			
<b>Provider</b>	<b>Provider ID Number</b>	<b>Citation</b>	<b>Description</b>
Shu, D.	002691249	CIC §734	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company can not provide proof of the date that the provider contract was uploaded from Emptoris into the RIMS claims system.
		CIC §790.02	The Company engaged in an unfair or deceptive act or practice in the business of insurance. There is a gap of 90 days from the date the provider signed the agreement to the date the welcome letter was sent to the provider, which does not meet the Company guidelines for contract uploading.
<b>Total Number of Files Reviewed in this Category: 50</b> <b>Total Number of Files with Citations in this Category: 45</b> <b>Total Number of Citations in this Category: 89</b>			

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Individual Provider Appeals</b>			
<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
Tobar, R./ Straub, J.	4911325-0-6	CCR §2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low. Processing error resulting in additional payment made. <b>NO INTEREST PAID AS APPLIED TO DEDUCTIBLE.</b>
Albarado, L./ Option Care	4912363-5-18	CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. No interest was paid following reprocessing of the claim. <b>Recovery: \$6.76</b>
Rahn, J./ Schwendig, J.	4913157-0-3	CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. No interest was paid following reprocessing of the claim. Claim processed as non-par in error, was reprocessed without interest. <b>Recovery: \$15.00</b>
Gibbons, Graybill Medical Group	4905006-0-16	CCR §2695.3(b)(2)	The Company failed to record in the file the date the Company received, date the Company processed and date the Company transmitted or mailed every relevant document in the file. The company batches appeals by date. Only the top appeal is date stamped. In this instance, the appeal in question was not date stamped.
Ye, J., Orthopedic Surgery and Sports Medicine Center	4904771-0-6	CIC §790.03(h)(5)  CIC §10123.13(a)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. Company can not support the original processing of the claim. The Company used its coding software and denied a charge even though it had the operative report which it ignored in favor of its coding software.  The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Web site missing on original EOB.
Novak, E., UCSD Medical Grp	4906382-0-2	CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Individual Provider Appeals</b>			
<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CCR §2695.3(a)	<p>review function. The Company disagrees stating the EOB does meet the requirements but it does not.</p> <p>The Company’s claim file failed to contain all documents, notes and work papers that pertain to the claim. The Company states that the denial of the code is due to the agreement with the provider but has not produced a copy of the signed provider contract.</p>
Pritchard, A., Green Dermatologic Medical Group	4911639-0-9	CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.
Knafo, A. Quest Diagnostics	4905461-0-17	CIC §10123.13(a)  CIC §790.03(h)(5)	<p>The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</p> <p>The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. Original bill received with two CPT codes 10040 and 17360. Company denied 10040 stating it was not reimbursable per its coding software program with the diagnosis code 272.2. The provider appealed and rebilled with diagnosis code 244.9, and the company allowed the charge. DOI, it is noted from national coverage determination (NCD) @ <a href="http://www.cms.hhs.gov">www.cms.hhs.gov</a> that 10040 is allowable with diagnosis code 272.2. When questioning the company about the difference the Company responded: “The coding software program that the company has in place is with McKesson Promatch and not with NCD and CMS. The processing of our claims must be based on the recommendations of the software program that the company utilizes and has in place. The company does effectuate prompt, fair, and equitable settlement of claims by handling claims based on the recommendations that are provided to us through the company's software program.” It is noted under Group Member Appeals/Bryan in the company response “PacifiCare follows Medicare billing</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Individual Provider Appeals</b>			
<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
			guidelines for processing automated laboratory services”.
Pak, R., Mission Childrens Medical Group	4907770-3-2	CIC §10123.13(a)  CIC §790.03(h)(5)  CCR §2695.3(a)	<p>The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</p> <p>The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. Original bill received with mod 25 for 99213 and preventative service 99392. Procedure code 99213-25 was denied. When appealed, the previously denied CPT code was adjusted to allow. The Company responded the questions regarding the original denial by providing its “Preventative Medicine and Screening Policy” which was effective 1/10/07. This document does not apply as its effective date is after the date of service of the claim in question. Additionally, it was noted at the time of appeal that the claim was paid. The company responds that the adjustment was made in error as it is its policy not to allow the charge in question.</p> <p>The Company’s claim file failed to contain all documents, notes and work papers that pertain to the claim. There is no documentation to support the denial of 99213-25.</p>
McMinn, W., Wong, M.	4905890-1-8	CIC §10123.13(a)  CIC §790.03(h)(5)	<p>The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</p> <p>The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. Original bill received with multiple surgical pathology charges. One of the billed services was originally denied and then upon appeal, the previously denied charge was allowed. The Company states that per its Laboratory Rebundling Policy the originally denied billed</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Individual Provider Appeals</b>			
<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CCR §2695.3(a)	<p>services were not covered and therefore the original denial was incorrect and the adjustment upon appeal was in error. The material provided in the company response does not provide that the services are not covered.</p> <p>The Company's claim file failed to contain all documents, notes and work papers that pertain to the claim. The company responds to this issue that the zero repricing of these codes was due to the reimbursement policy, which is a contract agreement between the provider and the network. A copy of the signed agreement was referenced, but not provided.</p>
Jerez, A., Descanso Dertmatology Med Grp.	4905501-0-15	<p>CIC §10123.13(a)</p> <p>CIC §790.03(h)(3)</p>	<p>The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</p> <p>The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. Claim received with a diagnosis of "Keloid Scar" which may or may not be cosmetic. At the time of receipt, the Company denied the claim without researching further to see if it was a covered benefit. The Company responds that a review of the records prior to claims processing is not required for a cosmetic diagnosis as it is a Limitation and Exclusion of the policy. It is the provider's responsibility to bill with the appropriate codes at the time of claim submission. Included with the provider dispute was a corrected billing, changing the ICD9 code to 706.2 Sebaceous Cyst along with the medical records that clearly support Cyst diagnosis.</p>
Cosgrove, K./Simon, F., M.D.	4912193-3-2	<p>CIC §10123.13(a)</p> <p>CIC §10123.13(b)</p>	<p>The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</p> <p>The Company failed to pay interest on an uncontested claim after 30 working days.</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Individual Provider Appeals</b>			
Insured/Provider	Claim Number	Citation	Description
		CIC §790.03(h)(3)	<p><b>RECOVERY: \$2.68</b></p> <p>The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company failed to follow its own procedure upon receipt of an emergency claim. No choice emergency claims, even at non-participating facilities, are to be processed as participating. The claim was originally processed as non-participating. The first appeal by the provider for additional benefits was denied by the Company. After the Company denial, the member submitted an appeal disputing the original benefit payment stating that the plan has an emergency benefits and additional benefit were due. After receipt of the member appeal, the company agreed and adjusted the claim. The company paid the original claim incorrectly and at the time of the provider appeal, continued to incorrectly interpret its own policy benefit. At the time of the claim and at the time of the provider appeal, the Company should have allowed the “emergency benefit” under the plan, but did not. Agree. A reminder will be sent to the claims personnel regarding handling of emergency benefits and the applicable interest.</p>
Jung, G., Los Angeles Orthopedic Center	4911989-0-10	CIC §10123.13(a)  CIC §790.03(h)(3)	<p>The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</p> <p>The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The claim was denied: This procedure is not commonly submitted with the accompanying diagnosis(es); therefore, it is not covered...” The billed dx: benign neoplasm of other &amp; unspecified sites. Procedure=excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous. Additionally, the secondary dx= localized superficial swelling, mass, or lump. This claim was payable when received. Disagree. The coding software (McKesson Promatch) program identified the CPT code (26116) as being an inappropriate procedure to be performed for the</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Individual Provider Appeals</b>			
<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CIC §10123.13(b)	<p>diagnosis code of 229. Coding software logic is applied after the claim is entered into the claims system. The program runs automatically on all HCFA claim forms. Until the operative notes were received and reviewed, benefits were not payable due to the diagnosis and procedure codes are not commonly submitted together. The notes were necessary to review for allowable benefits.</p> <p>The Company failed to pay interest on an uncontested claim after 30 working days. The Company disagrees that interest is due. This claim was payable at the time of receipt. The Company paid interest when the provider appealed and records were received, but the interest amount was not calculated using the received date of the claim to the date the claim was adjusted.</p>
Satalowich, C., Najmabadi, S.	4913208-0-10	<p>CIC §10123.13(a)</p> <p>CIC 10169(i)</p> <p>CCR §2695.11(b)</p>	<p>The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</p> <p>The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.</p> <p>The Company failed to provide an explanation of benefits. Disagree. The Company referenced the original denial. This citation relates to the adjusted EOB which does not meet the requirements.</p>
Hu, J., Radiology Medical Group	4912729-0-7	<p>CIC §10123.13(a)</p> <p>CIC §10169.(i)</p>	<p>The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</p> <p>The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Individual Provider Appeals</b>			
<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CCR §2695.3(a)	<p>have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.</p> <p>The Company's claim file failed to contain all documents, notes and work papers that pertain to the claim. No proof that code A4215 X2 was adjusted. Response: The original file does include the provider and insured explanation of benefits for the adjusted claim.</p>
Hu, J. Geonomic Health, Inc.	4912729-0-12	CIC §790.03(h)(3)	<p>The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company has no procedure in place to process a non-par claim at a par level when billed with the par doc information. Disagree. The physician who referred this member to this lab for the test was a participating provider. It is not a requirement to provide consideration for referrals from a participating provider. The member's policy defines non participating providers and the benefits available if no participating provider is available. The member's plan does not contain a provision to process charges at a participating level for non-participating providers which was included in the response letter within the claims file.</p>
Magpiong, L., North County OB-GYN Re-referred 10/10/07	4913865-0-9	<p>CIC §10123.13(a)</p> <p>CIC §10123.13(b)</p> <p style="background-color: yellow;">CIC §790.03(h)(3) Change Cite?</p>	<p>The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</p> <p>The Company failed to pay interest on an uncontested claim after 30 working days. <b>RECOVERY: \$54.43</b></p> <p>The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company appeal response procedures/timelines were not followed. Agree. This original provider dispute was received at PacifiCare on 8/29/06 which is prior to when American Security began to administer this business on 9/1/06. American Medical Security received our provider dispute on 4/10/07 which was promptly</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Individual Provider Appeals</b>			
<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
			<p>responded to on 4/12/07. After receiving the provider dispute on 4/10/07, it is also our assumption based on the documentation we are provided with, that PacifiCare may not have responded to the original dispute.</p> <p>CIC §790.03(h)(5) The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The Company can not support the original denial when billed with a modifier and with a diagnosis of twin birth.</p> <p>CCR §2695.3(a) The Company's claim file failed to contain all documents, notes and work papers that pertain to the claim. Original claim not in file. Disagree. The claim file does contain a copy of the original Health Insurance Claim Form 1500 for the claim in question on the provider dispute. DOI: The only claim in file was provided by the provider at the time of the provider dispute. The original claim received by the Company was not provided to the Department.</p> <p>CCR §2695.3(b)(2) The Company failed to record in the file the date the Company received, date the Company processed and date the Company transmitted or mailed every relevant document in the file. The date the Company received the claim was not provided.</p> <p>CCR §2695.3(b)(2) <b>Remove?</b> Date the 8/29/06 appeal was received.</p> <p>CCR §2695.3(b)(3) The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years. Copy of original payment/EOB issued for the appealed charge not provided. Company: The original file included a response indicating that the original claim was denied at PacifiCare prior to AMS taking over the administration of the business. The Company was unable to obtain a copy of the EOB sent on the original claim as the system only retains a copy of an EOB for a claim that is processed on our system. We did provide a screen print from the PacifiCare system which captures the processing of the original claim. The Company later stated it produced a copy of the EOB from archive but it only produced the first of the 3 page EOB which was sent to the provider and did not produce the EOB sent to the member.</p>

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<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
Murcia, P., Postolov, A., M.D.	4913220-0-1	CIC §10169(i)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.
		CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Web site missing on original EOB. Agree.
		CCR §2695.5(a)	The Company failed to respond to a Department of Insurance inquiry within 21 calendar days. The Department requested if the member did not choose the psyc rider as so stated in the appeal denial. The Company responded: After reviewing the provider dispute response, the L&E within the letter may not have been the most appropriate referenced as to why the services were not covered. Attached you will find a portion of the member's policy and the schedule of benefits that outline the coverage available for these services. Note, The Company did not respond to the issue presented. Reference CIC §10123.15, was the psyc benefit OFFERED to the group?
<b>Total Number of Files Reviewed in this Category: 28</b> <b>Total Number of Files with Citations in this Category: 20</b> <b>Total Number of Citations in this Category: 43    <span style="color: green;">Removed 790.03(h)(3)-Costgrove</span></b>			

