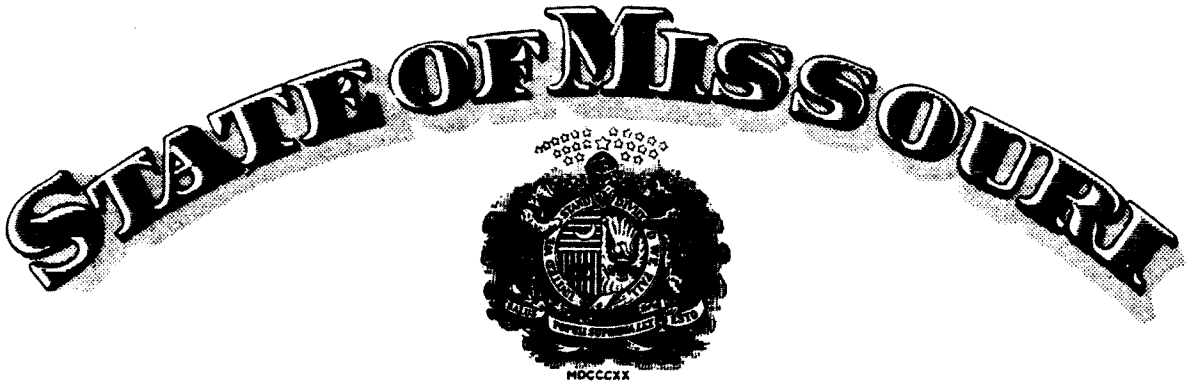

DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

P.O. Box 690, Jefferson City, Mo. 65102-0690

In re:	)	
United Healthcare Insurance Co. (NAIC #79413)	)	Examination No. 0603-17 and -19-GT
and ACN, Inc.	)	

ORDER OF THE DIRECTOR

NOW, on this 25th day of August, 2009, Director John M. Huff, after consideration and review of the market conduct examination report of United Healthcare Insurance Co. (NAIC #79413), (hereafter referred to as "UHIC") and ACN, report numbered 0603-17 and -19-TGT, prepared and submitted by the Division of Insurance Market Regulation pursuant to §374.205.3(3)(a), RSMo, and the Stipulation of Settlement and Voluntary Forfeiture ("Stipulation") does hereby adopt such report as filed. After consideration and review of the Stipulation, report, relevant workpapers, and any written submissions or rebuttals, the findings and conclusions of such report is deemed to be the Director's findings and conclusions accompanying this order pursuant to §374.205.3(4), RSMo.

This order, issued pursuant to §§374.205.3(4) and 374.280, RSMo and §374.046.15. RSMo (Cum. Supp. 2006), is in the public interest.

IT IS THEREFORE ORDERED that UHIC and the Division of Insurance Market Regulation have agreed to the Stipulation and the Director does hereby approve and agree to the Stipulation.

IT IS FURTHER ORDERED that UHIC shall not engage in any of the violations of law and regulations set forth in the Stipulation and shall implement procedures to place UHIC in full compliance with the requirements in the Stipulation and the statutes and regulations of the State of Missouri and to maintain those corrective actions at all times.

IT IS FURTHER ORDERED that UHIC shall pay, and the Department of Insurance, Financial Institutions and Professional Registration, State of Missouri, shall accept, the Voluntary Forfeiture of $361,706.25, payable to the Missouri State School Fund.

IT IS SO ORDERED.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of my office in Jefferson City, Missouri, this 25th day of August, 2009.

John M. Huff
Director

TO: United Healthcare Insurance Co.
Office of the President
13655 Riverport Dr.
Maryland Heights, MO 63043

RE: Missouri Market Conduct Examination 0603-17 and -19-TGT
United Healthcare Insurance Co. (NAIC #79413) and ACN, Inc.

STIPULATION OF SETTLEMENT AND VOLUNTARY FORFEITURE

It is hereby stipulated and agreed by John M. Huff, Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration, hereinafter referred to as "Director," and United Healthcare Insurance Company (NAIC #79413) and ACN, Inc., (hereafter collectively referred to as "UHIC"), as follows:

WHEREAS, John M. Huff is the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration (hereafter referred to as "the Department"), an agency of the State of Missouri, created and established for administering and enforcing all laws in relation to insurance companies doing business in the State in Missouri; and

WHEREAS, UHIC has been granted a certificate of authority to transact the business of insurance in the State of Missouri; and

WHEREAS, the Department conducted a Market Conduct Examination of UHIC and prepared reports numbered 0603-17 and -19-TGT; and

WHEREAS, the report of the Market Conduct Examination has alleged the following errors:

1. In some instances, UHIC used a chiropractic rider form that limited coverage in a

calendar year, in violation of the mandate of §376.1230, RSMo.

2. In some instances, UHIC denied payment of benefits for chiropractic care by limiting coverage to 26 visits per calendar year, in violation of the mandate of §376.1230, RSMo.

3. In some instances, UHIC failed to pay benefits for medically necessary chiropractic care, in that it denied claims on the basis that the insured and the provider failed to submit or re-submit a Complete Clinical Notification (CCN) in order to obtain reimbursement, relying solely upon administrative requirements rather than on any basis in medical necessity or the lack thereof. As such, the Company's actions violated §§376.1007(1), (3), and (4), 376.1230, and 376.1350, RSMo.

4. In some instances, UHIC denied payment of benefits for chiropractic care by failing to make any determination on the medical necessity of additional visits and by requiring notification within the first 26 visits in a policy period as a condition of coverage, thereby violating the mandates of §§376.1230, 376.1361, and 376.1400, RSMo.

5. In some instances, UHIC failed to pay the appropriate amount on the claims it partially covered, in violation of §376.383, RSMo.

6. In some instances, UHIC denied chiropractic claims by incorrectly coding the denials of the claims.

7. UHIC failed to include in its complaint/appeal file one complaint resolution letter as required by 20 CSR 100-8.040(2), as amended.

WHEREAS, UHIC denies the findings or violations set forth above and enumerated in the examination report; and

WHEREAS, UHIC hereby agrees to take remedial action and agrees to maintain those corrective actions at all times, including, but not limited to, taking the following actions:

1. UHIC agrees to take corrective action to assure that the errors noted in the above-referenced market conduct examination reports do not recur;

2. UHIC agrees to review its contract language with respect to chiropractic care benefits to ensure that the language in those group policies and riders comply with §376.1230, RSMo, and refile contract amendments or endorsements for all such policies whose language does not conform to the mandates of §376.1230, RSMo, within 60 days of the entry of an Order finalizing this examination;

3. UHIC agrees to review all of its H0, J0, M0, 9L, and JO coded denied claims dated 1/1/04 through the date that a final Order is entered closing this examination to identify all improperly denied claims as described in the exam report. For those claims improperly denied, UHIC must reopen and pay those claims, including interest from the 46th day after receipt of the claim to the date of payment, as required by §376.383.5, RSMo. UHIC will follow the review

process outlined in Exhibit A. A letter must be included with the refund payments or on the EOB indicating that the payments are made "as a result of a Missouri Market Conduct examination." Additionally, evidence must be provided to the Department that such payments have been made within 270 days after the date of the Order finalizing this examination;

4. UHIC agrees to take all necessary steps to assure that it administers its chiropractic care benefits in a manner consistent with Missouri law, specifically, §376.1230, RSMo, such that in determining whether to pay or deny a claim for benefits within the first 26 visits per policy period, it makes individual determinations of eligibility and medical necessity based on the individual claimant's medical records and in accordance with the provisions of §§376.1350 through 376.1390, RSMo; and

5. UHIC agrees to file documentation of all remedial actions taken by it to implement compliance with the terms of this Stipulation and to assure that the errors noted in the examination report do not recur, including explaining the steps taken and the results of such actions, with the Director within 270 days of the entry of a final Order closing this examination.

WHEREAS, UHIC is of the position that this Stipulation of Settlement and Voluntary Forfeiture is a compromise of disputed factual and legal allegations, and that payment of a forfeiture is merely to resolve the disputes and avoid litigation; and

WHEREAS, UHIC, after being advised by legal counsel, does hereby voluntarily and knowingly waive any and all rights for procedural requirements, including notice and an opportunity for a hearing, which may have otherwise applied to the above referenced Market Conduct Examination; and

WHEREAS, UHIC hereby agrees to the imposition of the ORDER of the Director and as a result of Market Conduct Examination #0603-17 and -19-TGT further agrees, voluntarily and knowingly to surrender and forfeit the sum of $361,706.25.

NOW, THEREFORE, in lieu of the institution by the Director of any action for the SUSPENSION or REVOCATION of the Certificate(s) of Authority of UHIC to transact the business of insurance in the State of Missouri or the imposition of other sanctions, UHIC does hereby voluntarily and knowingly waive all rights to any hearing, does consent to the ORDER of the Director and does surrender and forfeit the sum of $361,706.25, such sum payable to the Missouri State School Fund, in accordance with §374.280, RSMo.

DATED: 7/31/09

President
United Healthcare Insurance Co.

EXHIBIT A

UHIC agrees to conduct a medical necessity review of denied chiropractic claims with dates of service 1/1/04 through the date of the final Order, in accordance with the following process:

1. UHIC will identify the universe of administratively denied claims during the time frame set forth above that were denied with the remark codes set forth in the stipulation (H0, J0, M0, 9L and JO). The companies will send a notice to each provider who submitted such claims. The notice will set forth in detail the process to be followed for a retrospective medical records review.

2. The notice will request that the provider send complete medical records for the patient within 30 days of receipt of the letter. Completion of the ACN Complete Clinical Notification form will not suffice to establish medical necessity.

3. The medical records submitted, if any, will be reviewed in accordance with ACN standards for record-keeping and medical necessity as set forth in the official ACN policies that are available on-line. The notice letter will list these policies and how to access them.

4. If the company determines that a claim is medically necessary and pays it, interest will be owed from the 46th day after the company initially received the claim until the date it was paid in full.

5. If a provider requests additional time to provide medical records to establish medical necessity, UHIC will allow providers an additional 30 days, for a total of 60 days. However, the request for an additional 30 days must be made before the expiration of the first 30 day period, and no interest will be due for the extended period to produce the medical records.

6. UHIC may deny a claim for failure to provide the requested medical information.

7. UHIC will follow its usual appeal procedures for any appeals requested by members or providers.

8. It is understood that this process will be followed only for the remediation process outlined in the stipulation. UHIC will follow state utilization review and prompt pay laws for the handling of claims received after the date of the Order.

STATE OF MISSOURI

DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

MARKET CONDUCT

FINAL EXAMINATION REPORT

OF

UNITED HEALTHCARE INSURANCE COMPANY

NAIC NUMBER: 79413

AND

ACN GROUP, INC.

