STATE OF ARIZONA
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DEPT. OF INSURANCE

REPORT OF TARGETED EXAMINATION

OF

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY

NAIC# 60305

AS OF

JUNE 30, 2006

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CHRISTINA URIAS
Director of Insurance

Honorable Christina Urias
Director of Insurance
State of Arizona
2910 North 44th Street, Suite 210
Phoenix, Arizona 85108-7269

Dear Director Urias:

Pursuant to your instructions and in conformity with the provisions of the Insurance Laws and Rules of the State of Arizona, a targeted examination has been made of the market affairs of:

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY

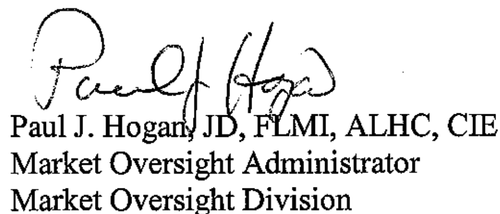
NAIC # 60305

The above examination was conducted by Sandra Lewis, CIE, Examiner-in-Charge, and Jerry Paugh, AIE, Senior Market Examiner.

The examination covered the period of July 1, 2005, through June 30, 2006.

As a result of that examination, the following Report of Examination is respectfully submitted.

Sincerely yours,



Paul J. Hogan, JD, FLMI, ALHC, CIE
Market Oversight Administrator
Market Oversight Division

AFFIDAVIT

STATE OF ARIZONA)
) ss.
County of Maricopa)

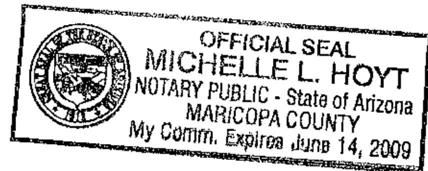
I, Sandra Lewis, CIE, being first duly sworn state that I am a duly appointed Market Examinations Examiner-in-Charge for the Arizona Department of Insurance, and that under my direction and with my participation and the participation of Jerry Paugh, AIE, Senior Market Examiner, the examination of American Community Mutual Insurance Company, hereinafter referred to as the "Company" was performed at the offices of the Arizona Department of Insurance. A teleconference meeting with appropriate Company officials was held to discuss the findings set forth in this Report. The information contained in this Report, consisting of the following pages, is true and correct to the best of my knowledge and belief and any conclusions and recommendations contained in and made a part of this Report are such as may be reasonably warranted from the facts disclosed in the Examination Report.

Sandra Lewis
Sandra Lewis, CIE
Market Examinations Examiner-in-Charge

Subscribed and sworn to before me this 31 day of Dec., 2007

Michelle L Hoyt
Notary Public

My Commission Expires 6-14-09



FOREWORD

This targeted market examination of American Community Mutual Insurance Company ("Company"), was prepared by employees of the Arizona Department of Insurance ("Department") as well as independent examiners contracting with the Department. A targeted market examination is conducted for the purpose of auditing certain business practices of insurers licensed to conduct the business of insurance in the State of Arizona. The Examiners conducted the examination of the Company in accordance with Arizona Revised Statutes (A.R.S.) §§ 20-142, 20-156, 20-157, 20-158, and 20-159. The findings in this report, including all work products developed in the production of this report, are the sole property of the Department.

The examination consisted of a review of the following components of the Company's major medical health insurance business:

1. The Company conducts a reasonable and timely investigation before denial of claims, and
2. The Company has appropriate procedures in place to identify and correct errors in its claim processing system.

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Director.

Failure to identify or criticize specific Company practices does not constitute acceptance of those practices by the Department.

SCOPE AND METHODOLOGY

The examination of the Company was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Department. The targeted market examination of the Company covered the period from July 1, 2005 through June 30, 2006 for the line of business reviewed. The purpose of the examination was to determine the Company's compliance with Arizona's insurance laws and to determine whether the Company's operations and practices are consistent with the public interest. This examination was completed by applying tests to each examination standard to determine compliance with the standard. The standards applied during the examination are stated in this Report at page 10.

In accordance with Department procedures, the Examiners completed a Preliminary Finding ("PF") on those policies, claims, complaints, and/or procedures not in apparent compliance with Arizona law. The PF forms were submitted for review and comment to the Company representative designated by Company management as being knowledgeable about the files. For each PF, the Company was requested to agree, disagree, or otherwise justify the Company's noted action.

The Examiners utilized both examination by test and examination by sample. Examination by test involves review of all records within the population, while examination by sample involves the review of a selected number of records from within the population. Due to the small size of some populations examined, examinations by test and by sample were completed as to those populations without the need to utilize computer software.

Denied claim file sampling was based on a review of denied claims overturned after a request for reconsideration made by or on behalf of the insured, and in part on statistical analysis of raw claims data. Denied claims samples were randomly or systematically selected by using Audit Command Language (ACL) software and computer data files provided by the Company's Representative, Peggy Crandell, Compliance Manager. Samples were tested for compliance with standards established by the NAIC and the Department. The tests applied to sample data resulted in an exception ratio, which determined whether or not a standard was met. If the exception ratio found in the sample was, generally, less than 5%, the standard was considered as "met". A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXECUTIVE SUMMARY

This examination was completed by applying tests to each examination standard to determine compliance with the standard. Each standard applied during the examination is stated in this report beginning at page 10, and the examination findings are reported beginning on page 5.