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<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
Gamez, J./ James R. Cohen MD	18861108	CIC § 10123.137(c)	The Company failed to issue a written determination within 45 working days after the date of receipt of the provider dispute. In this case, there was no response letter sent.
Jaggers, J./ Riverside Healthcare System	18904564	CIC § 10123.137(c)	The Company failed to issue a written determination within 45 working days after the date of receipt of the provider dispute. In this case, there was no response letter sent.
Breedlove, C./ Rohit Bhaskar MD	19758379	CIC §10123.13(a)  CCR §2696.3(a)	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. The claim was denied inappropriately for pre-existing condition and later reprocessed when the COCC was received.  The Company failed to maintain all documents, notes and work papers in the claim file. There is no documentation in the claim file to support the reason for the denial of the claim.
Scott, T./ Radiological Associates of Sacramento Medical Group	19877731	CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. No interest was paid following reprocessing of the claim. <b>Recovery: \$20.80</b>
Bullard, C./ Schaefer Ambulance Service	19916317	CIC § 10123.137(c)	The Company failed to issue a written determination within 45 working days after the date of receipt of the provider dispute. In this case, the dispute was not resolved timely. Claim received on 10/19/06 was not paid until 8/18/07.
Kiyoi, S./ San Ramon Regional Medical Center	19974814	CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. Claim was underpaid. <b>Recovery: \$6.76</b>
Reynolds, D./ Saint Francis Memorial Hospital	20100909	CIC §790.03(h)(3)  CCR § 2695.3(a)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. Request for further information letter and EOB were sent a day apart which was against Company policy and procedure.  The Company failed to maintain all documents,

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Provider Appeals</b>			
<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
			notes and work papers in the claim file. The copy of the request for more information was not located in the claim file.
Gillette, J./ UCI Medical Center	20151219	CIC §10133.66(c)  CIC §10123.137(c)	The Company failed to acknowledge receipt of the claim within 15 days. Claim received 12/14/06 was not acknowledged until 3/15/07. <b>The DOC DNA project team was implemented to identify timely processing.</b>  The Company failed to issue a written determination within 45 working days after the date of receipt of the provider dispute. In this case, the dispute was not resolved timely as there was a delay in receiving the PDR from the DocDNA system. Claim received on 12/14/06 was not paid until 3/20/07. <b>The DOC DNA project team was implemented to identify timely processing.</b>
Beyer, S./ Lodi Memorial Hospital	19019014	CIC §10123.147(a)	The Company failed to include the factual or legal basis for the denial of the claim. The EOB stated a lack of response from the provider to a request for medical records, which was in error. <b>The Company has change verbiage on the EOP/EOB related to "prior requests" when the intent was regarding the initial request.</b>
Penalosa, O./ Labcorp of America Holdings	19053517	CIC §10169(i)	The Company failed to advise of the right to an Independent Medical Review. <b>The Company will provide changes to the EOB/EOP language to include the contract language by 10/15/07.</b>
Sandbothe, L./ The Emory Clinic Inc.	19079205	CIC §10123.137(c)	The Company failed to issue a written determination within 45 working days after the date of receipt of the provider dispute. Claim received on 10/24/06 was not paid until 8/8/07. <b>Training to be conducted and feedback given to the examiner.</b>
Slaughter, T./ Cedars Sinai Med Center	19092271	CIC §10123.13(a)  CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, the EOB did not include the web address of the California Department of Insurance. <b>Corrective action plan will provide the Plan website.</b>  The Company failed to include the factual or legal basis for the denial of the claim. The EOB was not specific regarding why the appeal was denied. <b>Examiner will be provided feedback.</b>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY</b> <b>Group Provider Appeals</b>			
<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
Lay-sok, J./ Pacific Valley Medical Group	19116747	CIC §10123.137(c)	The Company failed to issue a written determination within 45 working days after the date of receipt of the provider dispute. Claim received on 8/21/06 was not paid until 6/9/07.
Benson, L./ Doctors Center Medical Group	19135981	CIC §10123.137(c)	The Company failed to issue a written determination within 45 working days after the date of receipt of the provider dispute. Claim received on 8/21/06 was not paid until 2/21/06.
		CIC §10169(i)	The Company failed to advise of the right to an Independent Medical Review.
		CIC §10133.66(c)	The Company failed to acknowledge receipt of the appeal claim within 15 days. Claim received 8/21/06 was not acknowledged until 2/27/07.
		CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. No interest was paid following reprocessing of the claim. NO INTEREST PAID AS APPLIED TO DEDUCTIBLE.
		CIC §10123.13(c)	The Company failed to pay interest on a contested claim after 30 working days. No interest was paid following reprocessing of the claim. The claim was denied inappropriately for pre-existing condition. As a result of the examination, an additional claim was located from the member that was inappropriately denied and reprocessed. <b>Recovery: \$38.82</b>
Duran, D./ Loma Linda University Medical Center	19174954	CIC §10123.137(c)	The Company failed to issue a written determination within 45 working days after the date of receipt of the provider dispute. No response letter was sent.
		CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, detailed comments on the reason for denial were not included.
Tuch, L./ Center For Ambulatory Surgery	19452834	CIC §10123.137(c)	The Company failed to issue a written determination within 45 working days after the date of receipt of the provider dispute. No response letter was sent.
		CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Provider Appeals</b>			
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			case, no proof given that an Explanation of Benefit letter was sent.
Baker, A./ Century City Doctors Hospital	19474781	CIC §10123.137(c)	The Company failed to issue a written determination within 45 working days after the date of receipt of the provider dispute. Claim received on 3/16/07 was not paid until 7/30/07.
Johnson, J./ Central Dupage Hospital	19494058	CIC §10123.137(c)  CIC §10169(i)  CIC §10123.13(a)  CCR §2696.3(a)	The Company failed to issue a written determination within 45 working days after the date of receipt of the provider dispute. Claim received on 11/6/06 was not paid until 3/6/07.  The Company failed to advise of the right to an Independent Medical Review.  The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. The claim was denied inappropriately for pre-existing condition and later reprocessed when PDR and medical records received.  The Company failed to maintain all documents, notes and work papers in the claim file. There is no documentation in the claim file to support the reason for the denial of the claim.
Reeves, M./ Academic Surgical 9/18/07 re- referred	19883420-01	CIC §10169(i)  CIC §10123.13(a)  CIC §10123.13(a)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.  The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Web site missing on original EOB. Agree.  The Company failed to include a statement advising the provider of its right to enter into a dispute resolution process described in section 10123.137.

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<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CIC §790.03(h)(5)  CCR §2695.3(a)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. Company can not support the denial due to modifier 59. Company states that procedure code 44640 can not be billed X2 same even with modifier.  The Company's claim file failed to contain all documents, notes and work papers that pertain to the claim. The Company states they requested COB information but has not provided the documentation to support that request. The Company provided a copy of print screen which states a letter was sent but did not provide a copy of the letter that was sent.
Morgan, M./ Southwest Healthcare	18320734-01	CIC §10169(i)  CIC §10123.13(a)  CCR §2695.3(b)(3)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.  The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Agree.  The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years. Claim has been archived. The data was archived on a server and a project was in progress to access the archived data when the acquisition with United Health Care occurred. The project was placed on hold and the files are not currently accessible.
Vasiliauskas, E./Santa Rosa Memorial Hosp.	19842777-01	CIC §10169(i)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Provider Appeals</b>			
<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Agree.
		CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company agrees that it did not follow its own procedure for sending a determination letter. Retraining will be conducted with the examiner.
		<b>CIC §790.03(h)(3) Change Citation?</b>	It appears that even though the company received medical records that did not provide that the condition was pre-existing, the claim(s) were not reprocessed. The Company in its response does not specifically address the issues in the DOI referral.
		CIC §10133.66(c)	The Company failed to acknowledge the claim within 15 days.
		CCR §2695.3(b)(3)	The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years. Customer Service notes have been archived.
		CCR §2695.11(b)	The Company failed to provide an explanation of benefits. The EOB does not provide that this is the maximum benefit has been paid. Agree. Retraining will be conducted to ensure EOB comments are clear and feedback given to the examiner who reprocessed the claim.
Panelo, A./ Regional Medical Center	187511119-01	CIC §10169(i)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.
		CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Provider Appeals</b>			
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		CIC §790.03(h)(3)	review function. Agree.  The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company failed to follow its own procedures. At the time of claim, a REVA case was not created until 5 months after receipt of correspondence, which delayed an acknowledgment/finalization of the appeal.
Leary, J./St. Joseph Hospital-Orange	199916272-01	CCR §2695.3(a)	The Company's claim file failed to contain all documents, notes and work papers that pertain to the claim. According to the Company, the worksheet notes document that the provider contacted Customer Service and the claim was adjusted. The worksheet notes do not document what the provider stated during the conversation, only the PC outcome.
		CCR §2695.11(b)	The Company failed to provide an explanation of benefits. The EOB states for a not covered amount Not Patient Responsibility when the amount is a Provider Discount. Disagree. Amount shown as "Not patient responsibility" is the provider write-off amount.
		CCR §2695.11(b)	The EOB does not provide state the covered amount after it has deducted the provider discount/Not patient responsibility amount. Co: response: The allowable amount (covered amount) is the sum of the deductible, co-insurance and plan payment.
		CCR §2695.11(b)	The EOB does not advise the member that the maximum benefit had been paid. Agree. Retraining will be conducted to ensure EOB comments are clear and feedback given to the examiner who reprocessed the claim.
Adams, P./Sacramento Radiology Medical Email sent 9/20/07	19762906-01	CIC §10169(i)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.
		CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Provider Appeals</b>			
<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CIC 10123.137(c)	<p>Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Agree.</p> <p>The Company failed to resolve a provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute. Dispute received 10/10/06, Company responded on 8/8/07. Company agrees but did not provide a corrective action.</p>
Salamon, J./Cottage Health Systems	19779911-01	CIC §10169(i)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.
		CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Agree.
		CCR §2695.5(a)	The Company failed to respond to a Department of Insurance inquiry within 21 calendar days. The Company has not responded to the three issues addressed in item #4 of the Departments referral.
Chen, A./UCLA School of Denistry	20126424-01	CIC §10169(i)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.
		CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Agree.

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<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CIC §10123.13(a)	The Company failed to provide written basis for the denial of the claim. The reason code ND does not meet the requirements. Agree.
Decker, T./Hoag Memorial Hospital	19952647-01	CIC §10169(i)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.
		CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Agree.
		CIC §10198.7(a)	No health benefit plan that covers 3 or more persons (Group or Individual Coverage) that is issued, renewed or written by any insurer shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than 6 months following the individual's effective date of coverage. Agree. Policies have been changed to reflect 6 months.
		CIC §790.03(h)(1)	The Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue. Company referenced a 1 year pre-exist time period on the EOB when in actuality there is only a 6 month pre-exist period. Agree.
		CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company is denying services as pre-existing when it does not have medical records to support its denial.
Perez, A., St. Jude Heritage	18929522-01	CIC §10169(i)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed

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			by the insurer, or by one of its contracting providers. Agree.
		CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Agree.
		CIC 10123.137(c)	The Company failed to resolve a provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute. Dispute received 9/23/06, Company responded 11/3/06=46 days. The response letter included in the file was for a second dispute sent from the provider. There was not a response letter sent for this claim.
		CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company agrees that it did not follow its own guidelines for sending a response to the provider. The examiner who failed to do so will be coached.
		CIC §10123.13(a)	The Company failed to provide the written basis for the denial of the claim. Agree. The explanation is not specific on the EOB. Additional training will be conducted and the employee will be coached.
Qiyuan, D., UCI Medical Center/Prof Fees	19014622-01	CIC §10169(i)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.
		CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Web site missing on original EOB. Agree.
		CIC §10123.13(b)	The Company failed to pay interest on an

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Provider Appeals</b>			
<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		<p>CIC §790.03(h)(3)</p> <p><b>CIC §790.03(h)(3) Why is this not a 2695.3(a)?</b></p> <p><b>CIC §790.03(h)(5) Why is this not a CIC §10123.13(a)?</b></p> <p>CCR §2695.3(b)(3)</p> <p>CCR §2695.3(b)(3)</p> <p>CCR §2695.3(b)(3)</p>	<p>uncontested claim after 30 working days. This is due to newborn charges not processed with mom's charges.</p> <p>The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. At the time of the mom' claim payment, the company had the newborn charges but processed the claim separately and inaccurately denied the charges.</p> <p>There is no documentation to support why it took over 60 days to deny the baby's charges, even though the denial was incorrect.</p> <p>The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. At the time of receipt of claim, the company waited over 60 days before denying the claim inaccurately.</p> <p>The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years. Copy of claim 19014622-01 has been archived.</p> <p>The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years. Copy of claim 19801246-01 has been archived.</p> <p>The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years. Copy of provider appeal has been archived.</p>
Ortiz, R., UCI Medical Center	18978263	CIC §10169(i)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Provider Appeals</b>			
<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Web site missing on original EOB. Agree.
		CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. This is due to newborn charges not processed with mom's charges. <b>RECOVERY: \$1.55</b>
		CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. After receiving what the company determined to be an incomplete COCC (dependent not listed on form received 10/27/06) the file does not document that the company pursued the information needed until the member initiated contact regarding the status.
		CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. <b>RECOVERY: \$92.68 TOWARDS DEDUCTIBLE</b>
		CCR §2695.3(a)	The Company's claim file failed to contain all documents, notes and work papers that pertain to the claim. Proof that interest was paid for all of this member's claims in history was not provided and/or proof of payment.
		CCR §2695.3(b)(3)	The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years. Original claim archived.
Hirschhorn, L., UCSF Medical Center	34174469-02	CIC §10169(i)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.