13655 Riverport Drive
Maryland Heights, Missouri 63043

May 29, 2009

DIFP EXAMINATON REPORT NUMBERS: 0603-17, 19-TGT

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FOREWORD

This market conduct report regarding the operations of the United Healthcare Insurance Company is in general, a report by exception. The examiners, in writing this report, cited errors made by the Company. However, the absence of comments on specific products, procedures, or files does not constitute approval thereof by the Missouri Department of Insurance, Financial Institutions and Professional Registration.

Wherever used in the report:

"ACN" refers to ACN Group, Inc. (formerly, American Chiropractic Network);

"CCN" refers to Complete Clinical Notification Form;

"Company" refers to United Healthcare Insurance Company, Inc.;

"COSMOS" refers to one of the Company's automated claim system programs;

"CSR" refers to Code of State Regulations;

"EOB" refers to Explanation of Benefits;

"DIFP" refers to the Missouri Department of Insurance, Financial Institutions, and Professional Registration;

"DOS" refers to date of service;

"MCR" refers to Medical Claim Review;

"NAIC" refers to the National Association of Insurance Commissioners;

"RSMo" refers to Revised Statutes of Missouri;

"TPA" refers to Third Party Administrator;

"UHIC" refers to United Healthcare Insurance Company;

"UNET" refers to the Company's main automated claim system;

"UR" refers to Utilization Review; and

"URC" refers to Usual, Reasonable and Customary.

SCOPE OF THE EXAMINATION

The DIFP has authority for performing this examination pursuant to, but not limited to, Sections 374.045, 374.110, 374.205, 375.445, 375.938, and 375.1009, RSMo. In addition, Section 447.572, RSMo grants authority to the DIFP to determine compliance with the Uniform Disposition of Unclaimed Property Act.

The examination primarily covered the period from January 1, 2004, through December 31, 2005.

The examination sought to determine whether UHIC complied with Missouri's Insurance Laws and with DIFP regulations. In addition, the examiners reviewed the operations of the Company to determine if these were consistent with the public interest.

The examination focused upon the general business practices of the Company, while the examination team cited errors found in individual files. The DIFP has adopted the "error tolerance ratio guidelines" published by the NAIC. Unless otherwise noted, the examiners applied a 10% error criterion to all operations of the Company except claims handling. The threshold for claims matters is 7%. The threshold for Prompt Pay issues is 5%. The DIFP deems Company operations and practices that exceed these thresholds to be inappropriate business practices and thus subject to regulatory action. The DIFP conducted this examination at the Company's offices in Maryland Heights, Missouri.

The DIFP reviewed the following operations of the Company:

Marketing

Underwriting

Claims Practices

Managed Care/ Utilization Review

Complaints/ Grievances

The DIFP conducted the examination at the following address:

United Healthcare Insurance Company
13655 Riverport Drive
Maryland Heights, Missouri 63043

EXECUTIVE SUMMARY

1. The Company unfairly denied benefit payments on a number of claim expenses incurred within the first 26 visits in a policy period on the basis that network providers failed to adhere to administrative requirements of ACN's network provider agreements.

2. The Company unfairly denied benefits to claimants on the basis that they had already exceeded the number of visits allowed by the HMO plan when this was not the case.

3. Based upon a chiropractic care rider, the Company imposed a limit of 20 visits on enrollees in some groups that resulted in denial of claims that were otherwise payable.

4. The Company misapplied certain remark codes that resulted in denial of claims that were otherwise payable.

5. The Company issued a chiropractic care rider that limited the number of visits in a calendar year to 26 dates of service. Consequently, the Company inappropriately denied coverage for medically necessary chiropractic care for visits in excess of 26 dates of service in a calendar year.

EXAMINATION FINDINGS

I. MARKETING

This section of the report details the examination findings regarding UHIC's and ACN's compliance with the laws that monitor marketing practices. The items reviewed included the Company's Certificate of Authority for Missouri, ACN network provider agreements and ACN's WEB page that highlight its network's marketing/advertising materials directed to existing and potential network providers or other interested parties.

A. Company Authorization

The Company has current authority to transact business in the following lines of insurance:

Health Insurance
Life Insurance

ACN holds a license to manage its chiropractic network and perform utilization review and claims processing as a TPA in the State of Missouri.

Regarding the Companies' operations in Missouri, the examiners determined that UHIC complies with its Certificates of Authority, and ACN complies with its licenses to operate in its capacities as a U R agent and as a TPA.

B. Advertising

The examiners reviewed advertising material made available by the Company for the period under review. The following details the examiners' findings.

The examiners noted no issues with regard to advertising material generated by UHIC. The examiners note that within the context of utilization review and network management, ACN leaves the determination of medical necessity to the network chiropractic providers and their patients.

II. UNDERWRITING

Forms and Filings

The examiners reviewed policy contracts and related forms to determine the Company's compliance with Missouri laws and regulations that refer to filing, approval, and content of policies and related forms. The examiners also reviewed the forms to ensure that the contracts contained unambiguous language and that the provisions adequately protect Missouri consumers. The Company initially filed its policy forms with the DIFP and received the necessary approvals from the DIFP. Subsequent to changes in the law that affected mandated benefits related to chiropractic care, the Company made the required filings to update its policy forms to meet compliance standards. The Company intended to comply with the mandated benefits by attaching riders to its contracts.

The examiners noted the following errors in this review:

1. The Company's Chiropractic rider form identified with the following Group policies and the coverage as described therein violate the requirements of the Missouri statute that mandates coverage for chiropractic care. Missouri mandates that the enrollee may receive medically necessary chiropractic care for 26 visits in a policy period without the necessity of providing notification. For treatment or tests in excess of 26 visits, the company may require notification or pre-authorization as a condition of coverage. The rider in question, (98CHIRO/NETPLS), (CHP152.DOC) (CHP2030.DOC), unfairly limits coverage to 20 visits in a calendar year.
Reference: Section 376.1230, RSMo

Group Policy Numbers

000194564*	*(Claim #s: 104116889701, 104116889801, 119631016801
000265391	The Company should pay the above noted three claims.
000703910	See Criticism # 27)
0004R1788	
000266515	
000195692	
000188527	

2. The Company's group policies and chiropractic riders describe the coverage afforded enrollees of group health plans as defined by section 376.1350, RSMo. The policies and riders place a limitation of 26 visits for chiropractic care in a calendar year or a policy period without regard to the issue of medical necessity.

During the period of the examination, the Company denied coverage for chiropractic care to enrollees who received treatment in excess of 26 visits in a policy period. The claim data reflected 30 group policies with "9L" denials processed in 2005 that involved 75 patients and 1,226 claim records.

The statute that mandates coverage for chiropractic care permits the company to require notification or pre-authorization as a condition of coverage after the first 26 visits in a policy period. However, subject to the terms and conditions of the policy, the statute does not allow for denial of coverage for medically necessary chiropractic care to treat the diagnosed disorder. The Company may not establish any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a chiropractic care condition than for access to treatment for another physical health condition. The limitation of 26 visits on an insured/patient specific to chiropractic care without regard to the issue of medical necessity places a greater financial burden upon the insured for access to medically necessary chiropractic care.

Reference: Section 376.1230, RSMo

Group Policy Forms

IND.1.01 MO
Choice Plus – H.01.MO/IL
Select Plus – H.01.MO/IL
Options PPO (80/80)
Managed Indemnity

III. CLAIM PRACTICES

The examiners reviewed the claim practices of the Company in order to determine its efficiency of handling, accuracy of payment, adherence to contract provisions, and compliance with Missouri law and regulations. Due to the large number of claim files, the examiners were unable to review every claim. Consequently, the examiners used a scientific sampling to review the Company's claim files. A claim file, as a sampling unit, is an individual demand, request for payment or action under an insurance contract for benefits which may or may not be payable. The most appropriate statistic to measure the Company's compliance with the law is the percentage of files in error. An example of an error includes, but is not limited to, any unreasonable delay in the acknowledgment, investigation, or payment/denial of a claim. An error could also include the failure of the Company to calculate claim benefits accurately, or the failure of the Company to comply with Missouri law regarding claim settlement practices.

A. Unfair Claim Practices

The examiners reviewed paid and denied claims to determine the Company's adherence to claim handling requirements. Whenever a claim file reflected that the Company failed to meet these standards, the examiners cited the Company for noncompliance with Missouri law.

The examiners noted the following in this review:

1. **Paid Claims**

Field Size:	154,709
Sample Size:	50
Type of Sample:	ACL Random
Number of Errors:	0
Within DIFP Guidelines?	Yes

The examiners noted no errors in this review.

2. **Denied Claims**

Field Size:	107,956
Sample Size:	50
Type of Sample:	ACL Random
Number of Errors:	13
Error Ratio:	26%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

a) The Company afforded the insured patient coverage under group policy number 0004R8533 effective February 1, 2004. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 01/28/2005 DOS per denial code "M0", that states "This date exceeds the number of visits indicated in the ACN notification response; re-notification was required. The patient may not be billed for amounts declined when administrative requirements are not followed."

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification or a re-notification. Part of the CCN included the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered

failure to re-submit a CCN grounds for denial of the claim. This practice violated the requirements of Missouri law.

The chiropractor who provided medical services to the member contracted with the ACN network. The ACN's network policy leaves the determination of medical necessity up to the provider and the patient. By its own admission, UHIC did not engage in utilization review of the services provided by ACN's network provider. According to both ACN and UHIC, ACN is not involved in the claim process. However, it appears that ACN initiates application of the "M0" remark code. This action resulted in denial of payment. It does not appear that UHIC made any determination on the issue of medical necessity, nor did it investigate the recovery milestone applicable to the specific patient under care. UHIC and ACN conducted neither utilization review nor an investigation to make a determination about the issue of medical necessity.

According to UHIC and ACN, the notification process requires a treating provider to submit a standardized medical record containing data about the patient under care. Once ACN receives notification from the provider, ACN establishes a milestone for the treatment and re-notification. If the patient's condition requires treatment beyond the established milestone, ACN requires the provider to re-submit a CCN. The CCN refers to the network's standardized medical forms. The CCN includes the provider's description of the patient's condition, a treatment plan, and a health questionnaire completed by the patient. During the period under review, ACN considered the CCN incomplete without the patient's health questionnaire. Failure to re-submit a CCN could, and, as in this case, did result in denial of payment for the services rendered.

The Company and ACN do not consider the notification process as a "pre-certification" or "pre-authorization" of treatment. According to the Company, application of the "M0" code does not deny services as non-covered or medically

unnecessary. However, the Company's application of the "M0" remark code did result in denial of benefits to the provider for services already performed.