1. The Company failed Standard No. 1 in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F) by failing to conduct a timely and reasonable investigation of claims before denying the claims. Twelve (52%) of 23 files reviewed for claims denied under CPT-4 Codes 76075 and 76076 failed Standard No. 1.

2. The Company failed Standard No. 1 in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F) by failing to conduct a timely and reasonable investigation of claims before denying the claims. Three (14%) of 22 files reviewed for claims denied under CPT-4 Code 82270 failed Standard No. 1.
3. The Company failed Standard No. 1 in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F) by failing to conduct a timely and reasonable investigation of claims before denying the claims. Seven (8%) of 88 files reviewed for claims denied under Reason Code 14 failed Standard No. 1.
4. The Company passed Standard 2.
5. The Company passed Standard 3 with comment.

PROCEDURES PERFORMED

The Examiners reviewed the Company's appeal policies and procedures, claims manuals, training manuals, and responses to interrogatories in preparation for the file reviews to be conducted.

The Company provided appeal logs indicating it had processed 22 appeals from denied claims during the examination period. The Examiners selected all of the 22 appeals for review. The review of the appeal files indicated trends of overturned denials related to CPT codes 76075 and 76076 (bone density scans) and Explanation of Benefits (EOB) message code 014 (eye exams and glasses not covered).

The Company provided a population of 25,799 claims denied during the examination period. A statistical analysis using ACL software identified five additional CPT codes, including code 82270 (colorectal cancer screening) and one additional EOB message code of interest. Using the CPT codes and EOB codes identified during the review of overturned appeals and the denied claim data, the Examiners extracted a subpopulation of 597 denied claims from which they selected six samples of CPT codes and two samples of EOB denial codes totaling 151 denied claims for review. Of the 151 denied claims selected for review, five files did not fit the sample criteria. Therefore, a total of 146 files were reviewed.

Since 100% of the files denied for CPT-4 codes 76075, 76076, and 82270 had been selected for review during Phase I of the exam, a Phase II was not called for these samples. Subsequent to the Phase I denied claim review, the Department initiated a Phase II examination

and selected an additional sample of the remaining 65 denied claim files which were denied using EOB code 14. Of the 65 denied claims selected for review for EOB denial code 14, four files did not fit the sample criteria. Therefore, a total of 61 additional files were reviewed. This brought the total number of denied claim files reviewed to 207.

As a result of the review of the 207 denied claims and 22 appeals, the Examiners identified the following findings.

EXAMINATION FINDINGS – FAILED STANDARD 1

Based on the Examiners' review of the Company's denied health care claims and appeals, the Company failed, with regard to claims denied under the CPT and EOB codes outlined below, to meet the following standard for review:

#	STANDARD	Regulatory Authority
1	The Company conducts timely investigations of claims and does not deny claims without conducting a reasonable investigation.	A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F)

Claim Denied Under CPT Codes 76075 and 76076

The Company failed to meet the standard for claims denied under CPT codes 76075 and 76076 (bone density scan) as follows:

The sub-population of 597 denied claims included a population of 21 denied claims under which were denied under CPT codes 76075 and 76076. The appeals log included a population of two claims which were originally denied under CPT codes 76075 and 76076 but were later overturned on appeal. The Examiners reviewed the total population of 21 (100%) of 21 claim files and two (100%) of two appeal files denied under CPT codes 76075 and 76076.

The Examiners identified ten claims and two appeals denied under CPT codes 76075 and 76076 where the Company coded the services as "routine" or "preventive" despite a diagnosis code indicating the services were provided due to illness or to symptoms of a possible medical condition. The Company denied these claims without conducting any investigation prior to denial.

Twelve (52%) of 23 denied claims and appeals with CPT codes 76075 and 76076 failed Standard 1 because the Company failed to conduct a reasonable investigation prior to the denial of claims in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C R20-6-801(F). Reference PF # 001 Revised.

Claim Denied Under CPT Code 82270

The Company failed to meet the standard for claims denied under CPT code 82270 (colorectal cancer scan) as follows:

The sub-population of 597 denied claims included a population of 22 denied claims which were denied under CPT code 82270. The Examiners reviewed the total population of 22 (100%) of 22 claim files denied under CPT code 82270.

The Examiners identified three denied claims with CPT code 82270 where the Company coded the services as "routine" or "preventive" despite a diagnosis code indicating the services were provided due to illness or to symptoms of a possible medical condition. The Company denied these claims without conducting any investigation prior to denial.

Three (14%) of 22 claims denied with CPT code 82270 failed Standard 1 because the Company failed to conduct a reasonable investigation prior to the denial of claims in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C R20-6-801(F). Reference PF # 002.