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<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Web site missing on original EOB. Agree.
		CIC §10123.13(c)	The Company failed to pay interest on a contested claim after 30 working days. It is noted that the Company did not pay the correct interest rate in 7 claims and an additional \$176.00 is due. <b>RECOVERY: \$ 212.40</b>
		CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.
Vierra, W., Sequoia Surgical Pavillion	18977666-01	CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The original processing of the claim did not reimburse per the provider contract with the company.
		CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. <b>RECOVERY: \$11.84</b>
		CIC §10123.147(b)	The Company failed to include all required information on the Explanation of Benefit. Health insurer time for reimbursement of complete claim; notice to contest or deny claim including the factual or legal basis for the reason to contest or deny; notice to provider and insured required shall include notice that either may seek review by the department and the notice shall include the address, internet web site address, and telephone number of the unit within the department that performs this review function.
		CCR §2695.5(b)	The Company failed to respond to communications within 15 calendar days with a complete response based on the facts as then known by the licensee. The provider appealed the benefit payment based on the provider contract with the Company. The provider listed per procedure how it should be reimbursed. The Company did not reimburse per the provider request and did not explain to the provider the reason for a different reimbursement amount

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		CCR §2695.11(b)	(lesser) than what was requested. Agree, but does not provide a corrective action.  The Company failed to provide an explanation of benefits or a clear explanation of benefits. The EOB dated 7/31/06 notes in the provider discount portion of the EOB \$21.38, not the 11,810.84 which is located in the Not Patient Responsibility portion of the EOB. The company states that due to the allowable being more than billed, the EOB is correct. Disagree. The EOB is not clear.
Yarbrough, R. / Cresswell Physical Therapy	19280467-01	CIC §10123.137(c)  CIC §2695.7(g)	The insurer shall resolve each provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute. The dispute was resolved in 86 days.  No insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The participating provider was paid at a rate that was less than the contracted rate. <b>Potential Recovery Pending. The Company is in the process of identifying claims submitted by this provider with CPT code 97110 that was under paid. The results of the review are pending.</b>
Buckly, B. / Sandra Hollenberg MD	19291058-01	CIC §10133.66(c)	The Company failed to acknowledge receipt of claim within 15 days. The claim was acknowledged on day 19.
Clark, C. / Corona Regional Medical Center	19572969-01	CCR §2695.3(b)(2)	The Company failed to record in the file the date the Company received, date the Company processed and date the Company transmitted or mailed every relevant document in the file. The file does not document when the Provider Dispute Resolution was received. Also the Provider Dispute Resolution form is not in the file.

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Provider Appeals</b>			
<b>Insured/Provider</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
Rivera, I. / Michael H. Dawson DC	19512078-01	CIC §10133.66(c)	The Company failed to acknowledge receipt of claim within 15 days. The claim was acknowledged on day 126.
		CIC §10123.137(c)	The insurer shall resolve each provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute. The dispute was resolved in 127 days.
<p><b>Total Number of Files Reviewed in this Category: 29 +28+3+7+</b>  <b>Total Number of Files with Citations in this Category: 37</b>  <b>Total Number of Citations in this Category: 103</b> <span style="float: right; color: green;"><b>Changed 1-790.03(h)(2) to 2695.5(b)</b></span></p>			

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Individual Member Appeals</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
Cheung, S.	4905787	CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. No interest was paid following reprocessing of the claim. <b>NO INTEREST PAID AS APPLIED TO DEDUCTIBLE.</b>
Hulse, C.	4917290	CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. <b>Recovery: \$3.69</b>
Peacock, C.	4913188	CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. <b>Recovery: \$4.80</b>
Toumani, T.	4905063	CIC §10123.13(a)	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.
Boehmer, K.	4907259-02	CIC §10123.13(a)	Health care service plan shall reimburse claim no later than 30 working days after receipt. The claim was reimbursed on day 87.
Kanzaki, C.	4906252-02	CIC §10123.13(a)	The Company failed to reimburse a health care claim no later than 30 working days after receipt. The appeal decision was rendered on 10/10/06. The decision was made to pay the claim. The claim was inventoried on 10/10/06 to be reprocessed. Inadvertently the claim was denied on 11/08/06 then subsequently paid on 12/12/06. As such the claim was reimbursed on day 63 after receipt.
		CIC §10123.13(c)	The Company failed to include interest on this claim that was reimbursed after 30 working days. Interest shall accrue and shall be payable at 10% per annum beginning with the 1 <sup>st</sup> calendar day after the 30 working day period.
<b>Total Number of Files Reviewed in this Category: 33</b> <b>Total Number of Files with Citations in this Category: 4</b> <b>Total Number of Citations in this Category: 4</b>			

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Member Appeals</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
Hoffman, S.	17961591-01	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, reference was incorrectly made to the DMHC on PPO claim.
		CIC §10123.13(a)	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.
Johnson, B.	16896128-01	CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. <b>Recovery: \$29.25</b>
Levenson, W.	15100617-01	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, reference was made to the DMHC on PPO claim.
		CIC §10123.13(a)	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.
Layland, J.	10642253-01	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, reference was made to the DMHC on PPO claim.
		CIC §10123.13(a)	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.
Blanchard, J.	18203917-01	CIC §10123.13(a)	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.
Axene, E.	06124e04301	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Member Appeals</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CIC §10123.13(a)	case, reference was made to the DMHC on PPO claim.  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.
Crespi, J.	15178872-01	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, reference was made to the DMHC on PPO claim.
		CIC §10123.13(a)	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.
Moffat, C.	16913821-01	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, reference was made to the DMHC on PPO claim.
		CIC §10123.13(a)	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.
		CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. <b>Recovery: \$12.42</b>
Malinak, M.	19703423-01	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, reference was made to the DMHC on PPO claim.
		CIC §10123.13(a)	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.
Walker, L.	20075311-01	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Member Appeals</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CIC §10123.13(a)	<p>case, reference was made to the DMHC on PPO claim.</p> <p>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.</p>
Swanson, C.	19341619-01	CIC §10198.7(a)	<p>The Company failed to provide coverage for any individual on the basis of a pre-existing condition provision for a period greater than 6 months following the individual's effective date of coverage. In this case, the member's enrollment date was 12/1/05, and the dates of service excluded were 8/7/06 to 9/27/06. .</p>
		CIC §10123.13(a)	<p>The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. The claim for dates of service 8/7/06 to 9/27/06 were denied inappropriately for pre-existing condition.</p>
		CIC §790.03(h)(1)	<p>The Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue. The Policies and Procedures and Certificates incorrectly stated the exclusionary period for pre-existing condition. The claim for dates of service 8/7/06 to 9/27/06 were denied inappropriately for pre-existing condition</p>
		CIC §10123.13(b)	<p>The Company failed to pay interest on an uncontested claim after 30 working days. No interest was paid on the reworked claims upon acceptance of coverage. <b>Recovery: \$1.06</b></p>
Le, T.	17986130-01	CIC §10123.147(a)	<p>The Company failed to include all required information on the Explanation of Benefit. In this case, reference was made to the DMHC on PPO claim.</p>
		CIC §10123.147(a)	<p>The Company failed to include all required information on the Explanation of Benefit. 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</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Member Appeals</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
			have the matter reviewed by the California Department of Insurance.
Sander, K.	19450664-01	CIC §10123.13(a)  CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, reference was made to the DMHC on PPO claim.  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.
Stern, R.	Case # 15210	CIC §10123.147(a)	The Company failed to include all required information on the Explanation of Benefit. The appeal denial letter that was sent to the insured on 8/2/06 did not provide a reference to the Department of Insurance. <b>The Company disagrees that a reference to the Department of Insurance is required on appeal denial letters.</b>
Yeganova, A.	Case # 15087	CIC §10123.13(a)  CCR §2695.3(a)  CCR §2695.5(b)	The Company failed to refer to specific policy provisions in the claim denial. Group health insurance improper denial. Claim was denied for pre-existing as there was no documentation of creditable coverage in the file. Company states claim was in fact denied for lack of information.  The Company failed to maintain all documents, notes and work papers in the claim file. The Company failed to properly document the claim file. Company failed to outline pre-existing periods and why dates of service would be considered pre-existing. There was no documented basis for the pre-existing denial of the claim.  The Company failed to respond to communications within 15 calendar days or with a complete response based on the facts as then known by the licensee. Appeal received 6/02/06 and response sent 7/19/06.
Pourkashef, M.	Case # 15050	CIC §10123.13(a)	Group health insurance improper denial. Claim was denied for pre-existing as there was no documentation of creditable coverage on the file. Company states claim was in fact denied for lack of information.

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Member Appeals</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CCR §2695.3(a)	The Company failed to maintain all documents, notes and work papers in the claim file. The Company failed to properly document the claim file. There was no documented basis for the pre-existing denial of the claim. Company failed to outline pre-existing periods and why dates of service would be considered pre-existing.
		CCR §2695.5(b)	The Company failed to respond to communications within 15 calendar days or with a complete response based on the facts as then known by the licensee. Appeal received 5/31/06 and response sent 6/30/06.
Hartwig, D.	Case # 15069	CIC §10123.147(a)	The Company failed to include all required information on the Explanation of Benefit. The appeal denial letter that was sent to the insured on 6/29/06 did not provide a reference to the Department of Insurance. <b>The Company disagrees that a reference to the Department of Insurance is required on appeal denial letters.</b>
Do, Thuan	Case # 15037	CIC §10123.13(a)	Group health insurance improper denial. Claim was denied for pre-existing as there was no documentation of creditable coverage on the file. Company states claim was in fact denied for lack of information.
		CCR §2695.3(a)	The Company failed to maintain all documents, notes and work papers in the claim file. The Company failed to properly document the claim file. Toddler diagnosed with abnormality of gait. Company failed to outline pre-existing periods and why dates of service would be considered pre-existing. There was no documented basis for the pre-existing denial of the claim.
Davies, K.	Case # 15376	CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The Company failed to reimburse the claim including interest. <b>Recovery:</b>
		CCR §2695.5(b)	The Company failed to respond to communications within 15 calendar days with a complete response based on the facts as then known by the licensee. Appeal received 6/22/06 and response issued 7/14/06.

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Member Appeals</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
Crawley, A.	066062600	CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. Company did not follow its own procedures for processing of ancillary providers in an emergency situation.
		CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.
		CCR §2695.3(b)(3)	The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years. Claim has been purged. Company produced an EDI print.
		CCR §2695.5(a)	The Company failed to respond to a Department of Insurance inquiry within 21 calendar days. The Company did not provide at the time of the initial examination, copies of the customer service phone call and/or documentation to support an adjustment made to the claim in question prior to the member appeal.
		CCR §2695.5(b)	The Company failed to respond to communications within 15 calendar days with a complete response based on the facts as then known by the licensee. The Company appeal denial letter did not address the issues the member brought forth in its appeal letter. The Company sent a “generic” letter to the member appeal which quoted a covered expense and percentage payable. The Company did not specifically address the emergency surgery and that the claim had previously been adjusted to allow benefits at what the plan had determined to be a higher rate due to the no-choice emergency situation.
		CCR §2695.11(b)	The Company failed to provide an explanation of benefits or a clear explanation of benefits. The adjusted EOB dated 12/21/05 does not indicate that a prior benefit payment (11/22/05) was deducted from the payment made. Therefore the EOB does not provide a clear computation of benefits.