UHIC does not receive a copy of the CCN submitted by the provider to ACN. UHIC only received the CMS 1500 claim form. Without conducting an investigation, UHIC could not make a determination about the medical necessity of the treatment provided by the chiropractor. The date of service was the 11th visit in the 2004 policy period. The Company may not require notification within the first 26 visits in a policy period as a condition of coverage. Unless UHIC bases its denial of payment upon a lack of medical necessity, the Company should pay for services already provided to this patient.

The examiners requested the Company to issue a benefit payment to the network provider $24.00. In addition, the Company owes interest on this electronically filed claim submitted on 02/15/05 at the rate of 1 percent per month from 45 days after the date submitted to the date paid.
Reference: Sections 375.1007(1), (3), (4), and (6), 376.383, and 376.1230, RSMo

Claim Number	Member ID #
104722139801	319663224

b) The Company afforded the insured patient coverage under group policy number 000706022, effective 07/01/2004. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 02/22/2005 DOS per denial code "M0", that states "This date exceeds the number of visits indicated in the ACN notification response; re-notification was required. The patient may not be billed for amounts declined when administrative requirements are not followed."

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification or a

re-notification. Part of the CCN included the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to re-submit a CCN grounds for denial of the claim. This practice violates the requirements of Missouri law.

The chiropractor who provided medical services to the member contracted with the ACN network. ACN's network policy leaves the determination of medical necessity up to the provider and the patient. UHIC did not engage in utilization review of the services provided by ACN's network provider. According to both ACN and UHIC, ACN is not involved in the claim process. However, it appears ACN initiated use of the "M0" remark code. This action resulted in denial of payment. It does not appear that UHIC made any determination on the issue of medical necessity, nor did it investigate the recovery milestone's applicability to the specific patient under care. UHIC conducted neither utilization review nor an investigation to make a determination about the issue of medical necessity.

According to UHIC and ACN, the notification process requires a treating provider to submit a CCN that contains data about the patient under care. Once ACN receives notification from the provider, ACN establishes a milestone for the treatment and re-notification. If the patient's condition requires treatment beyond the established milestone, ACN requires the provider to re-submit a CCN. The CCN refers to the network's standardized medical forms. The CCN includes the provider's description of the patient's condition, a treatment plan, and a health questionnaire completed by the patient. During the period under review, ACN considered the CCN incomplete without the patient's health questionnaire. The provider's failure to resubmit a follow-up CCN could, and in this case did result in denial of payment for the services rendered.

The notification process is not a "pre-certification" or "pre-authorization" of the treatment according to ACN. According to the Company, application of the "M0" code does not deny services as non-covered or medically unnecessary. However,

the Company's use of the "M0" remark code did result in denial of benefits to the provider for services already performed.

UHIC did not receive a copy of the CCN submitted by the provider to ACN. UHIC only received the CMS 1500 claim form. Without conducting an investigation, UHIC could not make a determination about the medical necessity of the treatment provided by the chiropractor. The date of service was the 21st visit in the 2004 policy period. The statute prohibits the notification requirement within the first 26 visits in a policy period. Unless UHIC bases its denial on a lack of medical necessity, the Company should pay for services already provided to this patient.

The examiners requested the Company issue a benefit payment to the network provider for $24.00.
Reference: Sections 375.1007(1), (3), (4), and (6), and 376.1230, RSMo

Claim Number	Member ID #
105503625101	476643849

c) The Company afforded the insured patient coverage under group policy number 000991911 effective March 1, 2004. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 01/05/2005 DOS on the basis that the insured and provider failed to submit a CCN. The Company did not contemplate the issue of medical necessity with its denial.

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification. Part of the CCN includes the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violates the requirements of Missouri law.

According to records provided by the Company, the provider submitted the claim in question (01/05/05) on 01/14/05. This is the same date the Company received notice of three other claims for the 01/6/05, 01/7/05, and 01/8/05 dates of service. While the Company initially denied these three dates of service, it did so on the basis that the dates exceeded the number of visits indicated on ACN's notification response. The reference to the notification response relative to dates of service in such close proximity to the 01/05/05, DOS indicates the provider submitted a notification that would have addressed all of the dates of service noted. It appears a series of processing errors resulted in non-payment of the claims. Though not a part of the sample of claims, the examiners noted that the Company received notice of the 01/04/05 DOS at the same time as the other claims and the Company also denied this claim per the "J0" remark code.

The examiners requested that the Company reprocess the claims for 01/04/05 and 01/05/05 and issue a benefit check to the network provider. Because of a number of inconsistencies in the processing of this insured's claims, the examiners could not readily ascertain the correct amounts payable. The examiners understand the Company makes payment to network providers based upon a "Day Rate" that allows $60 for the initial visit and $44.00 for subsequent visits in the geographic area where the enrollee incurred the expense. The claim records showed the allowed amounts for the 01/6/05, 01/7/05, and 01/8/05 DOS equaled $45.00, $60.00, and $60.00 respectively. The examiners requested an explanation for these inconsistencies. The Company may make corrections to previously paid claims when it re-adjudicates the claim in question. The Company overstated the allowed amount on one claim by $16.00 and another by $1.00, while the Company should base the payment due for the 01/04/05 and 01/05 DOS on a $44.00 "Day Rate". Reference: Sections 375.1007(1), (3), and (4), and 376.1230, RSMo

Claim Number	Member ID #
102875715401	486708750

d) The Company afforded the insured patient coverage under group policy number 000707768 effective February 1, 2005. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 06/27/2005 DOS per denial code "M0", that states "This date exceeds the number of visits indicated in the ACN Group notification response; re-notification was required. The patient may not be billed for amounts declined when administrative requirements are not followed."

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification or a re-notification. Part of the CCN included the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to re-submit a CCN grounds for denial of the claim. This practice violated the requirements of Missouri law.

The chiropractor who provided medical services to the member contracted with the ACN network. The managed care policy of ACN leaves the determination of medical necessity up to the provider and the patient. UHIC does not engage in utilization review of the services provided by ACN's network providers. According to both ACN and UHIC, ACN is not involved in the claim process. However, it appears that ACN initiated use of the "M0" remark code. This action resulted in denial of payment. It does not appear that UHIC made any determination on the issue of medical necessity, nor did it investigate the recovery milestone applicable to the patient under care. UHIC conducted neither utilization review nor an investigation to make a determination about the issue of medical necessity.

According to UHIC and ACN, the notification process requires a treating provider to submit standardized medical forms containing data about the patient under care. Once ACN receives notification from the provider, ACN establishes a milestone for the treatment and re-notification. If the patient's condition requires treatment beyond the established milestone, ACN requires the provider to re-submit a CCN.

The CCN refers to the standardized medical forms required of ACN's network providers. The CCN includes the provider's description of the patient's condition, a treatment plan, and a health questionnaire completed by the patient. During the period under review, ACN considered the CCN incomplete without the patient's health questionnaire. The provider's failure to resubmit a follow-up CCN could and in this case did result in denial of payment for the services rendered.

The notification process is not a "pre-certification" or "pre-authorization" of the treatment. According to the Company, application of the "M0" code does not deny services as non-covered or medically unnecessary. However, the Company's use of the "M0" remark code did result in denial of benefits to the provider for services already performed

UHIC does not receive a copy of the CCN submitted by the provider to ACN. UHIC only received the CMS 1500 claim form. Without conducting an investigation, UHIC could not make a determination about the medical necessity of the treatment provided by the chiropractor. The DOS was the 10th visit in the 2005 policy period. The statute prohibits the notification requirement within the first 26 visits in a policy period. Unless UHIC bases its denial on a lack of medical necessity, the Company should pay for services already provided to this patient.

The examiners requested the Company issue a benefit payment to the network provider for $39.00 for the 6/27/05 DOS. In addition, the Company owes interest on this electronically filed claim submitted on 07/01/05 at the rate of 1 percent per month from 45 days after the date submitted to the date paid.
Reference: Sections 375.1007(1), (3), (4), and (6), 376.1230, and 376.1361(13), RSMo

Claim Number	Member ID #
113760128701	486928585

Inexplicably, the Company paid for the following dates of service: 07/06/05, 07/07/05, 07/11/05, 07/20/05, 07/25/05, and 07/27/05. These dates of service fell between and subsequent to dates of service for which the Company denied benefits. This inconsistent claim payment activity demonstrates the Company deemed the treatment received during this period medically necessary on some occasions while it refused to pay for other dates of service occurring within this 28-day period. Nothing indicates the Company had been prejudiced in any way by the provider's actions.

Note: Though not a part of the sample, the examiners requested the Company pay benefits on related claims for treatment received on the following dates: (The circumstances for these claims mirrored the claim in question)

Claim Number	Date of Service - Visit Number	
1133844510010	6/23/05	9th
1137601287010	6/27/05	10th
1137601288010	6/29/05	11th
1138540709010	6/30/05	12th
1149026108010	7/14/05	16th
1149026108010	7/18/05	17th

e) The Company afforded the insured patient coverage under group policy number 000274147 effective December 1, 2004. The Company unfairly denied payment of benefits for chiropractic care for the 01/04/2005 DOS (first visit in 2004 policy period) on the basis that the insured and provider failed to submit a CCN. The Company did not contemplate the issue of medical necessity with its denial.

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification. Part of the CCN includes the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to submit a

CCN grounds for denial of the claim. This practice violated the requirements of Missouri law.

The examiners requested the Company issue a benefit payable to the network provider based on the $40.00 "Day Rate" for the Raymore, MO area, less the appropriate co-payment for the 01/04/05 DOS. In addition, the Company owes interest on this electronically filed claim submitted on 01/21/2005 at the rate of one percent per month from 45 days after the date submitted to the date paid. Reference: Sections 375.1007(1), (3) and (4), 376.383, and 376.1230, RSMo

Claim Number	Member ID #
103258157701	488729635

f) To understand the examiner's analysis of the claim considered in this review some background on the enrollees' claim history and coverage is in order. The Company afforded the insured patient coverage under UHCMW group policy number 000705812 effective July 1, 2004. It appears that UHIC wrote the coverage as of the renewal date (07/01/05) under the same group policy number. During the 2005 calendar year the Company's UNET system processed claims for both the UHIC and UHCMW policies. The following describes the claim activity during the 2005 calendar year.

UHCMW processed claims for 30 DOS from 01/01/05 through 06/27/05. UHIC paid for 26 visits based upon a $40.00 "Day Rate". It applied $25 to the co-pay and paid $15.00 on each claim. UHIC overcharged the enrollee's co-pay by $5.00 for each of the 26 DOS. The examiners requested UHIC to reimburse the enrollee $130.00 for the overcharges plus interest on these e-filed claims per Section 376.383, RSMo. UHIC denied benefits for the 05/23/05, 05/26/05, 06/13/05, and 06/27/05, DOS for exceeding the maximum visits allowed under the policy.