Claim Denied Under EOB Message Code 14

The Company failed to meet the standard for claims denied under EOB code 14 (Eye exams and glasses not covered) as follows:

The sub-population of 597 denied claims included a population of 90 claims which were denied under EOB code 14. The appeals log included a population of three claims which were originally denied under EOB code 14. The Examiners reviewed the total population of 90 (100%) of 90 claim files and three (100%) of three appeal files denied under EOB code 14. Five of the denied claim files failed to meet the sample criteria and therefore a total of 85 denied claim files were reviewed. EOB code 14 states: "Your policy does not cover expenses incurred for eye examinations, for eye refractions, eye glasses or contact lenses, and their fittings."

The Examiners identified four claims and three appeals denied under EOB code 14 where the Company coded the services as "not covered" despite a diagnosis code indicating the services were covered under the member's policy and in some cases the Company had paid for services provided for a similar diagnosis on other claims processed by the Company. The Company denied these claims without conducting any investigation prior to denial.

Seven (8%) of 88 claims and appeals denied under EOB code 14 failed Standard 1 because the Company failed to conduct a reasonable investigation prior to the denial of claims in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C R20-6-801(F). Reference PF # 003 and 004.

Summary of Findings – Standard 1

Files Reviewed	Population	Sample Size	Exceptions	Error Ratio	PF #
Bone Density	23	23	12	52%	#001 revised
Colorectal Cancer Screening	22	22	3	14%	#002
Eye Exams/Glasses	88	88	7	8%	#003, #004

An error ratio greater than 5% does not meet the standard; therefore recommendations are warranted.

Recommendations 1 through 9

Within 90 days of the filed date of this report, the Company should:

1. Provide documentation that the Company has appropriate procedures and controls in place to ensure that the Company completes a timely investigation of claims as prescribed by A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F);
2. Reprocess the ten claim files identified under Preliminary Finding 001 Revised where services were denied for Bone Density Scans (CPT-4 codes 76075 and 76076) on the basis that the services were routine and preventive to determine whether these claims were denied inappropriately;
3. Reprocess the three claim files identified under Preliminary Finding 002 where services were denied for Colorectal Cancer Screening (CPT-4 code 82270) on the basis that the services were routine and preventive to determine whether these claims were denied inappropriately;
4. Reprocess the four claims identified under Preliminary Finding 004 where services were denied under EOB code 14 as "not covered" to determine whether these claims were denied inappropriately;
5. Perform a self-audit of all bone density scan (CPT-4 codes 76075 and 76076) claims received during the three years prior to the date of the Report to determine whether other claims had been denied inappropriately and without adequate investigation;
6. Perform a self-audit of all colorectal (CPT-4 code 82270) claims received during the three years prior to the date of the Report to determine whether other claims have been denied inappropriately and without adequate investigation;

7. Perform a self-audit of all claims, received during the three years prior to the date of the Report, which were denied under EOB code 14 to determine whether other claims have been denied inappropriately and without adequate investigation;
8. Pay restitution, including interest at the legal rate of 10% per annum, on claims reprocessed in accordance with Items 2, 3, and 4 above and/or identified from the self-audits performed in accordance with Items 5, 6, and 7 above, as having been denied inappropriately; and
9. With each payment of restitution, provide a letter indicating that an audit of claims following an examination by the Arizona Department of Insurance had resulted in the identification of claims where restitution was owed.

EXAMINATION FINDINGS – STANDARD 3 PASSED WITH COMMENT

Based on the Examiners' review of the Company's denied health care claims, the Company passed the following standard for review with comment:

#	STANDARD	Regulatory Authority
3	Where appropriate under the circumstances, the Company pays interest on overturned denied claims.	A.R.S. § 20-462(A)

During Phase I and Phase II of the Examination, the Examiners reviewed a sample of 85 claims for eye examinations that were not covered under the policy. Of these, one file (1%) was denied although the diagnosis and treatment contained on the original claim described a medical condition and services for which policy benefits were available. The Company reprocessed this claim and paid it after an appeal by the insured, but the Company failed to pay interest at the legal rate due from the date the claim was received until the date paid, in apparent violation of A.R.S. § 20-462(A). See Preliminary Finding #006. Although a 1% error rate is sufficient to pass the Standard, the need for additional restitution for this insured warrants comment in this Report.

Subsequent Events

The Company agreed with Preliminary Finding #006 and paid accrued interest in the amount of $16.63 to the insured. On September 18, 2007, the Company supplied proof to the Examiners that the interest was paid to this insured.

Recommendation 10

Within 90 days of the filed date of this report the Company should provide proof that the Company has appropriate policies and procedures in place for the payment of interest at the legal rate of 10% per annum on all claims submitted by an insured whenever such claims are paid more than 30 days after receipt of adequate proofs of loss, as prescribed by A.R.S. §§ 20-462(A).

SUMMARY OF STANDARDS

#	STANDARD FOR REVIEW	PASS	FAIL
1	The Company conducts timely investigations of claims and does not deny claims without conducting a reasonable investigation, per A.R.S. §§ 20-461(A)(3) and (4) and A.A.C. R20-6-801(F).		X
2	The Company provides a prompt and reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision, per A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a).	X	
3	Where appropriate under the circumstances, the Company pays interest on overturned denied claims, per A.R.S. § 20-462(A).	X (With Comment)	