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<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
Bowman, R.	075647100	CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.
		CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. <b>RECOVERY: \$62.17</b>
		CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. Company states paid incorrectly and adjusted. Issue, DOI questioned how the company determined the rate for the billed procedure specifically due to the appeal of the allowable. Company agrees that the claim was priced incorrectly using the limited fee rate. The claim should have been processed using U&C rate. Claim reprocessed to use ERAP guidelines. Pacificare will provide feedback to the staff involved with this case regarding the need to ensure claim was processed using the correct rates. <b>RECOVERY: \$ 467.61</b>
		CCR §2695.5(b)	The Company failed to respond to communications within 15 calendar days with a complete response based on the facts as then known by the licensee. In the Company appeal denial it did not address the issues the member brought forth in the appeal letter.
Paul, R.	016578000	CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.
		CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. <b>RECOVERY: \$156.69</b>
		CCR §2695.3(b)(3)	The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years. 1 <sup>st</sup> appeal referenced in 2 <sup>nd</sup> member appeal co states they do not have, but an adjustment

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Member Appeals</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CCR §2695.5(b)	<p>was made prior to the 2<sup>nd</sup> appeal so it appears the company may have lost the 1<sup>st</sup> member appeal.</p> <p>The Company failed to respond to communications within 15 calendar days with a complete response based on the facts as then known by the licensee. The Company appeal denial did not address the issues the member brought forth in its appeal letter. The member appeal letter specifically states that the schedule of benefits implies 80% or 60% of the billed amount. The company response does not address this statement only addresses that the claim was “paid” per the policy. The member further addresses that they are paying 62% of the billing and PacifiCare is paying 38%. It is clear that the member is upset regarding the amount covered which was determined by the company and not specifically addressed in the company response. Disagree. We explained to the member that he is responsible for the difference between the Covered Expense and billed charges and provided the language from the certificate to support that decision.</p>
McGue, D.	075215000	CIC §790.03(h)(3)	<p>The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company failed to follow its own procedure for non-emergent charges in a no-choice non-par/ancillary situation.</p>
		CIC §790.03(h)(5)	<p>The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. At the time of adjudication an incorrect adjustment was made. The DOI questioned why the claim was sent for re-pricing and the EOB indicated a provider write-off amount when this was a non-participating provider. There was an examiner error as the claim was processed using an “oa” remark code which is used when making an adjustment for a participating provider. The remark code utilized should have been “au” which would have shown the difference between billed charges and allowed amount as the member’s responsibility. The Company did not provide a corrective action to its latest response.</p> <p><b>RECOVERY:</b> Pending proof of payment from the company.</p>
		CIC §10123.13(a)	<p>The Company failed to notify the member or</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Member Appeals</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CIC §10123.13(b)	<p>provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</p> <p>The Company failed to pay interest on an uncontested claim after 30 working days. Company states that claim was processed incorrectly and interest was paid. <b>RECOVERY: Awaiting proof</b></p>
Bobich, E.		CIC §10169(i)  CIC §10123.13(a)	<p>The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.</p> <p>The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Web site missing on original EOB. Agree.</p>
Ward, J.	082045100	CIC §790.03(h)(3)  CIC §10123.13(a)  CCR §2695.3(a)	<p>The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company has no procedure in place when a non-covered professional component is billed/denied and then appealed to check history to see if the facility billed also. If not billed, charge allowable.</p> <p>The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</p> <p>The Company's claim file failed to contain all documents, notes and work papers that pertain to the claim. A copy of the claims history was requested and not provided.</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY</b> <b>Group Member Appeals</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CCR §2695.3(b)(3)	The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years. Claim has been purged.
Smith, B.	025819500	CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.
		CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. Additional interest is due on adjusted claims but was not provided. <b>RECOVERY: \$1.14</b>
		CCR §2695.5(b)	The Company failed to respond to communications within 15 calendar days with a complete response based on the facts as then known by the licensee. The Company has no procedure in place to utilize the facility or the referring physician or facility on the HCFA at the time of receipt of claim to process ancillary providers at the par rate. Member in participating hospital for kidney infection and stones treatment by specialist was required no choice situation for member. Company failed to address why a no-choice in hospital ancillary provider would not be paid as par. Disagree. The Company responds that the physician was non-participating for the DOS billed, but did not address that the facility was participating.
Fortune, V.	073124200	CCR §2695.3(a)	The Company failed to maintain all documents, notes and work papers in the claim file. Member had surgery in a participating facility with a participating surgeon on 2/2/06; the anesthesiologist was not a participating provider. Member appealed non-participating payment made to anesthesiologist based on no choice provision by surgeon and facility. The Company quoted in its denial letter that there are 12 par anesthesiologists that could have been utilized but provided no proof the anesthesiologists had privileges at the surgical facility. The Company provided the CDI a 10/2/07 print out from its internet site which does not prove that the physicians were

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Member Appeals</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CIC §10123.13(a)	<p>participating at the facility or listed as participating providers at the time the service was rendered.</p> <p>The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</p>
Hanson, P.	088344300	CIC §790.03(h)(3)	<p>The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company procedure to utilize the facility or the referring physician on the HCFA at the time of receipt of claim to process ancillary providers at the par rate was not followed. <b>Agree. The Company will provide feedback by October 15<sup>th</sup>.</b></p>
		CIC §10123.13(a)	<p>The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</p>
Huseman, Q.	067236700	CIC §790.03(h)(5)	<p>The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. It is unclear how the company made its appeal determination without having a copy of the pre-certification letter. Disagree. Although a copy of the auth letter isn't available the screen print provided provides authorization comments for services in question. The member was billed for the difference between U&amp;C and billed charges.</p>
		CIC §10123.13(a)	<p>The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</p>
		CCR §2695.3(b)(3)	<p>The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Member Appeals</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CCR §2695.5(b)	<p>five years. Company provided a print screen of the pre-authorization, but was not able to produce a copy of the prior authorization letter sent to the member. Records have been purged.</p> <p>The Company failed to respond to communications within 15 calendar days with a complete response based on the facts as then known by the licensee In the Company appeal denial letter, it did not address the issues the member brought forth in its appeal letter. Agree that the appeal response did not address the specific issue in the member’s appeal. PacifiCare will provide specific feedback to the staff involved with this case regarding the need to address specific issues brought fourth in the appeal. In addition, all staff members were reminded of the importance of addressing the specific issues in the staff meeting held on 9/25/07.</p>
Jones, T.	052615700-04	CIC §10123.13(a)	<p>The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</p>
		CCR §2695.3(b)(3)	<p>The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years. Claim has been archived.</p>
Gins, N.	0003066511	CIC §10123.13(a)	<p>The Company failed to include all required information on the Explanation of Benefit. In this case, reference was made to the DMHC on PPO claim appeal.</p>
		CIC §790.03(h)(3)	<p>The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The original claim had all of the required information to process the ancillary provider with a par referral, but the company failed to utilize that information. Disagree. Claim was paid at the correct benefit level.</p>
		CIC §10123.13(a)	<p>The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address,</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Member Appeals</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CCR §2695.5(b)	<p>the Internet Web site address, and telephone number of the unit within the Department that performs this review function. No CDI language on appeal denial</p> <p>The Company failed to respond to communications within 15 calendar days with a complete response based on the facts as then known by the licensee. The Company denial of the appeal did not address the issues the member brought forth. The point of the member appeal was a no choice/ancillary provider-a bill for radiology services at a participating hospital. The appeal denial did not address to the member that the calendar year deductible would need to be met for both par and non-par providers. Company provided a form letter which still does not address the issues in the member appeal. Disagree. Explained that no additional payment was due.</p>
Reid, W.	074921800	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, reference was made to the DMHC on PPO claim appeal.
		CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.
Bero, D.	061689100	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, reference was made to the DMHC on PPO claim appeal.
		CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. <b>Disagree that it is necessary on appeal.</b>
		CCR §2695.5(b)	The Company failed to respond to communications within 15 calendar days with a complete response based on the facts as then known by the licensee. The appeal requested payment of a non-par provider

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Member Appeals</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CCR §2695.11(b)	<p>(anesthesiologist) at par for the billed service. The Company response did not provide specific information regarding the payment for services. Agree. PacifiCare will provide specific feedback to the staff involved with this case regarding the need to address specific issues brought fourth in the appeal when responding to the member. In addition, all staff members will be reminded of the importance of addressing the specific issues in the next staff meeting scheduled on 9/25/07.</p> <p>The Company failed to provide an explanation of benefits. The EOB provided does not contain the required computation of benefits. Agree that the EOB does not provide a clear computation of benefits. There was a system error that listed \$1,036.30 (difference between covered expense and billed charges) in several different columns. This amount should have only been listed as patient responsibility. The Company did not provide a corrective action.</p>
Rafizad, H.	065138700	CIC §10123.13(a)  CCR §2695.3(b)(3)	<p>The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</p> <p>The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years. Claim has been purged. Company provided an EDI claim but the print out does not provide the documentation necessary for review.</p>
Hammerle, T.	036920500	CIC §10123.13(a)  CCR §2695.5(b)	<p>The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.</p> <p>The Company failed to respond to communications within 15 calendar days with a complete response based on the facts as then known by the licensee The appeal requested payment of a non-par provider at par for the billed service. The Company response</p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Member Appeals</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
			did not provide the information requested. Agree. PacifiCare will provide specific feedback to the staff involved with this case regarding the need to address specific issues brought fourth in the appeal when responding to the member. In addition, all staff members will be reminded of the importance of addressing the specific issues in the next staff meeting scheduled on 9/18/07.
<p><b>Total Number of Files Reviewed in this Category: 44</b>  <b>Total Number of Files with Citations in this Category: 35</b>  <b>Total Number of Citations in this Category: 90</b> Changed 6 790.03(h)(2) to 2695.5(b), McGue-790.03(h)(5) removed. Deleted 790.03(h)(3) for Smith and changed to 5(b), 790.03(h)(5) removed on Smith</p>			

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Individual Denied Claims</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
Pham, T.	4915431	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB. <b>The EOB will undergo modification to include the DOI web address, scheduled to be implemented in October of 2007.</b>
		CCR §2695.3(b)(3)	The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years The EOB from the original claim was not able to be produced.
Yoo, H.	4916982	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Bowden, M.	4905494	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Byi, B.	4910405	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
O'Donnell, T.	4913661	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB. <b>The EOB will undergo modification to include the DOI web address, scheduled to be implemented in October of 2007.</b>
		CCR §2695.3(b)(3)	The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years The EOB from the original claim is not able to be reproduced.
Long, I.	4905447	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY</b> <b>Individual Denied Claims</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
			case, there is no reference to the California Department of Insurance web address on the EOB.
Fyock, K.	4913050	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Lee, R.	4915294	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Dighera, K.	4913607	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Precup, C.	4910109	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Bayley, L.	4913736	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB. .
		CIC §10123.13(a)	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. The claim for date of service 7/27/06 was denied inappropriately as duplicate.
		CCR §2695.3(b)(3)	The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years. The EOB from the original claim is not able to be reproduced
Madden, C.	4910731	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Benjamin-Johnson, A.	4923775	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Individual Denied Claims</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
Tuvell, M.	4912021	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Shepherd, C.	4916081	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Terrell, A.	4911056	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Malik, K.	4904314	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Slatter, J.	4911883	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Baumgartner, S.	4906074	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Murcia, P.	4913220-00-0001-01	CIC §10123.13(a)	Group or individual health insurance policies; time for reimbursement of claims; reasonably contested claims, notice of contested or denied claim, including the factual or legal basis for the reason to contest or deny; notice to provider and insured required shall include notice that either may seek review by the department and the notice shall include the address, internet web site address, and telephone number of the unit within the department that performs this review function. The notice shall also include a statement advising the provider of its right to enter into a dispute resolution process described in Section 10123.137. The Department of Insurance internet web site address was not included on the EOB sent to the insured.