UHIC processed claims for eight DOS from 7/26/05 through 12/08/05, paid for the 07/26/05 DOS, but denied the next seven DOS for exceeding the maximum number of visits allowed by the policy.

The examiners concluded that the UNET claim system tracked the number of DOS in the 2005 calendar year without regard to which policy underwrote the coverage. Once the system tracked the payment of 26 DOS in the calendar year, it denied the succeeding claims for exceeding the maximum number of visits allowed. Because UHIC wrote a new policy effective 07/01/05, a new count on the number of visits allowed under its policy was in order.

Under the UHIC group policy, it unfairly denied payment of benefits for chiropractic care for the 12/08/2005 DOS (8th visit in 2005 policy period) per remark code "9L" which states, "According to our records, your annual maximum benefit for this therapy service and/or associated expense has been paid. Therefore, no further benefits are payable for this benefit period." The Company did not contemplate the issue of medical necessity with its denial.

The examiners requested the Company issue a benefit payable to the network provider based on the $40.00 "Day Rate" for the Independence, MO area, less the appropriate co-payment for the 12/08/05 DOS. In addition, the Company owes interest on this electronically filed claim submitted on 12/12/2005 at the rate of one percent per month from 45 days after the date submitted to the date paid. Reference: Sections 375.1007(1), (3), and (4), 376.383, and 376.1230, RSMo, and 20 CSR 400-7.100

Claim Number	Member ID #
124362631001	494460086

NOTE: While not a part of the review, and therefore not subject to the error ratio contemplated for this review of denied claims, the examiners noted that the

company inappropriately denied an additional six claims in the 2005 policy period on the basis of the "9L" remark code. The examiners requested the Company re-process these claims based on the $40.00 day rate. Because the provider filed the claims electronically, the Company owes payment of interest on these late paid claims. The examiners requested that the Company calculate the interest payment for each claim at the rate of one percent per month from 45 days after the date submitted to the date paid.

Date of Service	Claim Number	Allowed	Co-Pay	$ Due
08/23/2005	117233196501(Z)	$40.00	$25.00	$15.00
09/20/2005	118991316801(Z)	$40.00	$25.00	$15.00
10/01/2005	119810952401(Z)	$40.00	$25.00	$15.00
10/15/2005	120707533101(Z)	$40.00	$25.00	$15.00
11/14/2005	122725440701(Z)	$40.00	$25.00	$15.00
11/30/2005	123775112501(Z)	$40.00	$25.00	$15.00

g) The Company afforded the insured patient coverage under group policy number 0003N9496 effective July 1, 2004. The Company unfairly denied payment of benefits for chiropractic care for the 06/13/2005 (8th visit in 2004 policy period) on the basis that the insured and provider failed to submit a CCN. The Company did not contemplate the issue of medical necessity with its denial.

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification. Part of the CCN includes the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violated the requirements of Missouri law.

The examiners requested the Company issue a benefit payable to the network provider based on the $40.00 "Day Rate" for the Holt, MO area, less the appropriate co-payment for the 06/13/2005 date of service.

Reference: Sections 375.1007(1), (3), and (4), and 376.1230, RSMo

Claim Number	Member ID #
113071597801	493647229

h) The Company afforded the insured patient coverage under group policy number 000428809 effective July 1, 2004. The Company unfairly denied payment of benefits for chiropractic care for the 10/31/2005 DOS (10th visit in 2005 policy period) per denial code "9L". The Company did not contemplate the issue of medical necessity with its denial.

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification. Based upon the use of the "9L" denial code, the examiners' concluded the Company attached its Chiropractic rider to the group policy in question. The chiropractic rider limited the number of visits allowed in a calendar year. This limitation is in conflict with the statute that allows access to medically necessary treatment in a policy period.

At the examiners' request, the Company agreed to issue a benefit payable to the enrollee for the URC allowed amount less the appropriate coinsurance charge. Based upon a review of past claim payments, the expected allowed amount equals $113.10, the coinsurance equals $33.93 and the amount payable equals $79.17. Reference: Sections 375.1007(1), (3), and (4), and 376.1230, RSMo

Claim Number	Member ID #
122069396001	497580490

NOTE: Though not a part of the denied claim review sample and not subject to the error ratio in this review, the Company agreed to re-process and pay benefits for the respective dates of service noted in the following claims:

Date of Service	Claim Numbers	Policy Period Visit #
10/17/2005	121515480901	8th
10/27/2005	122069396101	9th
11/07/2005	122499725301	11th
11/17/2005	123370453501	12th
11/23/2005	123789651801	13th
12/01/2005	124169867001	14th

i) The Company afforded the insured patient coverage under group policy number 000706442 effective October 1, 2004. The Company unfairly denied payment of benefits for chiropractic care for the 08/04/2005 DOS (first visit in 2004 policy period) on the basis that the insured and provider failed to submit a CCN The Company did not contemplate the issue of medical necessity with its denial.

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification. Part of the CCN includes the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violated the requirements of Missouri law.

The examiners requested the Company issue a benefit payable to the network provider based on the $44.00 "Day Rate" for the St. Louis, MO area, less the appropriate deduction for the enrollee's portion for the 08/04/05 DOS. In addition, the Company owes interest on this electronically filed claim submitted on 08/08/2005 at the rate of one percent per month from 45 days after the date submitted to the date paid.
Reference: Sections 375.1007(1), (3), and (4), 376.383, and 376.1230, RSMo, and 20 CSR 300-2.200(2)(B)

Claim Number	Member ID #
116077073101	498668240

NOTE: Though not a part of the sample of the denied claims review and therefore not subject to the error ratio, the examiners noted the Company inappropriately denied the enrollee's 08/12/2005 DOS (2nd visit in policy period) per denial code "J0". The examiners asked the Company to re-process this claim.

j) The Company afforded the insured patient coverage under group policy number 000308398 effective July 1, 2004. The Company unfairly denied payment of benefits for chiropractic care for the 04/25/2005 DOS (7th visit in 2004 policy period) on the basis that the insured and provider failed to submit a CCN. The Company did not contemplate the issue of medical necessity with its denial.

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification. Part of the CCN includes the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violates the requirements of Missouri law.

The examiners requested the Company issue a benefit payable to the network provider based on the $40.00 "Day Rate" for the Liberty, MO area, less the appropriate co-payment for the 04/25/05 DOS. In addition, the Company owes interest on this electronically filed claim submitted on 04/27/2005 at the rate of one percent per month from 45 days after the date submitted to the date paid. Reference: Sections 375.1007(1), (3), and (4), 376.383, and 376.1230, RSMo

Claim Number	Member ID #
109420119701	499788107

k) The Company afforded the insured patient coverage under group policy number 000704440 effective October 1, 2004. The Company unfairly denied payment of benefits for chiropractic care for the 01/05/2005 DOS (5th visit in 2004

policy period) on the basis that the insured and provider failed to submit a CCN. The Company did not contemplate the issue of medical necessity with its denial.

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification. Part of the CCN includes the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violates the requirements of Missouri law.

The examiners requested the Company issue a benefit payable to the network provider based on the $44.00 "Day Rate" for the O'Fallon, MO area, less the appropriate co-payment for the 01/05/05 DOS.
Reference: Sections 375.1007(1), (3), and (4), and 376.1230, RSMo

Claim Number	Member ID #
103475436101	499823985

l) The Company afforded the insured patient coverage under group policy number 000382719 effective January 15, 2005. The Company unfairly denied payment of benefits for chiropractic care for the 10/04/2005 DOS (4th visit in 2005 policy period) on the basis that the insured and provider failed to submit a CCN The Company did not contemplate the issue of medical necessity with its denial.

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification. Part of the CCN includes the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violated the requirements of Missouri law.

The examiners requested the Company issue a benefit payable to the network provider based on the $40.00 "Day Rate" for the Kansas City, MO area, less the appropriate co-payment for the 10/04/05 date of service. In addition, the Company owes interest on this electronically filed claim submitted on 10/13/2005 at the rate of one percent per month from 45 days after the date submitted to the date paid. Reference: Sections 375.1007(1), (3), and (4), 376.383, and 376.1230, RSMo

Claim Number	Member ID #
120417650501	515984907

m) The Company afforded the insured patient coverage under group policy number 000707056 effective January 1, 2005. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 05/16/2005 DOS per denial code "M0" which states, "This date exceeds the number of visits indicated in the ACN notification response; re-notification was required. The patient may not be billed for amounts declined when administrative requirements are not followed."

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification or a re-notification. Part of the CCN included the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to re-submit a CCN grounds for denial of the claim. This practice violated the requirements of Missouri law.

The chiropractor who provided medical services to the member contracted with the ACN network. The ACN network policy leaves the determination of medical necessity up to the provider and the patient. By its own admission, UHIC does not engage in utilization review of the services provided by ACN's network providers. According to both ACN and UHIC, ACN is not involved in the claim process. However, ACN initiated application of the "M0" remark code that resulted in denial

of payment. UHIC conducted neither utilization review nor an investigation to make a determination on the issue of medical necessity.

According to UHIC and ACN, the notification process requires a treating provider to submit a standardized medical record containing data about the patient under care. After ACN receives notification from the provider, ACN establishes a milestone for the treatment and re-notification. If the patient's condition requires treatment beyond the established milestone, the provider is required to re-notify ACN. The CCN refers to the standardized medical forms required of ACN's network providers. The CCN includes the provider's description of the patient's condition, a treatment plan, and a health questionnaire completed by the patient. During the period under review, UHIC and ACN considered the CCN incomplete without the patient's health questionnaire. The provider's failure to resubmit a follow-up CCN could and did result in denial of payment for the services rendered.

Both ACN and UHIC have taken the position that the notification response letter issued by ACN is not used for utilization review of the specific patient's condition and is not intended to be an authorization or a determination of medical necessity. According to the Company, application of the "M0" code does not deny services as non-covered or medically unnecessary. However, the Company's use of the "M0" remark code resulted in denial of benefits to the provider for services already performed.

UHIC does not receive a copy of the CCN that the provider submitted to ACN. UHIC only received the CMS 1500 claim form. Without conducting an investigation, UHIC could not make a determination about the medical necessity of the treatment provided by the chiropractor. The DOS represented the 18th visit in the 2005 policy period. The Company may not require notification or re-notification within the first 26 visits in a policy period as a condition of coverage. Unless UHIC bases its denial on a lack of medical necessity, the Company should pay for services already provided to this patient.

The examiners requested the Company issue a benefit payment to the network provider for $29.00 for the 5/16/05 DOS.
Reference: Sections 375.1007(1), (3), and (4), (6), and 376.1230, RSMo

Claim Number	Member ID #
116038554801	559931586

B. Target Review – H0 Denied Claims

Field Size:	3,292
Sample Size:	50
Type of Sample:	ACL Random
Number of Errors:	38
Error Ratio:	76%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

1. The insured/patients received chiropractic care on the dates indicated below. The Company denied payment of benefits for these patients' dates of service per remarks code H0. In the absence of documentation to the contrary, the Company failed to pay benefits for medically necessary chiropractic care received by these patients on the dates indicated, contrary to the requirements of Missouri.

Section One reflects claims incurred in the 2005 – 2006 policy year. Section Two reflects claims incurred in the 2004 – 2005 policy year, but in the 2005 calendar year.
Reference: Sections 375.1007(1), (3), and (4), and 376.1230, RSMo

(Errors noted in the following are based upon analysis of ACL claim data provided by the Company)

SECTION ONE – 2005-2006 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
489941592 (EE)	000707768	107549618601(W)	03/23/2005 - #1
566418523 (EE)	000385318	111373214401(U)	05/20/2005 - #8
490549082 (EE)	000390687	123609980401(U)	11/18/2005 - #6
497785929 (EE)	000340411	125378905001(S)	12/22/2005 - #4
486541052 (EE)	000468002	124686265501(U)	12/13/2005 -#25
497789942 (EE)	000186567	109563511101(G)	04/22/2005 - #8
489848206 (CH)	000385835	116835050201(U)	08/16/2005 - #2
497526232 (CH)	000473384	108265243401(U)	04/01/2005 -#26
493602370 (EE)	000374896	125150128701(U)	12/14/2005 -#15
498924950 (EE)	0005R4078	115911529101(U)	07/01/2005 -#18
497809099 (CH)	000287650	111483563401(S)	05/24/2005 - #5
500665874 (EE)	000707031	114297983701(W)	04/06/2005 - #3
513880772 (EE)	000465074	107044405601(U)	03/14/2005 -#25
500748777 (SP)	000705671	114571933101(Z)	07/07/2005 -#24

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
345329499 (EE)	000345765	102852542901(S)	01/12/2005 - #5
490720738 (EE)	000463634	122385991501(U)	11/02/2005 -#21
513589971 (EE)	000448921	118294342501(U)	08/30/2005 -#19
487768378 (EE)	0001K8055	113031640201(S)	06/15/2005 - #8
487485100 (SP)	000704382	105980542801(Z)	01/25/2005 - #2
489889782 (EE)	000422070	109973205901(U)	04/26/2005 - #5
226908234 (SP)	000706901	110633806201(W)	05/10/2005 -#17
488747301 (SP)	000705680	109747545601(Z)	04/22/2005 -#12
497785929 (CH)	000340411	102368498301(S)	01/05/2005 -#13
167423656 (SP)	0005R3423	102647285001(U)	01/11/2005 - #2
498963919 (EE)	000705992	104020750201(Z)	01/26/2005 -#17
494666724 (EE)	000415884	106780123301(U)	01/04/2005 - #3
497885575 (EE)	000705936	105698911401(Z)	01/05/2005 - #1
497800287 (SP)	000339313	109904286501(S)	04/29/2005 - #6
499787664 (SP)	0002P0431	117455564901(U)	08/19/2005 -#10
491661687 (EE)	000437955	106704102401(U)	02/25/2005 - #6

2. The insured/patients received chiropractic care on the dates indicated below. The Company denied payment of benefits for these patients' dates of service per

remarks code H0. From a review of the documentation provided by the Company, the examiners determined that the Company failed to pay benefits for medically necessary chiropractic care received by these patients on the dates indicated, contrary to the requirements of Missouri Law.
Reference: Sections 375.1007(1), (3), and (4), and 376.1230, RSMo

(Errors noted in the following are based upon analysis of hard copy documentation provided by the Company.)

2005-2006 POLICY YEAR CLAIMS

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
400002154 (EE)	000275267	106703166801(S)	01/04/2005 - #1
355408229 (EE)	000706621	111462020101(W)	05/18/2005 -#14
499486261 (EE)	000707581	117981330001(W)	08/31/2005 -#11
491729871 (EE)	000474938	108934717801(U)	02/06/2005 - #1
488764704 (EE)	0001K8631	105132621001(S)	01/10/2005 - #1
336568995 (EE)	000418613	107695442701(U)	03/23/2005 -#12
489645640 (EE)	000276376	110200615701(S)	05/05/2005 -#13
490886937 (EE)	000704440	117443630001(Z)	08/09/2005 -#11

C. Target Review – J0 Denied Claims

Field Size:	13,650
Sample Size:	50
Type of Sample:	ACL Random
Number of Errors:	45
Error Ratio:	90%
Within DIFP Guidelines?	No

The examiners' review of documentation provided by the Company, determined the following:

During their respective benefit periods, the enrollees listed below submitted claims for chiropractic care for specific dates of service under coverage afforded by their respective policies. The Company improperly denied payment of benefits for these claims on the basis that the network providers failed to submit CCNs to ACN as required by the providers' network agreements.

Section 376.1230.1, RSMo, provides mandatory coverage for chiropractic care. The coverage shall include initial diagnosis and clinically appropriate and medically necessary service to treat the diagnosed disorder, subject to the terms and conditions of the policy. According to the statute, an enrollee may access chiropractic care for a total of 26 chiropractic physician office visits per policy period, but may be required to provide notice prior to any additional visits. The insurance policies do not require notification or authorization prior to treatment.

Both ACN and UHIC have taken the position that the notification response letter issued by ACN is not used for utilization review of the specific patient's condition and is not intended to be an authorization or a determination of medical necessity. The Company did not deny the claims on the question of medical necessity, but relied upon administrative requirements. Per the Company's EOB, the Company denied the claims because ACN did not receive the required CCNs from the providers.

By definition, the participating provider, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health services to enrollees with an expectation of receiving payment, other than co-payments or deductibles, directly or indirectly from the health carrier. Under the circumstances associated with the following list of claims, the enrollees received medically necessary care from the network providers. Each claim references a visit within the first 26 dates of service within the respective policy periods, and the providers should receive payment of benefits for the associated services.
Reference: Sections 375.1007(1), (3), and (4), 376.1230, and 376.1350, RSMo

(Errors noted in the following are based upon analysis of hard copy documentation provided by the Company.)

SECTION ONE – 2005-2006 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
491567994 (EE)	0005R4202	103495097701(U)	01/03/2005 - #1
497462268 (EE)	000466024	115645024201(U)	07/18/2005 - #1
330659905 (EE)	000705671	117995716201(Z)	08/29/2005 - #2
486869875 (EE)	000707567	107522023401(W)	03/09/2005 - #2
498909116 (EE)	000704873	104975466101(Z)	01/14/2005 - #3
491806958 (EE)	000364464	110524733201(S)	05/10/2005 - #3

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
513962753 (EE)	000194564	112401032501(Q)	06/02/2005 -#12
492906729 (EE)	000396890	103946986501(U)	01/19/2005 - #1
500601000 (EE)	000706579	116668492701(W)	08/10/2005 -#14
492680555 (EE)	0002P0431	103388143701(U)	01/06/2005 - #2
494543411 (SP)	000432598	102647253601(U)	01/07/2005 - #4
490843276 (EE)	0005R3035	106292780801(U)	03/07/2005 - #3
331546448 (EE)	000706161	105503492401(Z)	02/22/2005 - #8
492948642 (EE)	000415866	110563139101(U)	05/04/2005 -#13
498481430 (EE)	000463183	105133004601(U)	01/27/2005 - #2

(Errors noted in the following are based upon analysis of ACL claim data provided by the Company)

SECTION ONE – 2005-2006 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
490767969 (EE)	0001P9001	103304894201(S+W)	01/17/2005 - #1
473728233 (EE)	000707955	112419715401(W)	05/03/2005 - #2
495669741 (EE)	0004N2024	119716126301(U)	06/03/2005 - #6
487408800 (SP)	000706790	104614132501(W)	02/01/2005 - #3

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
499684075 (EE)	0003N5564	115673162801(S)	07/28/2005 - #4
499684075 (EE)	0003N5564	119632095801(S)	09/26/2005 - #6
524902546 (EE)	000702017	109031920201(U+Y)	04/13/2005 - #2
478842520 (EE)	000458582	104435411401(U)	01/15/2005 - #2
490721784 (CH)	000374227	105671430701(U)	01/19/2005 - #1
490721784 (CH)	000374227	106907808201(U)	01/20/2005 - #2
489728162 (CH)	000397157	113530404801(U)	04/18/2005 - #6
500480032 (EE)	000707052	116723972601(W)	08/08/2005 -#13

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
494769780 (EE)	0002J0637	103857415101(S)	01/24/2005 - #5
486801045 (SP)	000706593	104219261301(W)	01/25/2005 - #5
489583496 (SP)	000705658	106900657101(z)	01/07/2005 -#11
500585127 (CH)	000444322	117200887301(U)	06/08/2005 - #3
493860773 (SP)	0005R1113	108297696501(U)	03/17/2005 -#16
503501708 (SP)	000341699	104592914501(S)	02/04/2005 -#13
226837476 (EE)	000706597	117493786101(W)	08/22/2005 -#10
430353750 (SP)	000274146	114014555401(S)	07/05/2005 -#23
330669978 (EE)	000318655	113509938001(S)	06/21/2005 -#23
496880366 (EE)	000441083	102401057701(U)	01/03/2005 - #3
493906096 (EE)	000342236	103258551301(S)	01/19/2005 - #2
490526627 (EE)	000458295	111549452301(U)	05/25/2005 - #3
496808650 (EE)	0004R7479	103229802401(S)	01/19/2005 - #4
496808650 (EE)	0004R7479	103945969201(S)	01/31/2005 - #8
488661855 (EE)	000407603	104703107901(U)	01/31/2005 - #5
495629795 (EE)	000352284	108373649001(S)	01/19/2005 - #2
156685388 (SP)	000705671	105305698801(Z)	02/01/2005 - #1
493860773 (EE)	0005R1113	108297696401(U)	03/30/2005 -#24
500761269 (EE)	000194564	104116889701(Q)	01/27/2005 -#2*
500761269 (EE)	000194564	104116889801(Q)	01/31/2005 -#3*

* Reference: Criticism # 27(Not included in error ratio)

D. Target Review – M0 Denied Claims

Field Size:	3,695
Sample Size:	50
Type of Sample:	ACL Random
Number of Errors:	29
Error Ratio:	58%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

1. During their respective benefit periods, the enrollees listed below submitted claims for chiropractic care for specific dates of service under coverage afforded by their respective policies. The Company improperly denied payment of benefits for these claims on the basis that the network providers failed to re-submit a CCN to ACN as required by the providers' network agreements.