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Individual Denied Claims			
Insured	Claim Number	Citation	Description
<b>Total Number of Files Reviewed in this Category: 38+</b> <b>Total Number of Files with Citations in this Category: 19</b> <b>Total Number of Citations in this Category: 24</b>			

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Denied Claims			
Insured	Claim Number	Citation	Description
Carnahan, D.	19393743	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB. <b>The EOB will undergo modification to include the DOI web address, scheduled to be implemented in October of 2007.</b>
Streitman, S.	33323769	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
		CIC §10133.66(c)	The Company failed to acknowledge receipt of a claim within 15 days. The original claim received prior to 11/25/06 was not acknowledged until paid 2/18/07, prompting a duplicate claim. <b>The vendor who prints the checks is validating the check file against the check register to ensure all checks are printed timely.</b>
		CIC §10123.13(a)	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. The original claim received prior to 11/25/06 was not paid until 2/18/07, prompting a duplicate claim.
Garcia, J.	19437852	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Montoya, J.	20337708	CIC §10123.13(a)	The Company failed to include all required

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY</b> <b>Group Denied Claims</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
			information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Simmons, M.	34217694	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Duldulao, A.	34516437	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Glover, T.	20014753	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
DeFoore, N.	19179723	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Stinson, T.	19225457	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Puccio, J.	34108647	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Newman, D.	34587307	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Gildea, S.	20253575	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
		CIC §10123.13(a)	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. The EOB dated 10/26/06 states the claim was denied for duplicate claim. The claim

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY</b> <b>Group Denied Claims</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
			was denied inappropriately as there was no duplicate. <b>This appears to be a data entry issue, as duplicate claims were entered into Claims Exchange and QicLink on different days. The data entry team will be provided feedback.</b>
McCarl, J.	334444354	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Thomas, E.	21025983	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Devlin, J.	20884496	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Kelman, B.	34080603	CIC §10123.13(a)	The Company failed to include all required information on the Explanation of Benefit. In this case, there is no reference to the California Department of Insurance web address on the EOB.
Kelterborn, J.	20173908-01	CIC §10123.13(a)	Health care service plan shall reimburse claim no later than 30 working days after receipt. The claim was originally denied incorrectly on 10/25/06. When the claim was pulled for this audit, the Plan recognized the error and reprocessed the claim and paid it under claim #20173908-02. The claim was originally received on 10/13/06. The claim was finally paid on 8/1/07. As such it took 292 days to properly process and pay this claim. <b>Deductible Recovery: \$93.60</b>
		CIC §10123.13(b)	If an uncontested claim is not reimbursed by delivery to the claimant's address of record within 30 working days after receipt, interest shall accrue and shall be payable at 10% per annum beginning with the 1 <sup>st</sup> calendar day after the 30 working day period. Interest was not included with claim reimbursement.
Guilburt, D.	18862715-01	CIC §10123.13(a)	Health care service plan shall reimburse claim no later than 30 working days after receipt. The claim was received on 7/14/06. It was denied on 7/18/06 for coordination of benefits information. On 8/21/06

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY</b> <b>Group Denied Claims</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
			the coordination of benefits information was received stating there was no other insurance. The claim was not reprocessed and paid until 8/21/07. As such it took 365 days to properly process and pay this claim. <b>Recovery: \$73.00</b>
Andrews, V.	33145273-01	CIC §10123.13(a)	Health care service plan shall reimburse claim no later than 30 working days after receipt. The claim was originally denied incorrectly. When the claim was pulled for this audit, the Plan recognized the error and reprocessed the claim and paid it under claim #33145273-02. The claim was originally received on 12/22/06. The claim was finally paid on 8/1/07. As such it took 222 days to properly process and pay this claim. <b>Recovery: \$29.75</b>
Ghianni, F.	33556361-01	CIC §10123.13(a)	Health care service plan shall reimburse claim no later than 30 working days after receipt. The claim was received on 3/1/07. It was denied on 3/21/07 for coordination of benefits information. On 4/2/07 the coordination of benefits information was received stating there was no other insurance. The claim was not reprocessed and paid until 8/4/07. As such it took 124 days to properly process and pay this claim. <b>Recovery: \$16,155.26</b>
Azevedo, D.	21030899-01	CIC §10169(i)  CIC §10123.13(a)  CCR §2695.3(a)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.  The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Agree  The Company failed to maintain all documents, notes and work papers in the claim file. The company did not produce the SIU file to explain the long delay in claim payment and can not explain why the SIU process took so long.

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY</b> <b>Group Denied Claims</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CCR §2695.3(b)(3)	The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years. The Company can not reproduce the acknowledgement letter sent at the time the claim was referred to its SIU Department.
Lane, S.	20350960-01	CIC §10169(i)  CIC §10123.13(a)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.  The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.
Carretero, C.	33069487-01	CIC §10169(i)  CIC §10123.13(a)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.  The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.
Warren, B.	3493623-01	CIC §10169(i)  CIC §10123.13(a)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.  The Company failed to notify the member or

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY</b> <b>Group Denied Claims</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
			provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.
Leung, A.	34106599-01	CIC §10169(i)  CIC §10123.13(a)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.  The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.
Klasser, K.	34920177-01	CIC §10169(i)  CIC §10123.13(a)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.  The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.
Sherrick, M.	33492385-01	CIC §10169(i)  CIC §10123.13(a)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.  The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY</b> <b>Group Denied Claims</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
			of the unit within the Department that performs this review function.
Patel, A.	33474798-01	CIC §10169(i)  CIC §10123.13(a)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Agree.  The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.
Beckwith, R.,	33144900-03	CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Agree
Saucier, S.A.	20900861-01	CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Agree
Valdez, E.	33724870-01	CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Agree
Ackley, J.	20957614-01	CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Agree
Balogh, K.	17332468-02	CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Denied Claims</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CIC §10123.13(a)	Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Agree  The Company failed to provide the written basis for the denial of the claim. The EOB denying charges stated that the claim was not a covered benefits and to refer to the certificate, which is not in compliance. Agree. <b>Changes to EOB/EOP will be made with training completed by 10/1/07.</b>
Riffert, A.	19495163-01	CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Agree
Whalen, F.	20396978-01	CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Agree
Hipp, T.	34346062-01	CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Agree
Wallace, J.	18688953-01	CIC §10123.13(a)	The Company failed to notify the member or provider that they may seek review by the Department and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. Agree
<b>Total Number of Files Reviewed in this Category: 64</b> <b>Total Number of Files with Citations in this Category: 37</b> <b>Total Number of Citations in this Category: 51</b>			

<b>ELECTRONIC DATA ANALYSIS PAID HEALTH CLAIMS</b>		
Population Category	Window: 6/23/06 – 5/31/07	Comments (Citation & Description)
<p><b>Group Paid Claims</b> Total Population Per Claims Operations Questionnaire Response &amp; Follow-up Referral Response</p>	<p>1,077,024</p>	<p>CIC § 10133.66(c) Failure to acknowledge receipt of claims</p> <p>Company states the process for printing acknowledgement letters moved from internal department to (IDC), to a vendor Duncan. It was discovered that during this transition, Duncan did not print system generated letters from July 2006 until January 2007. On 10/17/07 Duncan was requested to generate a weekly report linking acknowledgement dates to claim numbers.</p> <p>Re-Referral outstanding on acknowledgement procedures – Due 10/22. The company has not provided documentation that acknowledgement letters are currently being generated.</p> <p>CCR §2695.3(a) - Company does not keep documentation of acknowledgement</p>
<p><b>Group Paid Claims</b> Total Population Not Paid within 30 working days of receipt of the claim Per Company Response &amp; CDI Analysis</p>	<p>37,238</p>	<p>CIC § 10123.13(a) Failure to reimburse claim as soon as practical, but no later than 30 working days after receipt of the claim.</p>
<p><b>Group Paid Claims</b> Total Population that did not include interest with the reimbursement Paid over 30 working days of receipt of the claim per CDI Analysis</p>	<p>14,011*</p> <p>4642 Applied to Deductible 3570 Recovery Request? 7 Paid to Member out of country 5792 Total # of Claims Interest Due</p>	<p>CIC § 10123.13(b) Failure to pay interest on an uncontested claim after 30 working days (Resolution: Company will manually adjust to pay claims and provide evidence to DOI. Estimated Completion Date 12/01/07)</p> <p>Re-Referral outstanding. Need explanation of Recovery Request – Due 10/22/07.</p> <p>CCR §2695.3(a) - Company does not keep documentation of acknowledgement</p>

<p><b>Individual Paid Claims</b>                  Total Population                  Per Claims Operations                  Questionnaire Response &amp;                  Follow-up Referral Response</p>	<p>48,683</p>	<p>CIC § 10133.66(c)                  Does not appear to be a procedure                  or process in place for                  acknowledging claims within 15                  working days of the date of the                  receipt of the claim.</p>
<p><b>Individual Paid Claims</b>                  Total Population                  Not Paid within 30 working days                  of receipt of the claim                  Per Company Response &amp; CDI                  Analysis</p>	<p>1329</p>	<p>CIC § 10123.13(a)                  Failure to reimburse claim as soon                  as practical, but no later than 30                  working days after receipt of the                  claim.</p>
<p><b>Individual Paid Claims</b>                  Total Population                  that did not include interest with                  the reimbursement Paid over 30                  working days of receipt of the                  claim                  per CDI Analysis</p>	<p>444</p>	<p>CIC § 10123.13(b)                  Failure to pay interest on an                  uncontested claim after 30                  working days. Outstanding                  Referral -Response Due: 10/16.</p>

CIC SECTION 12938 REPORT OF THE MARKET CONDUCT EXAMINATION  
OF THE CLAIMS PRACTICES OF THE  
**PACIFICARE LIFE AND HEALTH INSURANCE COMPANY**

**NAIC # 70785 CDI # 3086-6**

AS OF JUNE 30, 2006

**STATE OF CALIFORNIA**



**DEPARTMENT OF INSURANCE  
MARKET CONDUCT DIVISION  
FIELD CLAIMS BUREAU**

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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



November 9, 2007

The Honorable Steve Poizner  
Insurance Commissioner  
State of California  
45 Fremont Street  
San Francisco, California 94105

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 practices and procedures in California of:

**PACIFICARE LIFE AND HEALTH INSURANCE COMPANY**

**NAIC #70785**

Hereinafter referred to as PacifiCare, or the Company.

This report is made available for public inspection and is published on the California Department of Insurance web site ([www.insurance.ca.gov](http://www.insurance.ca.gov)) pursuant to California Insurance Code section 12938.

## **SCOPE OF THE EXAMINATION**

The examination covered the claims handling practices of the aforementioned Company during the period July 1, 2005, through June 30, 2006. The examination was made to discover, in general, if these and other operating procedures of the Company conform with the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR), and case law. This report contains alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al.

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 fair claims settlement practices.
2. A review of the application of such guidelines, procedures, and forms, by means of an examination of claims files and related records.
3. A review of consumer complaints received by the California Department of Insurance (CDI) in the most recent year prior to the start of the examination.

The examination was conducted at the offices of the Company in Cypress, California.

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 only a summary of pertinent information about the lines of business examined and details of the non-compliant or problematic activities or results that were discovered during the course of the examination along with the insurer’s proposals for correcting the deficiencies, if any. When a violation is discovered that results in an underpayment to the claimant, the insurer corrects the underpayment and the additional amount paid is identified as a recovery in this report. All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment on or criticize activities does not constitute acceptance of such activities.

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.

## CLAIM SAMPLE REVIEWED AND OVERVIEW OF FINDINGS

The examiners reviewed files drawn from the category of Closed Claims for the period July 1, 2005, through June 30, 2006, commonly referred to as the “review period”. The examiners reviewed 297 PacifiCare claim files. The examiners cited 43 claim handling violations of the Fair Claims Settlement Practices Regulations and/or California Insurance Code Section 790.03 within the scope of this report. Further details with respect to the files reviewed and alleged violations are provided in the following tables and summaries.

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY</b>			
<b>LINE OF BUSINESS/CATEGORY</b>	<b>CLAIMS FOR REVIEW PERIOD</b>	<b>REVIEWED</b>	<b>CITATIONS</b>
Group Dental PPO	64,141	68	25
Health-Indemnity Group	9,150	68	13
Health-PPO Group	1,246,766	68	1
Health-PPO Individual	41,384	68	4
Policy Terminations	25	25	0
<b>TOTALS</b>	1,361,466	297	43

**TABLE OF TOTAL CITATIONS**

<b>Citation</b>	<b>Description</b>	
CCR §2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	10
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.	9
CCR §2695.11(b)	The Company failed to provide an explanation of benefits.	9
CCR §2695.3(a)	The Company's claim file failed to contain all documents, notes and work papers that pertain to the claim.	5
CIC §790.03(h)(1)	The Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue.	3
CCR §2695.5(a)	The Company failed to respond to a Department of Insurance inquiry within 21 calendar days.	2
CCR §2695.5(e)(3)	The Company failed to begin investigation of the claim within 15 calendar days.	2
CCR §2695.11(a)(2)(c)	The Company improperly sought reimbursement of an overpayment beyond 6 months of the initial payment	1
CCR §2695.4(a)	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	1
CCR §2695.5(e)(1)	The Company failed to acknowledge notice of claim within 15 calendar days.	1
<b>Total Citations</b>		<b>43</b>

## TABLE OF CITATIONS BY LINE OF BUSINESS

<b>GROUP DENTAL PPO</b>	<b>NUMBER OF CITATIONS</b>
CCR §2695.7(g)	9
CIC §790.03(h)(3)	7
CCR §2695.11(b)	6
CCR §2695.3(a)	1
CCR §2695.5(a)	1
CCR §2695.5(e)(3)	1
<b>SUBTOTAL</b>	<b>25</b>

<b>HEALTH-INDEMNITY GROUP</b>	<b>NUMBER OF CITATIONS</b>
CCR §2695.3(a)	3
CIC §790.03(h)(1)	3
CIC §790.03(h)(3)	2
CCR §2695.11(b)	1
CCR §2695.7(g)	1
CCR §2695.5(e)(3)	1
CCR §2695.11(a)(2)(c)	1
CCR §2695.5(e)(1)	1
<b>SUBTOTAL</b>	<b>13</b>

<b>HEALTH-PPO GROUP</b>	<b>NUMBER OF CITATIONS</b>
CCR §2695.11(b)	1
<b>SUBTOTAL</b>	<b>1</b>

<b>HEALTH-PPO INDIVIDUAL</b>	<b>NUMBER OF CITATIONS</b>
CCR §2695.3(a)	1

CCR §2695.5(a)	1
CCR §2695.4(a)	1
CCR §2695.7(g)	1
<b>SUBTOTAL</b>	<b>4</b>

<b>TERMINATIONS</b>	<b>NUMBER OF CITATIONS</b>
	0
<b>SUBTOTAL</b>	<b>0</b>

<b>TOTAL</b>	<b>43</b>
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## SUMMARY OF 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. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. 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. Regardless of the remedial actions taken or proposed by the Company, it is the Company's obligation to ensure that compliance is achieved. Money recovered within the scope of this report was \$471.46. Pursuant to the findings of the examination referenced below in number 1, the Company conducted a closed claim survey resulting in additional payments of \$30,000. As a result of the examination, the total amount of money returned to claimants within the scope of this report was \$30,471.46.