Section 376.1230.1, RSMo, provides mandatory coverage for chiropractic care. The coverage shall include initial diagnosis and clinically appropriate and medically necessary services…to treat the diagnosed disorder, subject to the terms and conditions of the policy. According to the statute, an enrollee may access chiropractic care for 26 chiropractic physician office visits per policy period, but may be required to provide notice prior to any additional visits. The policies do not require notification or authorization prior to treatment during the first 26 dates of service.

Both ACN and UHIC have taken the position that the notification response letter issued by ACN is not based upon utilization review of the specific patient's condition and is not intended to be an authorization or a determination of medical necessity. The Company did not deny these claims on the question of medical necessity, but relied upon administrative requirements of the providers' contracts. The Company issued its denial of benefits for these claims with remark code "M0". The EOBs' explanation of this code states, "This date exceeds the number of visits

indicated in the ACN Group notification response; re-notification was required. The patient may not be billed for amounts declined when administrative requirements are not followed."

By definition, the participating provider, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health services to enrollees with an expectation of receiving payment, other than co-payments or deductibles, directly or indirectly from the health carrier. Under the circumstances associated with the following list of claims, the enrollees received medically necessary care from the network providers. Each claim references a visit within the first 26 dates of service within the respective policy periods and the providers should receive payment of benefits for the associated services.
Reference: Sections 375.1007(1), (3), and (4), 376.1230, and 376.1350, RSMo

(Errors noted in the following are based upon analysis of hard copy documentation provided by the Company.)

SECTION ONE – 2005-2006 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
487924723 (SP)	0001K8631	120661176001(S)	10/11/2005 -#17
498787125 (EE)	000396862	106704080501(U)	03/14/2005 -#13
547863506 (EE)	0003N9157	122073313901(U)	08/18/2005 -#11
514666662 (EE)	000704464	115413753101(Z)	07/13/2005 -#19
499582667 (EE)	000313131	115179927001(S)	07/11/2005 - #4
449981884 (EE)	000299050	115022785401(S)	07/18/2005 -#17

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
487602466 (SP)	000438696	106544724901(U)	02/28/2005 -#18
493945169 (EE)	000705793	106620378401(Z)	02/15/2005 - #7

(Errors noted in the following are based upon analysis of ACL claim data provided by the Company)

SECTION ONE – 2005-2006 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
355484115 (EE)	000385522	113078260001(U)	04/11/2005 - #5
355484115 (EE)	000385522	113078260001(U)	04/13/2005 - #6
510844095 (EE)	000488646	116390096601(U)	08/05/2005 -#14
421640250 (EE)	000410661	118409046101(U)	09/09/2005 -#21
488968240 (EE)	000375190	110172187501(U)	04/29/2005 -#18
487965131 (EE)	0003N7600	105326517801(U)	02/04/2005 - #2
490589009 (EE)	000468442	113616156401(U)	06/27/2005 -#11
487768635 (EE)	000392250	122171385201(U)	10/11/2005 -#13

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
488947409 (EE)	000319018	107404950701(S)	03/23/2005 -#15
513828901 (EE)	000701328	117736241901(Y)	06/09/2005 -#12
497548073 (EE)	000706057	111560516701(Z)	05/26/2005 -#12
498346522 (SP)	000323663	110736337401(S)	04/29/2005 - #9
488561290 (CH)	000325138	104491556301(S)	01/31/2005 -#10
492504659 (EE)	000703567	107420232901(M)	03/11/2005 -#15
492706255 (SP)	000323595	106992478101(S)	03/04/2005 -#17
551671653 (EE)	000442331	107074441301(U)	03/07/2005 -#10
511662282 (EE)	000357092	114558268801(S)	07/11/2005 -#18
488826870 (EE)	000700728	109673967501(F)	04/22/2005 -#22
488826870 (EE)	000700728	109673967601(F)	04/20/2005 -#21
488826870 (EE)	000700728	110701694801(F)	04/29/2005 -#23
498449206 (SP)	000346322	116230249101(S)	08/03/2005 -#19

E. Target Review – 9L Denied Claims

Field Size:	1,053
Sample Size:	30
Type of Sample:	ACL Random

Number of Errors:	11
Error Ratio:	36.66%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

Based upon data provided by the Company, the examiners made a random sample of claims denied per remark code "9L". This denial code states, "According to our records, your annual maximum benefit for this therapy service and/or associated expenses has been paid. Therefore, no further benefits are payable for this benefit period." The examiners determined that the Company improperly denied the following claims.

Missouri law mandates chiropractic benefits for the diagnosis and treatment of medically necessary and clinically appropriate chiropractic care for 26 visits in a policy period. The Company did not deny the claims listed below for reasons of medical necessity. Instead, the Company based its denial of benefits on the basis that the insured/patient had exceeded the number of visits allowed by the policy. It appears that the Company calculated its policy benefits based upon utilization within the calendar year as opposed to the benefit period of the policy. In each instance, the DOS did not exceed the number of visits allowed by the plan or by Missouri's mandated chiropractic benefit statute.

The Company did not pay the claims within 45 days of receipt as required by statute. The examiners requested the Company review these claims and issue benefits based upon the applicable "Day Rate".

For those claims filed electronically, the Company is responsible for payment of interest according to the requirements of section 376.383, RSMo. Based upon the claim data provided by the company, the examiners identified two claims that subject to payment of interest (124923731001 and 123098638201).

Reference: Sections 375.1007(1), (3), (4), and (6), 376.383, and 376.1230, RSMo

(Errors noted in the following are based upon analysis of ACL claim data provided by the Company)

SECTION ONE – 2005-2006 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
510662775 (EE)	000704440	122755702501(Z)	11/14/2005 - #8
508722467 (EE)	000326288	*124923731001(S)	12/13/2005 -#7
497704904 (EE)	000445507	123327247501(U)	11/17/2005 - #7
495820801 (EE)	000433902	123251431401(U)	11/02/2005 -#11
488503553 (EE)	000705812	114814867801(Z)	07/13/2005 - #3
488503553 (EE)	000705812	115909052401(Z)	07/29/2005 - #5
490647065 (SP)	000706065	125263203301(W)	12/21/2005 -#12
359563251 (EE)	000706065	123098638201(Z)	11/17/2005 -#19
953657745 (SP)	000375229	**124220222801(U)	11/30/2005 -#28
486708750 (EE)	000391911	122849498401(U)	11/04/2005 -#18

* NOTE: The Company underpaid this claim. The Company only allowed $25 as opposed to the $40 day rate. The Company applied $20 to the co-pay and only paid $5.00 as opposed to $20.00. $15.00 remains payable to the provider.

** NOTE: The Company did not deny any of the dates of service for this insured/patient based on lack of medical necessity. While this was the 28th visit in the 2005 policy year, the Company had only paid 20 visits to this point in the 2005 policy year. According to the terms of the chiropractic rider, the Company owed payment for an additional six visits. The Company failed to pay the six preceding (9/21/05, 9/27/05, 10/11/05, 10/26/05, 11/1/05, and 11/16/2005) dates of service. Consequently, this claim would be payable even under the terms of the rider as it would not exceed the limit of 26 visits.

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
488966550 (EE)	0004R3497	102208530101(Z)	12/27/2004 - #3
500761269 (EE)	000194564	119631016801	09/28/2005 -#26

F. Target Review – JO Denied Claims

Field Size:	72
Sample Size:	72
Type of Sample:	Census
Number of Errors:	38
Error Ratio:	52.77%
Within DIFP Guidelines?	No

The examiners conducted a review of chiropractic claims that the Company denied with remark code "JO". The examiners analyzed the enrollees' claim histories to ensure that the dates of service in question were not subsequently paid or denied for another valid reason. The examiners listed only claims that would otherwise have been paid had the proper determination been made. The examiners excluded those claims denied with both a "JO" (alpha) remark code and a "J0" (numeric) remark code in order to avoid duplication of the issues relative to the "J0" denials addressed elsewhere in the report. The study involved 33 enrollees with 72 DOS.

It appears the Company inadvertently denied the following Chiropractic claims with remark code "JO". The interpretation for this code states, "Your supplemental executive plan has a dental benefit limit. Payment has been made based upon that limit." The code failed to reflect a proper claim determination relative to the circumstances of the claims in question.
Reference: Sections 375.1007(1), (3), (4), and (6), 376.383, and 376.1230, RSMo

The examiners requested the Company issue benefit payments to the network providers associated with the claims.

Member ID #	Group Pol. #	Date of Service	Claim Number
493844568 (EE)	000395709	04/06/05	109112116402
490767969 (EE)	0001P9001	01/19/05	103387724201
506749947 (CH)	0005R0655	02/28/05	105807657702
559825064 (EE)	000438718	01/26/05	106544690601

Member ID #	Group Pol. #	Date of Service	Claim Number
559825064 (EE)	000438718	01/27/05	106544690601
559825064 (EE)	000438718	01/28/05	106544690602
559825064 (EE)	000438718	01/31/05	106544690602
559825064 (EE)	000438718	02/02/05	106544690603
559825064 (EE)	000438718	02/04/05	106544690603
559825064 (EE)	000438718	02/14/05	106544690605
559825064 (EE)	000438718	02/17/05	106544690605
559825064 (EE)	000438718	02/24/05	106544690605
499909212 (EE)	000273445	06/02/05	112629004601
494445797 (EE)	000707599	05/02/05	112322545102
494445797 (EE)	000707599	05/09/05	112322545102
494445797 (EE)	000707599	05/16/05	112322545102
491780295 (SP)	000707170	04/12/05	110502538301
499781581 (EE)	000467905	07/13/05	114974127301
500525501 (EE)	000375190	01/31/05	104674189302
488747301 (SP)	000705680	02/02/05	104409787801
493908303 (EE)	000705812	07/13/05	118191384501
493908303 (EE)	000705812	07/14/05	118191384501
493908303 (EE)	000705812	07/18/05	118191384501
493908303 (EE)	000705812	07/20/05	118191384501
493908303 (EE)	000705812	07/25/05	118191384501
493908303 (EE)	000705812	07/05/05	118191384503
493908303 (EE)	000705812	07/06/05	118191384503
493908303 (EE)	000705812	07/07/05	118191384503
493908303 (EE)	000705812	08/24/05	118191384503
500584204 (EE)	000708003	07/11/05	114559813701
496981195 (SP)	000330999	10/25/05	123088558601
500608775 (EE)	000385495	01/26/05	103671229201
482566563 (EE)	000294849	02/22/05	107424183201
424820952 (EE)	000707321	11/07/05	125710341201
424820952 (EE)	000707321	11/14/05	125710341201
424820952 (EE)	000707321	11/21/05	125710341201
424820952 (EE)	000707321	11/28/05	125710341201
424820952 (EE)	000707321	12/05/05	125710341201

IV. COMPLAINTS AND GRIEVANCES

Missouri law requires the Company to maintain a register of any complaints it receives and to retain the documentation regarding the handling of complaints. The examiners reviewed all complaints made through the DIFP's Consumer Affairs

division to determine the Company's handling of the complaints and its adherence to requirements of Missouri's laws that relate to complaints or related issues.

The examiners noted the following errors in this review:

Consumer Complaints, Grievances and Appeals

The complaint/appeal file did not contain a complaint resolution letter sent to the provider The Company failed to maintain a complete record of complaints in a manner that allows the examiner to readily ascertain the complaint handling procedures.
Reference: 20 CSR 300-2.200(2)

Case Number	Member ID #
206427	49264991401

V. CRITICISM AND FORMAL REQUEST TIME STUDY

The examiners performed a time study to determine the amount of time it took for the Company to respond to criticisms and requests submitted by the examiners during the examination. A review of the Company's response time follows.

FORMAL CRITICISM TIME STUDY

Number of Days	Number of Criticisms	Percentage
0 to 10	13	52%%
11 to 20	12*	48%
Totals	25	100%

FORMAL REQUEST TIME STUDY

Number of Days	Number of Requests	Percentage
0 to10	13	81.3%
21 to 30	3*	18.7%
Totals	16	100%

* (The examiners granted the Company's requests for extensions of time to respond to some requests and criticisms. The Company provided all requests and criticisms within the revised time period requested.)

EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of United Healthcare Insurance Company (NAIC #79413), Examination #0603-17, 19-TGT. This examination was conducted by William Schneider, Randy Kemp, and Walt Guller. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated November 20, 2007. Any changes from the text of the Market Conduct Examiner's Draft Report reflected in this Final Report were made by the Chief Market Conduct Examiner or with the Chief Market Conduct Examiner's approval. This Final Report has been reviewed and approved by the undersigned.

Michael W. Woolbright 5/29/09

Michael W. Woolbright Date
Chief Market Conduct Examiner

UnitedHealthcare Insurance Company, Inc.

The Company has structured the responses as follows:

- Exam Report Allegation
- Company Response

FORMS AND FILINGS

The examiners reviewed policy contracts and related forms to determine the Company's compliance with Missouri laws and regulations that refer to filing, approval, and content of policies and related forms. The examiners also reviewed the forms to ensure that the contracts contained unambiguous language and that the provisions adequately protect Missouri consumers. The Company initially filed its policy forms with the DIFP and received the necessary approvals from the DIFP. Subsequent to changes in the law that affected mandated benefits related to chiropractic care, the Company made the required filings to update its policy forms to meet compliance standards. The Company intended to comply with the mandated benefits by attaching riders to its contracts.

The examiners noted the following errors in this review:

2. The Company's group policies and chiropractic riders describe the coverage afforded enrollees of group health plans as defined by section 376.1350, RSMo. The policies and riders place a limitation of 26 visits for chiropractic care in a calendar year or a policy period without regard to the issue of medical necessity.

During the period of the examination, the Company denied coverage for chiropractic care to enrollees who received treatment in excess of 26 visits in a policy period. The claim data reflected 30 group policies with "9L" denials processed in 2005 that involved 75 patients and 1,226 claim records.

The statute that mandates coverage for chiropractic care permits the company to require notification or pre-authorization as a condition of coverage after the first 26

visits in a policy period. However, subject to the terms and conditions of the policy, the statute does not allow for denial of coverage for medically necessary chiropractic care to treat the diagnosed disorder. The Company may not establish any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a chiropractic care condition than for access to treatment for another physical health condition. The limitation of 26 visits on an insured/patient specific to chiropractic care without regard to the issue of medical necessity places a greater financial burden upon the insured for access to medically necessary chiropractic care.

Reference: Section 376.1230, RSMo

Group Policy Forms

IND.1.01 MO
Choice Plus – H.01.MO/IL
Select Plus – H.01.MO/IL
Options PPO (80/80)
Managed Indemnity

Company Response:

These Group policies, including options for chiropractic coverage limitations, were all reviewed and approved by the Missouri Department of Insurance prior to the policies being issued

It appears that based on its current interpretation of 376.1230, RSMo the Department believes that all policies must provide for unlimited coverage of chiropractic treatment determined to be medically necessary. The Department's basis for issuing this deficiency appears to be related to; the Department's opinion that medically necessary chiropractic care extends beyond 26 visits in a calendar or policy year, and that a coverage limitation of 26 chiropractic visits places a greater financial burden on an insured for access to treatment for a chiropractic condition than for access to treatment for another physical health condition.

a. Medically necessary chiropractic treatment

In June of 2005 the Department of Health and Human Services Office of Inspector General (OIG) published the report "Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis". Among the

findings in this study the OIG determined that of a sample of $457 million of chiropractic services 64% of these allowed services were either not medically necessary, not documented as having taken place, or involved up coding, and as a result should not have been allowed:

55% of services were not medically necessary
6% of services were not documented as having taken place
3% of CMT services were up coded

With regard to the services determined to be not medically necessary the OIG found a strong correlation between medical necessity of chiropractic services and the number of visits received by a patient in a year. The OIG determined that when chiropractic care extends beyond 12 treatments in a year, it becomes increasingly likely that individual services are not medically necessary. The OIG determined that:

50% of visits between 1 and 12 were not medically necessary
67% of visits between 13 and 24 were not medically necessary
100% of visits greater than 24 were not medically necessary

In response to the OIG report, the Association of Chiropractic Colleges (ACC), the American Chiropractic Association (ACA), the Congress of Chiropractic State Associations (COCSA), and the Federation of Chiropractic Licensing Boards (FCLB) jointly published "The Chiropractic Profession's Proposed Action Plan in Response to the June 2005 Office of Inspector General Report". In this document the ACC, ACA, COCSA and FCLB state, "These organizations made a conscious decision not to challenge the findings in the report nor the underpinnings of such document, despite concerns that some of the methodologies and data may have led to findings which overstate the depth of the documentation problem facing the profession."

Based upon the findings of the DHHS OIG report, and the chiropractic profession's conscious decision not to challenge the findings of the report nor the underpinnings of the document, it would appear that there is no basis for mandating coverage for chiropractic visits in excess of 26 in a policy period as 100% of these visits would be medically unnecessary. Additionally other payors in the state of Missouri appear to limit coverage for chiropractic treatment to 26 visits per calendar or policy year. Any action that would cause UHIC to provide greater coverage for chiropractic treatment than other payors would create a competitive disadvantage for UHIC.

b. Equal access to chiropractic treatment and treatment of other physical health conditions

Physical health conditions are primarily treated with Physical Medicine and Rehabilitation (PMR) services billed using CPT codes 97010 through 97546. The "Rehabilitation Services - Outpatient Therapy" section of the UHIC Certificate of Coverage describes a range of visit limits that fully insured employers can select from in developing the level of coverage the employer will provide to employees with physical health conditions. Given the visit based coverage limitations that have always existed for treatment of physical health conditions, the presence of a 26 visit coverage limitation for treatment of a chiropractic condition does not place a greater financial burden on an insured than for access to treatment for another physical health condition.

Summary: The Missouri Department of Insurance approved the chiropractic coverage limitations in the group policies noted in this deficiency. As a result UHIC believed that the policies were in compliance with the provisions of 376.1230, RSMo. UHIC would appreciate the opportunity to meet with the Department to review the Department's interpretation of this statute, whether other payors have similar 26 visit chiropractic coverage limitations, and actions UHIC and other payors can take to comply with the Department's current interpretation of the provisions of 376.1230, RSMo.

UNFAIR CLAIM PRACTICES

The examiners reviewed paid and denied claims to determine the Company's adherence to claim handling requirements. Whenever a claim file reflected that the Company failed to meet these standards, the examiners cited the Company for noncompliance with Missouri law.

The examiners noted the following in this review:

1. **Paid Claims**

Field Size:	154,709
Sample Size:	50
Type of Sample:	ACL Random
Number of Errors:	0
Within DIFP Guidelines?	Yes

The examiners noted no errors in this review.

2. **Denied Claims**

Field Size:	107,956
Sample Size:	50
Type of Sample:	ACL Random
Number of Errors:	13
Error Ratio:	26%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

a) The Company afforded the insured patient coverage under group policy number 0004R8533 effective February 1, 2004. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 01/28/2005 DOS per denial code "M0", that states "This date exceeds the number of visits indicated in the ACN notification response; re-notification was required. The patient may not be billed for amounts declined when administrative requirements are not followed."

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification or a re-notification. Part of the CCN included the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to re-submit a CCN grounds for denial of the claim. This practice violated the requirements of Missouri law.

The chiropractor who provided medical services to the member contracted with the ACN network. The ACN's network policy leaves the determination of medical necessity up to the provider and the patient. By its own admission, UHIC did not engage in utilization review of the services provided by ACN's network provider.

According to both ACN and UHIC, ACN is not involved in the claim process. However, it appears that ACN initiates application of the "M0" remark code. This action resulted in denial of payment. It does not appear that UHIC made any determination on the issue of medical necessity, nor did it investigate the recovery milestone applicable to the specific patient under care. UHIC and ACN conducted neither utilization review nor an investigation to make a determination about the issue of medical necessity.

According to UHIC and ACN, the notification process requires a treating provider to submit a standardized medical record containing data about the patient under care. Once ACN receives notification from the provider, ACN establishes a milestone for the treatment and re-notification. If the patient's condition requires treatment beyond the established milestone, ACN requires the provider to re-submit a CCN. The CCN refers to the network's standardized medical forms. The CCN includes the provider's description of the patient's condition, a treatment plan, and a health questionnaire completed by the patient. During the period under review, ACN considered the CCN incomplete without the patient's health questionnaire. Failure to re-submit a CCN could, and, as in this case, did result in denial of payment for the services rendered.

The Company and ACN do not consider the notification process as a "pre-certification" or "pre-authorization" of treatment. According to the Company, application of the "M0" code does not deny services as non-covered or medically unnecessary. However, the Company's application of the "M0" remark code did result in denial of benefits to the provider for services already performed.

UHIC does not receive a copy of the CCN submitted by the provider to ACN. UHIC only received the CMS 1500 claim form. Without conducting an investigation, UHIC could not make a determination about the medical necessity of the treatment provided by the chiropractor. The date of service was the 11th visit in the 2004 policy period. The Company may not require notification within the first

26 visits in a policy period as a condition of coverage. Unless UHIC bases its denial of payment upon a lack of medical necessity, the Company should pay for services already provided to this patient.