### GROUP DENTAL PPO

**1. In nine instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low.**

(A.) The Company automatically defaults dental PPO-Fee out-of-network claims to Region 1 (Los Angeles/Orange County) rates on some dental policies. In these policies The Company separates the state into five regions where scheduled reimbursement levels are higher for providers in regions three thru five than regions one and two. The Certificate of Coverage page six, number seven, defines a covered expense: "for Non-Participating Providers, does not exceed the lesser of billed charges and the scheduled fee or Usual and Customary Charges". Page ten of the Certificate of Coverage defines a Usual and Customary charge as: "1) A Provider's usual charge for furnishing treatment, service or a supply; or 2) the charge the Company determines to be the general rate charged by others who render or furnish such treatment, services or supplies to persons who reside in the same geographic area and whose Accidental Injury or Sickness is comparable in nature and severity". When customers in regions three thru five receive treatment out of network their providers are paid a percentage of the scheduled benefit based on Region 1 rates of reimbursement. When the Company defaults to Region 1 pricing they are not basing reimbursements on the actual scheduled fee in effect for in-network providers in regions three thru five. Further, the Company is not adhering to their definition of usual and customary charges.

(B.) In one instance, an erroneous procedure code of D7110 was used. The Company indicates the correct procedure code should have been D7140 which has an allowable amount of \$68.00. As a result of the examination findings, a check was issued to the claimant for \$16.80. In one instance, The Company was still utilizing the old 2004 rates for Procedure D1201 under Region 1 for 2005. The Company only paid an allowable amount of \$66.00. As a result of the examination findings, a check was issued to the claimant for \$11.00.

The Department alleges these acts are in violation of CCR §2695.7(g).

**Summary of Company Response:**

(A) The out of network claims are processed on a contractually specified co-insurance using either a) the HIAA table of allowance or b) the Region 1 fee schedule table of allowance for each product ID. The Region 1 fee schedule was used as the basis for a “maximum allowable charge” (MAC) for the out of network claims. This MAC was used to set premium levels by zip code for the associated product ID’s. This allows employer groups to choose from various rate structures. One PPO product pays out of network claims using the Region 1 fee schedule for all members. We believe the reimbursement method is in accordance with the plan’s contractual obligation.

This remains an unresolved issued, which may result in further administrative action.

(B) A data keying error when updating the Fee Schedule for 2005 has been identified as the reason for the discrepancy with the eligible expense and fee rate schedule. An audit was conducted for all claims using procedure codes D0272 or D1201 and D7110 or D7140 for dates of service 1/1/05-8/30/06. Additional monies owed plus applicable interest was processed totaling \$30,000. Further, the fees will update in the computer system to reflect the correct dollar amount as indicated on the rate schedule for future claims processing.

**2. In seven instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.** The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company utilizes an outdated HIAA schedule to pay out-of-network claims under its PPO-UCR dental PPO plan. The Company has no system, policy or procedure in place to update its claims paying system to the most current and applicable dental rates in line with industry standards and practices. The Department alleges these acts are in violation of CIC §790.03(h)(3).

**Summary of Company Response:** The HIAA schedule used for claims processed in the window period July 1, 2005-June 30, 2006 was in accordance with the benefit structures for the associated members. The Company updated its UCR schedule in 2003 to the 2000 version of HIAA table of allowance. The Company’s reimbursement methodology for services rendered by non-contracted providers is based on statistically credible information purchased from Ingenix. The prevailing health care charges data is reviewed annually to determine if an update to the reimbursement schedule is necessary in order to remain fair and equitable in the settlement of claims as required under the California Insurance Code for standards of prompt, fair and equitable settlements. Our review includes such factors as: The magnitude and relative impact of allowable charges. Location of members and associated impacts; member utilization by procedure code; the percentile level being used to determine the allowable rate. If for example, we change to a new version of the schedule, we might also change the percentile level used to determine allowable rate in order to maintain appropriate benefit cost ratios. Although the Company utilizes a prior year HIAA schedule for UCR determination, we believe that reimbursements offered are not unreasonably low and are within a fair and equitable range of settlement.

**3. In six instances, the Company failed to provide to the claimant an explanation of benefits including the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.** The Company did not provide complete breakdown, disclosure and information about the ineligibility of this charge on its EOB. The specific ADA procedure code “200” has been modified by the Company to D7110 without any clear explanation. The Department alleges these acts are in violation of CCR §2695.11(b).

**Summary of Company Response:** The Company acknowledges the findings and states the issue has been reported to its computer technology staff (IT) to research and determine a resolution for extracting the appropriate explanation code to print on the Explanation of Benefit (EOB) for frequency limitations when processing x-rays. Further, in the instances noted, the Company corrected the EOB.

**4. In one instance each, the Company failed to comply with the following sections of the Fair Claims Settlement Practices Regulations.** In one instance each the Company failed to comply with the following: CCR§ 2695.3(a), CCR§ 2695.5(a), and CCR§ 2695.5(e)(3). The Department alleges these acts are in violation of the Fair Claims Settlement Practices Regulations.

**Summary of Company Response:** The Company acknowledges the above instances. The Company maintains these are isolated instances and not reflective of the Company’s standard claims handling procedures in place at the time of the exam.

## **HEALTH-INDEMNITY GROUP**

**5. In three instances, the Company failed to maintain all documents, notes and work papers in the claim file.** In one instance the Company denied a claim because of a prior request for information was made. However, there is no documentation in the file to support this request was made. In one instance the Company was unable to produce an Explanation of Benefits (EOB). In one instance a denied bill for medical treatment was not in the claim file and was not produced by the Company from archives for examiner review. The Department alleges these acts are in violation of CCR §2695.3(a).

**Summary of Company Response:** The Company acknowledges the issue of the missing request for prior information. This has been identified as a training issue and will be addressed accordingly with staff.

In the other instances cited the Company states that electronic data is stored on the system for 12 months from the received date. After the 12 month period, the data files are archived and stored for future retrieval.

This is an unresolved issue and may result in further administrative action.

**6. In three instances, the Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue.** In one instance a system generated remark code found on the EOB states that “Claims and Claims Procedures for Insurance” are found in Section 10 of the Certificate of Coverage. This is not correct, the information is found in Section 2 of the Certificate of Coverage. In one instance a system generated remark code found on the EOB states that “Definitions” are found in Section 4 of the Certificate of Coverage. This is not correct, the information is found in Section 5 of the Certificate of Coverage. In one instance a claim was processed with a system generated remark code that said, “The plan only allows 20% of Medicare’s approved amount.” This is an error and the remark code should have said, “This amount represents PacifiCare Network discount.” The Department alleges these acts are in violation of CIC §790.03(h)(1).

**Summary of Company Response:** The Company acknowledges the above instances.

This is an unresolved issue and may result in further administrative action.

**7. In two instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.** In one instance there was a gap in file activity between 5/23/05 and 7/6/05. In one instance the Company denied a claim as falling within the pre-existing period. The proof of creditable coverage received clearly indicates the prior coverage was COBRA. COBRA eligibility is only available when prior medical coverage has been provided thru an employer. The Company failed to investigate coverage prior to COBRA. The Department alleges these acts are in violation of CIC §790.03(h)(3).

**Summary of Company Response:** The Company acknowledges the gap in file activity. This has been identified as a training issue and will be addressed accordingly with staff.

**8. In one instance the Company attempted to settle a claim by making a settlement offer that was unreasonably low.** The claim was processed for 1 unit when 4 units totaling \$802.64 were billed. The claim was reprocessed with interest. As a result of the examination findings, a check was issued to the claimant for \$443.66. The Department alleges this act is in violation of CCR§ 2695.7(g).

**Summary of Company Response:** The Company acknowledges the above instance and reprocessed the claim with interest.

**9. In one instance, the Company sought reimbursement of an overpayment more than six months from the date of error.** The Company sought reimbursement for a claims overpayment more than six months from the date of the erroneous payment. The original claim was processed 8/1/05 indicating on the Explanation of Payment (EOP) benefits were coordinated with Medicare. The physician advised that Medicare paid as primary on 5/12/06. A request for reimbursement from the provider was made by the Company on 6/20/06. The Department alleges this act is in violation of CCR§ 2695.11(a)(2)(c).

**Summary of Company Response:** The Company disagrees with the citation and states it does not solicit refunds in California beyond 365 days. The Company does not believe a violation occurred as the Company was acting upon notice from the provider.

This remains an unresolved issue that may result in legal action.

**10. In one instance each, the Company failed to comply with the following sections of the Fair Claims Settlement Practices Regulations.** In one instance each the Company failed to comply with the following: CCR§ 2695.5(e)(2), CCR §2695.11(b), and CCR§ 2695.5(e)(3). The Department alleges these acts are in violation of the Fair Claims Settlement Practices Regulations.

**Summary of Company Response:** The Company acknowledges the above instances. The Company states these are isolated instances and not reflective of the Company's standard claims handling procedures in place at the time of the exam.

### **HEALTH-PPO GROUP**

**11. In one instance, the Company failed to provide to the claimant an explanation of benefits including the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.** Company's EOB is non-specific as to which maximum limit of the policy was applied. The EOB does not include a clear explanation of benefits denied. The Department alleges these acts are in violation of CCR §2695.11(b).

**Summary of Company Response:** The Company acknowledges the above instances.

### **HEALTH-PPO INDIVIDUAL**

**12. In one instance each, the Company failed to comply with the following sections of the Fair Claims Settlement Practices Regulations.** In one instance each the Company failed to comply with the following: CCR§ 2695.7(g), CCR §2695.5(a), CCR §2695.3(a) and CCR§ 2695.4(a). The Department alleges these acts are in violation of the Fair Claims Settlement Practices Regulations.

**Summary of Company Response:** The Company acknowledges the above instances. The Company maintains these are isolated instances and not reflective of the Company's standard claims handling procedures in place at the time of the exam.

### **TERMINATIONS**

There were no citations alleged or criticisms of insurer practices in this line of business within the scope of this report.

REPORT OF THE MARKET CONDUCT EXAMINATION  
OF THE CLAIMS PRACTICES OF THE  
**PACIFICARE LIFE AND HEALTH INSURANCE COMPANY**

**NAIC # 70785 CDI # 3086-6**

AS OF JUNE 30, 2006

**STATE OF CALIFORNIA**



**DEPARTMENT OF INSURANCE  
MARKET CONDUCT DIVISION  
FIELD CLAIMS BUREAU**

## **NOTICE REGARDING CONFIDENTIALITY**

**The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code 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. Section 12938 of the California Insurance Code requires the publication of certain legal documents and examination reports.**

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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



November 8, 2007

The Honorable Steve Poizner  
Insurance Commissioner  
State of California  
45 Fremont Street  
San Francisco, California 94105

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 practices and procedures in California of:

**PACIFICARE LIFE AND HEALTH INSURANCE COMPANY**

**NAIC #70785**

Hereinafter referred to as PacifiCare, or the Company.

## **SCOPE OF THE EXAMINATION**

The examination covered the claims handling practices of the aforementioned Company during the period July 1, 2005, through June 30, 2006. The examination was made to discover, in general, if these and other operating procedures of the Company conform with the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains alleged violations of laws other than Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. A report of violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. will be made available for public inspection and published on the Department's web site pursuant to Section 12938 of the California Insurance Code.

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 fair claims settlement practices.
2. A review of the application of such guidelines, procedures, and forms, by means of an examination of claims files and related records.
3. A review of consumer complaints received by the California Department of Insurance (CDI) in the most recent year prior to the start of the examination.

The examination was conducted at the offices of the Company in Cypress, California.

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 only a summary of pertinent information about the lines of business examined and details of the non-compliant or problematic activities or results that were discovered during the course of the examination along with the insurer's proposals for correcting the deficiencies, if any. When a violation is discovered that results in an underpayment to the claimant, the insurer corrects the underpayment and the additional amount paid is identified as a recovery in this report. All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment on or criticize activities does not constitute acceptance of such activities.

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.

## CLAIM SAMPLE REVIEWED AND OVERVIEW OF FINDINGS

The examiners reviewed files drawn from the category of Closed Claims for the period July 1, 2005, through June 30, 2006, commonly referred to as the “review period”. The examiners reviewed 297 PacifiCare claim files. The examiners cited 27 claim handling violations of the California Insurance Code within the scope of this report. Further details with respect to the files reviewed and alleged violations are provided in the following tables and summaries.

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY</b>			
<b>LINE OF BUSINESS/CATEGORY</b>	<b>CLAIMS FOR REVIEW PERIOD</b>	<b>REVIEWED</b>	<b>CITATIONS</b>
Group Dental PPO	64,141	68	1
Health-Indemnity Group	9,150	68	19
Health-PPO Group	1,246,766	68	5
Health-PPO Individual	41,384	68	2
Policy Terminations	25	25	0
<b>TOTALS</b>	1,361,466	297	27

**TABLE OF TOTAL CITATIONS**

<b>Citation</b>	<b>Description</b>	
CIC §10123.13(a)	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim or the Company failed to notify the claimant in writing within 30 working days of receipt of the claim that the claim was contested or denied or the Company failed to include the factual and legal basis for the denial of the claim.	17
CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days.	5
CIC §10198.7(a)	The Company failed to provide coverage for any individual on the basis of a pre-existing condition provision for a period greater than 6 months following the individual's effective date of coverage. No health benefit plan that covers 3 or more persons (Group or Individual Coverage) that is issued, renewed or written by any insurer shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than 6 months following the individual's effective date of coverage.	5
<b>Total Citations</b>		27

## TABLE OF CITATIONS BY LINE OF BUSINESS

<b>GROUP DENTAL PPO</b>	<b>NUMBER OF CITATIONS</b>
CIC §10123.13(a)	1
<b>SUBTOTAL</b>	<b>1</b>

<b>HEALTH-INDEMNITY GROUP</b>	<b>NUMBER OF CITATIONS</b>
CIC §10123.13(a)	12
CIC §10198.7(a)	4
CIC §10123.13(b)	3
<b>SUBTOTAL</b>	<b>19</b>

<b>HEALTH-PPO GROUP</b>	<b>NUMBER OF CITATIONS</b>
CIC §10123.13(a)	3
CIC §10123.13(b)	2
<b>SUBTOTAL</b>	<b>5</b>

<b>HEALTH-PPO INDIVIDUAL</b>	<b>NUMBER OF CITATIONS</b>
CIC §10123.13(a)	1
CIC §10198.7(a)	1
<b>SUBTOTAL</b>	<b>2</b>

<b>TERMINATIONS</b>	<b>NUMBER OF CITATIONS</b>
	0
<b>SUBTOTAL</b>	<b>0</b>

<b>TOTAL</b>	<b>27</b>
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## SUMMARY OF 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. Regardless of the remedial actions taken or proposed by the Company, it is the Company's obligation to ensure that compliance is achieved. Money recovered within the scope of this report was \$877.83.

### **GROUP DENTAL PPO**

1. **In one instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim.** The Department alleges this act is in violation of CIC §10123.13(a).

**Summary of Company Response:** The Company acknowledges the issue. This has been identified as a training issue and will be addressed accordingly with staff.

### **HEALTH-INDEMNITY GROUP**

2. **In 12 instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim or the Company failed to notify the claimant in writing within 30 working days of receipt of the claim that the claim was contested or denied or The Company failed to include the factual and legal basis for the denial of the claim.**

(A) In eight instances the Company failed to reimburse claims within 30 working days. As a result of the examination findings, checks were issued to two claimants for \$842.33 and \$20.29.

(B) In two instances the Company failed to contest or deny the claim within 30 working days.

(C) In two instances the Company failed to include the factual and legal basis for the denial of the claim. Claim denied because a prior request for insurance was made. The claim should have been closed with a request for Medicare Explanation of Benefits (EOB) so that benefits could be coordinated. Claim denied because a prior request for insurance was made. The claim included proof of Medicare payment but was denied in error.

The Department alleges these acts are in violation of CIC §10123.13(a).

#### **Summary of Company Response:**

(A) The Company acknowledges delayed reimbursement in two of the above instances and made payments to the claimants when due. The issue of delayed payments has been recognized. The Company has addressed this with the appropriate contact and is working on a resolution.

(B) The issue of delayed denials has been recognized. The Company has addressed this with the appropriate contact and is working on a resolution.

(C) Education will be provided to the examiner(s) who requested the Medicare Explanation of Benefits (EOB) in error or failed to request the Medicare EOB.

**3. In four instances, The Company failed to provide coverage for any individual on the basis of a pre-existing condition provision for a period greater than 6 months following the individual's effective date of coverage. No health benefit plan that covers 3 or more persons (Group or Individual Coverage) that is issued, renewed or written by any insurer shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than 6 months following the individual's effective date of coverage.** The Department alleges these acts are in violation of CIC §10198.7(a)

**Summary of Company Response:** The Company acknowledges the citations and responds that the Company's training materials were updated to reflect a 6 month pre-existing review period and subsequent training of staff was completed in December 2006 team meetings. An automated update of the claims system was made in December 2006 and the pre-existing field is set for 6 months for California Plans. In March 2007, the Company issued Large Group plan amendments changing the exclusionary period to 6 months and communications were sent to the affected groups advising them of the changes. In April of 2007 the Company completed a self-review of all group claims denied for pre-existing during the period January 1, 2006-December 31, 2006 when the number of days between the enrollee's effective date and the incurred date of service was between seven and twelve months (181 to 365 days).

**4. In three instances, the Company failed to pay interest on an uncontested claim after 30 working days.** As a result of the examination findings, a check was issued to a claimant for \$15.00. The Department alleges these acts are in violation of CIC §10123.13(b).

**Summary of Company Response:** This has been identified as a training issue and will be addressed accordingly with the appropriate examiners.

## **HEALTH-PPO GROUP**

**5. In three instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim.** In one instance adjusters were using the date PacifiCare received the provider's appeal as the received date for reprocessing claims. The Department alleges these acts are in violation of CIC §10123.13(a).

**Summary of Company Response:** The standard policy and procedure has been updated. If the claim was initially processed in error due to the fault of PacifiCare, when the claim is reprocessed for correction the received date will be the received date from the original claim. The issue of delayed payments has been recognized. The Company has addressed this with the appropriate contact and is working on a resolution.

**6. In two instances, the Company failed to pay interest on an uncontested claim after 30 working days.** As a result of the examination findings, a check was issued to a claimant for \$0.21. The Department alleges these acts are in violation of CIC §10123.13(b).

**Summary of Company Response:** This has been identified as a training issue and will be addressed accordingly with the appropriate examiners.

## **HEALTH-PPO INDIVIDUAL**

7. **In one instance, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim.** The Department alleges these acts are in violation of CIC §10123.13(a).

**Summary of Company Response:** The issue of delayed payments has been recognized. The Company has identified this as a training issue which was addressed with the appropriate staff during the on-site exam.

8. **In one instance, The Company failed to provide coverage for any individual on the basis of a pre-existing condition provision for a period greater than 6 months following the individual's effective date of coverage. No health benefit plan that covers 3 or more persons (Group or Individual Coverage) that is issued, renewed or written by any insurer shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than 6 months following the individual's effective date of coverage.** The Department alleges this act is in violation of CIC §10198.7(a)

**Summary of Company Response:** The Company acknowledges the citation and responds that the Company's training materials were updated to reflect a 6 month pre-existing review period and subsequent training of staff was completed in December 2006 team meetings. An automated update of the claims system was made in December 2006 and the pre-existing field is set for 6 months for California Plans. In March 2007, the Company issued Large Group plan amendments changing the exclusionary period to 6 months and communications were sent to the affected groups advising them of the changes. In April of 2007 the Company completed a self-review of all group claims denied for pre-existing during the period January 1, 2006-December 31, 2006 when the number of days between the enrollee's effective date and the incurred date of service was between seven and twelve months (181 to 365 days).

## **TERMINATIONS**

There were no citations alleged or criticisms of insurer practices in this line of business within the scope of this report.

**TABLES OF SPECIFIC FINDINGS**

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Dental PPO</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
Tan, A.	061370111900	CCR §2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low. Company automatically defaults dental PPO-Fee out-of-network claims to Region 1 fee rates. Claim provider is under Region 3.
Minas, M.	061210021600	CCR §2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low. Company automatically defaults dental PPO-Fee out-of-network claims to Region 1 fee rates. Claim provider is in Oregon.
Judal, B.	06110E000200	CCR §2695.11(b)	The Company failed to provide an explanation of benefits. Company disallowed one charge for one film. The Company did not provide complete breakdown, disclosure and information about the ineligibility of this charge on its EOB.
Araujo, M	060890073600	CCR §2695.11(b)  CCR §2695.7(g)	The Company failed to provide an explanation of benefits. Company disallowed one charge for one film. The Company did not provide complete breakdown, disclosure and information about the ineligibility of this charge on its EOB.  The Company attempted to settle a claim by making a settlement offer that was unreasonably low. Company paid less than its approved fee rate for Procedure D1201 under Region 1 for 2005. Company was still utilizing the old 2004 rates. <b>Recovery: \$ 11.00</b>
De la Cruz, L.	06083E014001	CIC §10123.13(a)  CCR §2695.5(a)	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. Initial receipt of claim on 3/23/06 was previously denied and reprocessed for payment on 5/15/06.  The Company failed to respond to a Department of Insurance inquiry within 21 calendar days. Referral made 9/8/06.
Xiao, Y.	060810048800	CCR §2695.11(b)	The Company failed to provide an explanation of benefits. The Company reflected an inaccurate or ineligible procedure code D2750 on its EOB which

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Dental PPO</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
			corresponds to a different fee amount. The Company however modified the payment of the claim based on a different procedure code D2790.
Schultheis, N.	060790022500	CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company utilizes an outdated HIAA schedule to pay out-of-network claims under its PPO-UCR dental PPO plan. The Company has no system, policy or procedure in place to update its claims paying system to the most current and applicable dental rates in line with industry standards and practices.
Hara, S.	060390065200	CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company utilizes an outdated HIAA schedule to pay out-of-network claims under its PPO-UCR dental PPO plan. The Company has no system, policy or procedure in place to update its claims paying system to the most current and applicable dental rates in line with industry standards and practices.
Leavitt, C.	06020005700	CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company utilizes an outdated HIAA schedule to pay out-of-network claims under its PPO-UCR dental PPO plan. The Company has no system, policy or procedure in place to update its claims paying system to the most current and applicable dental rates in line with industry standards and practices.
Aquino, J.	060040100700	CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company utilizes an outdated HIAA schedule to pay out-of-network claims under its PPO-UCR dental PPO plan. The Company has no system, policy or procedure in place to update its claims paying system to the most current and applicable dental rates in line with industry standards and practices.

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Dental PPO</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
Bond, R.	052920079900	CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company utilizes an outdated HIAA schedule to pay out-of-network claims under its PPO-UCR dental PPO plan. The Company has no system, policy or procedure in place to update its claims paying system to the most current and applicable dental rates in line with industry standards and practices.
Herrera, R.	052860074900	CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company utilizes an outdated HIAA schedule to pay out-of-network claims under its PPO-UCR dental PPO plan. The Company has no system, policy or procedure in place to update its claims paying system to the most current and applicable dental rates in line with industry standards and practices.
Steber, M.	052850059600	CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company utilizes an outdated HIAA schedule to pay out-of-network claims under its PPO-UCR dental PPO plan. The Company has no system, policy or procedure in place to update its claims paying system to the most current and applicable dental rates in line with industry standards and practices.
Lu, F.	06062005000	CCR §2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low. Company automatically defaults dental PPO-Fee out-of-network claims to Region 1 fee rates. Claim provider is under Region 3.
Hidalgo, R.	060310060900	CCR §2695.7(g)  CCR §2695.11(b)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low. Company automatically defaults dental PPO-Fee out-of-network claims to Region 1 fee rates. Claim provider is under Region 4.  The Company failed to provide an explanation of benefits. Company disallowed one charge for one film. The Company did not provide complete

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Group Dental PPO</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
			breakdown, disclosure and information about the ineligibility of this charge on its EOB.
Grant, M.	052790044100	CCR §2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low. Company automatically defaults dental PPO-Fee out-of-network claims to Region 1 fee rates. Claim provider is under Region 3.
Danon, S.	060520006700	CCR §2695.3(a)  CCR §2695.5(e)(3)	The Company failed to maintain all documents, notes and work papers in the claim file. No documentation that the Company contacted the provider office for additional information.  The Company failed to begin investigation of the claim within 15 calendar days. No significant file activities undertaken from receipt of claim on 2/2/06 to 2/21/06.
Luna, F.	060370078700	CCR §2695.11(b)	The Company failed to provide an explanation of benefits. The Company reflected an inaccurate or ineligible procedure code D2750 on its EOB which corresponds to a different fee amount. The Company however modified the payment of the claim based on a different procedure code D2790.
Benitez, I.	060250046000	CCR §2695.11(b)  CCR §2695.7(g)	The Company failed to provide an explanation of benefits. The specific ADA procedure code "200" has been modified by the Company to D7110 without any clear explanation. The Company agrees a wrong procedure code was selected by its processor on this claim.  The Company attempted to settle a claim by making a settlement offer that was unreasonably low. As a result of the erroneous procedure code of D7110, the Company indicate the correct procedure code should have been D7140 which has an allowable amount of \$68.00. The Company only paid an allowable amount of \$66.00. <b>Recovery: \$ 16.80</b>
Chavez, F.	053000062700	CCR §2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low. Company automatically defaults dental PPO-Fee out-of-network claims to Region 1 fee rates. Claim provider is under Region 3. Company paid 80% of U&C based on the lower rates in Region 1 rather

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY</b> <b>Group Dental PPO</b>			
Insured	Claim Number	Citation	Description
			than based on the higher rates of Region 3.
Medina, N.	052440139800	CCR §2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low. Company automatically defaults dental PPO-Fee out-of-network claims to Region 1 fee rates. Claim provider is under Region 3. Company paid 80% of U&C based on the lower rates in Region 1 rather than based on the higher rates of Region 3.
<b>Total Number of Files Reviewed in this Category: 68</b> <b>Total Number of Files with Citations in this Category: 21</b> <b>Total Number of Citations in this Category: 27</b>			

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY</b> <b>Health-Indemnity Group</b>			
Insured	Claim Number	Citation	Description
Taylor, K.	11379785-02	CIC §10198.7(a)  CIC §790.03(h)(3)	<p>The Company is including a pre-existing conditions clause greater than 6 months on a group policy. The Company received proof that COBRA creditable coverage began 11/1/04 and calculated that the pre-existing period applies until 10/31/05.</p> <p>The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company denied the claim as falling within the pre-existing period. The proof of creditable coverage received clearly indicates the prior coverage was COBRA. COBRA eligibility is only available when prior medical coverage has been provided thru an employer. The Company failed to investigate coverage prior to COBRA.</p>
Sexton, E.	12873850-01	CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. Unexplained gap in file activity from receipt of claim on 5/23/05 to 7/6/05.

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Health-Indemnity Group</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CCR §2695.5(e)(1)	The Company failed to acknowledge notice of claim within 15 calendar days.
		CCR §2695.5(e)(3)	The Company failed to begin investigation of the claim within 15 calendar days.
		CIC §10123.13(a)	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. Claim received 5/23/05 was only paid on 7/6/05.
DiCenzo, D.	12947688-01	CIC §10123.13(a)	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. Company reprocessed this claim various times while awaiting Medicare information. Upon receipt of other insurance information on 11/7/05, the Company failed to process promptly and paid claim only on 12/19/05.
		CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. <b>Recovery:\$1.19</b>
Wohleen, A.	13203114-01	CCR §2695.11(b)	The Company failed to provide an explanation of benefits. EOB closure due to “lack of response” to prior request for additional information is an inaccurate statement. EOB verbiage is not consistent or supported by claim file activity.
Cavanaugh, R.	13230271-02	CCR §2695.11(a)(2)(c)	The Company improperly sought reimbursement of an overpayment beyond 6 months of the initial payment (error). Company issued payment on 8/1/05 and pursued recovery efforts on 6/20/06, or more than 10 months from commission of error. Company collected \$258.94 from claimant.
Uribe, B.	13346514-01	CIC §10123.13(a)	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. Claim received on 6/23/05 was processed on 8/9/05.
		CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. <b>Recovery: \$ 15.00</b>
Crichton, R.	13397603-02	CIC §10123.13(a)	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. All complete claim

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY</b> <b>Health-Indemnity Group</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CIC §10123.13(b)	documentation received on 8/30/05 claim processed for payment on 11/23/05.  The Company failed to pay interest on an uncontested claim after 30 working days. <b>Recovery: \$ 7.45</b>
Ahearn, C.	14994788-01	CIC §790.03(h)(1)  CIC §10123.13(a)	The Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue. Remark code found on the EOB states that "Claims and Claims Procedures for Insurance" are found in Section 10 of the Certificate of Coverage. This is not correct, the information is found in Section 2 of the Certificate of Coverage.  The Company failed to notify the claimant in writing within 30 working days of receipt of the claim that the claim was contested or denied. Claim received 9/20/05 and denied 12/6/05.
Armstrong, L.	18114935-01	CCR §2695.3(a)	The Company failed to maintain all documents, notes and work papers in the claim file. Claim received on 5/23/06 for DOS 5/8/06. Claim was denied 5/27/06 because a prior request for insurance information was made. There is no documentation in the file to support this assertion. Company unable to reproduce EOB.
Bruns, K.	15329965-01	CIC §10123.13(a)	The Company failed to include the factual basis for the denial of the claim. Claim for DOS 11/11/05 received 12/21/05 and denied 12/31/05 because a prior request for insurance was made. The claim should have been closed with a request for Medicare EOB so that benefits could be coordinated. Carrier failed to issue corrected EOB on referral and claim remains unpaid.
McGriff, L.	15244324-01	CIC §10123.13(a)	The Company failed to include the factual and legal basis for the denial of the claim. Claim for DOS 10/25/05 received 12/21/05 and denied 12/22/05 because a prior request for insurance was made. The claim included proof of Medicare payment but was denied in error. The claim was paid on 1/20/06.
Spencer, D.	18596738-01	CIC §10198.7(a)	The Company is including a pre-existing conditions clause greater than 6 months on a group policy.

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY</b> <b>Health-Indemnity Group</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
		CCR §2695.3(a)	The Company failed to maintain all documents, notes and work papers in the claim file. Company unable to reproduce EOB.
Crockett, S.	14385340-01	CIC §10123.13(a)	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. Claim received 9/15/05 and paid 10/29/05 with interest.
Hanson, M.	14927467-01	CIC §790.03(h)(1)  CCR §2695.7(g)	<p>The Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue. Remark code found on the EOB states that “Definitions” are found in Section 4 of the Certificate of Coverage. This is not correct, the information is found in Section 5 of the Certificate of Coverage.</p> <p>The Company attempted to settle a claim by making a settlement offer that was unreasonably low. Claim received 11/16/05 and paid 12/03/05 in the amount of \$136.03. The claim was processed for 1 unit when 4 units totaling \$802.64 were billed. Claim was reprocessed on 9/6/06 with \$35.56 interest. <b>Recovery: \$443.66</b></p>
Rich, D.	08134937-02	CCR §2695.3(a)  CIC §10123.13(a)	<p>The Company failed to maintain all documents, notes and work papers in the claim file. Bill for DOS 11/02/04 denied 4/11/06 is missing from the claim file.</p> <p>The Company failed to notify the claimant in writing within 30 working days of receipt of the claim that the claim was contested or denied. Information in claim file indicates bill received 12/8/04 and denied 4/11/06.</p>
Rigney, B.	15166793-01	CIC §10198.7(a)  CIC §10123.13(a)	<p>The Company is including a pre-existing conditions clause greater than 6 months on a group policy.</p> <p>The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. Claim denied 12/19/05, requested proof of creditable coverage. Proof received on 2/14/06 but claim was not processed for payment with interest until 9/7/06. <b>Recovery: \$842.33</b></p>

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Health-Indemnity Group</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
Rogers, C.	18476757-01	CIC §790.03(h)(1)	The Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue. Claim processed with a remark code that said, "The plan only allows 20% of Medicare's approved amount." This is an error and the remark code should have said, "This amount represents PacifiCare Network discount."
Russell, I.	07540925-01	CIC §10123.13(a)	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. Claim incorrectly processed and closed for Medicare Explanation of Benefits on 1/24/05 and 8/22/05. Medicare EOB was provided in both instances. Claim processed for payment with interest on 9/7/06. <b>Recovery: \$20.29</b>
Ingalz, C.	17399973-01	CIC §10123.13(a)  CIC §10198.7(a)	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. Claim for DOS 11/2/05, 11/9/05, 11/17/05, 11/30/05 denied 4/8/06, due to lack of required information, requested proof of creditable coverage. Insured provided a signed PPO/Indemnity Medical Claim Form 2/27/06. The Claim Form includes a medical release of information and information about the current insurance carrier (wife has insurance thru her employer, as well as coverage thru spouse). Per notes in file dated 6/7/06 received proof of coverage from Aetna 5/1/05-7/31/05 and Cigna 8/1/05-current. Bill was never reprocessed for payment.  The Company is including a pre-existing conditions clause greater than 6 months on a group policy.
<b>Total Number of Files Reviewed in this Category: 68</b> <b>Total Number of Files with Citations in this Category: 20</b> <b>Total Number of Citations in this Category: 33</b>			

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Health-PPO Group</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
Endres, L.	10542039-02	CIC §10123.13(a)	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. All complete claim documentation received on 7/31/05 was reprocessed for payment on 9/7/06)
		CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. Claim received 7/31/05 was only partially paid. Balance due to underpayment issued only on 9/7/06. <b>Recovery: \$7.45</b>
Hernandez, S.	13381900-01	CCR §2695.11(b)	The Company failed to provide an explanation of benefits. Company's EOB is non-specific as to which maximum limit of the policy was applied. The EOB does not include a clear explanation of benefits denied.
Hoffstetter, D.	14335723-01	CIC §10123.13(a)	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. Reprocessed claim should have original receipt date of 10/19/05. Claim was not paid until 1/31/06.
		CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days. Claim received 10/19/05 was only paid on 1/31/06. <b>Recovery: \$ .21</b>
Crowe, C.	14383995-01	CIC §10123.13(a)	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. Claim received 8/29/05 was only paid on 10/25/05.
<b>Total Number of Files Reviewed in this Category: 68</b> <b>Total Number of Files with Citations in this Category: 4</b> <b>Total Number of Citations in this Category: 6</b>			

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY Health-PPO Individual</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
Karahalios, K.	17588537-01	CCR §2695.3(a)	The Company failed to maintain all documents, notes and work papers in the claim file. Claim for DOS 2/9/06 received 3/21/06 was denied on 4/20/06 as previously processed. When questioned about denial, carrier provided proof the claim was processed on 3/2/06 but claim was not paid. Unknown why claim was not paid on 3/2/06, no EOB provided.
Keith, R.	17751231-01	CCR §2695.5(a)  CCR §2695.4(a)	The Company failed to respond to a Department of Insurance inquiry within 21 calendar days. Referral made 9/7/06, no response received.  The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. Statement of Benefits in the file indicates office visits in the network are paid at 100% and out of network at 50% of limited fee schedule. No payment was made on this claim-office visit applied to the deductible was not 100% or 50% of the billed code.
Lawson, L.	17253196-01	CIC §10198.7(a)  CCR §2695.7(g)	The Company is including a pre-existing conditions clause greater than 6 months on a group policy.  The Company attempted to settle a claim by making a settlement offer that was unreasonably low. Statement of Benefits appears to indicate 70% reimbursement rate, however it appears the claim was paid at 65%. Total billed was \$2830 and total paid was \$1832.50.
Rowe, R.	18001721-01	CIC §10123.13(a)	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. Claim received 3/27/06 paid on 5/18/06 with interest.
<b>Total Number of Files Reviewed in this Category: 68</b> <b>Total Number of Files with Citations in this Category: 4</b> <b>Total Number of Citations in this Category: 6</b>			

November 6, 2007

<b>PACIFICARE LIFE AND HEALTH INSURANCE COMPANY</b>			
<b>Terminations</b>			
<b>Insured</b>	<b>Claim Number</b>	<b>Citation</b>	<b>Description</b>
<b>Total Number of Files Reviewed in this Category: 25</b>			
<b>Total Number of Files with Citations in this Category: 0</b>			
<b>Total Number of Citations in this Category: 0</b>			