The examiners requested the Company to issue a benefit payment to the network provider $24.00. In addition, the Company owes interest on this electronically filed claim submitted on 02/15/05 at the rate of 1 percent per month from 45 days after the date submitted to the date paid.
Reference: Sections 375.1007(1), (3), (4), and (6), 376.383, and 376.1230, RSMo

Claim Number	Member ID #
104722139801	319663224

Company Response:

The Denied Claims deficiency noted involves the administrative claims denial of services for which a chiropractor did not submit a Complete Clinical Notification (CCN), and the Department's interpretation that 376.1230, RSMo does not permit any form of prospective utilization review of the necessity of chiropractic treatment during the first 26 visits in a calendar or policy year.

376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees***.

376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. While the statute acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by the

statute. The notification process does not inhibit an enrollee's access to 26 clinically appropriate and medically necessary chiropractic visits during the policy period as required by the statute and allowed by the enrollee's Certificate of Coverage.

UHIC and ACN have both interpreted 376.1230, RSMo as specific to the issue of enrollee notification requirements in the first 26 chiropractic visits. The UHIC Certificate of Coverage filed with and approved by the Missouri Department of Insurance clearly states that enrollees do not have a notification requirement when accessing chiropractic services. As described in both the ACN Group provider agreement filed with and approved by the Missouri Department of Insurance and in the ACN Group Utilization Management (UM) program filed with and approved by the Missouri Department of Insurance the ACN Group Notification process is a provider requirement, not an enrollee requirement. To follow is a history of the Missouri Department of Insurance review and approval of the ACN Utilization Review (UR) application, UM program, Provider Manual and ACN forms.

Filing Year	**What Submitted**	**Date Submitted**	**Date Approved**
1999	UR Application UM Plan - REV3/15/99 Provider Manual Response Template	3/15/99	3/22/99
2000	UR Application	Unknown	2/07/00
2001	UR Application Evidence of URAC Accreditation	1/08/01	2/1/01
2002	UR Application UM Plan REV 9/04/01 ACN Forms Packet Provider Manual	3/08/02	4/4/02
2003	UR Application UM Plan REV9/16/02	2/27/03	3/11/03
2004	UR Application UM Program – REV11/13/03 ACN Locations	3/08/04	3/30/04
2005	UR Application UM Program – 2005 ACN Location Changes Officers and Directors Fine Information	3/15/05	3/30/05
2006	UR Application Change to NY 800 Number	1/27/06	8/1/06

2007	UR Application UM Program - 2007 ACN Group Locations Fine Information	2/2/07	3/23/07

Through this annual review and approval process ACN believed that it was in full compliance with all Missouri statutes, including provisions of 376.1230, RSMo.

The examination report states:

> "The CCN includes the provider's description of the patient's condition, a treatment plan, and a health questionnaire completed by the patient. During the period under review, ACN considered the CCN incomplete without the patient's health questionnaire. Failure to re-submit a CCN could and did result in denial of payment for services rendered."

The examiners have misinterpreted the definition of a CCN to include a requirement that the enrollee complete the ACN Patient Health Questionnaire. The definition of a complete clinical notification (CCN) does not include the completion and submission of the ACN Group Patient Health Questionnaire (PHQ).

- Tier 1 providers are not required to use or submit the PHQ
- Tier 2 providers who submit the Provider Notification electronically report patient historical data derived from the provider's standardized patient intake and are not required to use the ACN Patient Health Questionnaire.

Tier 2 providers who voluntarily choose to submit the Provider Notification via paper as opposed to electronically via the ACN Group provider portal are required to attach the PHQ to the ACN Provider Notification. For these providers:

- Not all PHQ questions must be completed in order to satisfy the requirements of a complete clinical notification.
- The PHQ data that is submitted is not proprietary to ACN Group, does not represent a separate and distinct ACN Group requirement, is aligned with public domain chiropractic record keeping guidelines and is already routinely collected by Missouri chiropractors.
- If a patient cannot or refuses to complete the PHQ form, the provider can make a notation to that effect on the submission, and it would not be considered an incomplete submission.

The following information is provided to illustrate that, for those Tier 2 providers who voluntarily choose to submit patient intake data using the PHQ, the PHQ does not represent the collection of additional patient information that is not already routinely collected by chiropractors consistent with international chiropractic record keeping guidelines and standards of care. Additionally, the requirement is completely the obligation of the Chiropractor, not the patient. There should be no adverse impact on the patient if the PHQ form is not submitted.

Chiropractic Record Keeping Guidelines

1. Collection of Patient Data

The collection of patient historical data using a standard history form at the time of the initial evaluation, and at 4 to 6 week intervals during treatment, represents standard chiropractic practice recommended/required by; public domain guidelines regarding chiropractic practice, chiropractic professional associations, and state chiropractic licensing boards. To follow are some selected excerpts from these documents

a. The American Chiropractic Associations Clinical Documentation Manual states:

An admittance/new patient intake form(s) is typically used to collect and record subjective information. The patient initially completes the form(s) which the Doctor of Chiropractic then reviews prior to examining the patient. Any sections of the form(s) that are unclear or incomplete are then completed, clarified, and detailed. Periodic re-examinations may be completed at approximately 30-day intervals or as needed for new injury, new complaints, acute exacerbations, etc. Outcome assessment tools and pertinent data must be used to quantify progress and to set further treatment goals.

b. The American Chiropractic Association's Medical Review Benchmarks states:

Documentation for the initial (new patient) visit, new injury or exacerbation should consist of the history and physical and the anticipated patient treatment plan. The initial treatment plan, except in chronic cases, should not extend beyond a 30-45 day interval.

c. The Guidelines for Chiropractic Quality Assurance and Practice Parameters states:

When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation.

d. The Council on Chiropractic Practice states:

Questionnaires may be used in the assessment of the performance of activities of daily living, pain perception, patient satisfaction, general health outcomes, patient perception outcomes, mental health outcomes, and overall quality of life, throughout a course of chiropractic care. Determination of the patient's progress must be made on a per-visit and periodic basis.

e. The International Chiropractors Association Recommended Clinical Protocols and Guidelines for the Practice of Chiropractic states:

The organization of the patient chart may be enhanced by using pre-printed forms and by having proper identifying information on each page. When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation. The use of forms can assist in tasks such as obtaining case history, noting examination findings and charting case progress.

f. The Canadian Chiropractic Association Glenerin Guidelines states:

Pre-printed history questionnaires that contain much of the above and other information may be used at the time of initial documentation.

The use of standardized intake forms, including measures used to evaluate patient progress, initially and at 4 to 6 week intervals is internationally recognized as standard chiropractic practice. The ACN Group Notification process is aligned with standard chiropractic practice which includes obtaining an initial patient history and performing periodic re-evaluations to document a patient's response to treatment.

2. Elements of Standardized Chiropractic Patient Intake

In addition to recommending the use of standardized patient intake forms to collect initial data regarding the patient's condition, and to monitor the patient's response to treatment at 4 to 6 week intervals, these same guidelines provide details regarding the specific data to be collected from patients using these standardized patient intake forms.

The patient data reported using the ACN Patient Health Questionnaire is very well aligned with the recommendations of these international chiropractic guidelines. In fact the majority of the questions on the PHQ are public domain questions as opposed to being proprietary to ACN Group. For those Tier 2 chiropractors who voluntarily choose to use the PHQ to report patient historical data, the PHQ is not associated with the requirement to capture any data beyond that routinely collected by chiropractors initially and at 4 to 6 week intervals as required by chiropractic documentation and record keeping.

Recording Keeping Practices of Individual Chiropractors

1. Collection of Patient Data by Missouri Chiropractors

Missouri chiropractors that post patient intake forms and policies on publicly available clinic websites uniformly follow chiropractic record keeping guidelines in that these chiropractors;

a. use standardized patient intake forms
b. have patients complete these forms prior to seeing the chiropractor on the first visit

Thus those Tier 2 chiropractors who voluntarily choose to submit patient historical data using the PHQ do not require that their patients engage in a separate and distinct patient intake process from what is performed as a matter of standard chiropractic practice.

2. Standardized Chiropractic Patient Intake Used by Missouri Chiropractors

Standardized patient intake forms posted by Missouri chiropractors on their publicly available clinic website were obtained and reviewed. A summary of the data collected by the standardized patient intake forms used by Missouri chiropractors yields several observations:

a. the record keeping practices of Missouri chiropractors are highly variable
b. the standard intake forms used by a majority of Missouri chiropractors already include many of the data elements required by chiropractic record keeping guidelines
c. For those Tier 2 chiropractors who voluntarily choose to report patient intake data using the ACN PHQ the provider can do so without having to obtain any additional data to that already collected using the provider's intake forms.

Summary: 376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. 376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees.*** Although the PHQ form requires information from the patient, it is the standard information the provider should be obtaining from the patient anyway in order to effectively treat the person. The patient has no obligation to fill out the form or submit the form. The obligation rests completely with the Chiropractor.

While 376.1230, RSMo acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by 376.1230, RSMo.

Through obtaining Missouri Department of Insurance approval of UHIC Certificates of Coverage and of the ACN UR Application and ACN UM Program UHIC and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHIC and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHIC and ACN can take to comply with the Department's current interpretation of the provisions of 376.1230, RSMo.

Compliance With 375.1007(1)(3)(4)(6) R.S.Mo.

This finding also refers to Section 375.1007(1)(3)(4)(6) R.S.Mo., which provides:

"375.1007. Any of the following acts by an insurer, if committed in violation of section 375.1005, constitutes an improper claims practice:
1. Misrepresenting to claimants and insured relevant facts or policy provisions relating to coverages at issue;
3. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;
4. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

6. Refusing to pay claims without conducting a reasonable investigation;"

Unfair Claims Settlement Practices is listed as a reference and the Company seeks to clarify that it has not committed any improper claims practices under 375.1007(1)(3)(4)(6) R.S.Mo. The Company has not utilized any business practices or conducted itself in conscious disregard of the Unfair Claims Settlement Practices provisions as outlined in 375.1005(1) R.S.Mo.

The Company has not misrepresented relevant facts or provisions to claimants and insureds. As indicated previously, enrollees received the services and the Company does not require the enrollee to seek prior authorization or notification in order to receive the 26 visits. In addition, the enrollee is not financially responsible for the claims since the provider failed to follow the administrative guidelines within the provider contract.

UHIC has implemented reasonable standards for the prompt investigation and settlement of claims. Since the denial is an administrative denial related to an ACN contracted provider not following the provisions of the signed ACN provider agreement, this administrative denial does not require any further investigation by the organization.

In addition, the Company is making good faith efforts to effectuate prompt, fair and equitable settlement of claims submitted where liability has become reasonably clear in compliance with 375.1007(4). If the provider follows the notification process outlined in the agreement, the Company promptly settles those claims in which liability is reasonably clear. Until the proper administrative process is followed, the Company's liability is not reasonably clear.

b) The Company afforded the insured patient coverage under group policy number 000706022, effective 07/01/2004. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 02/22/2005 DOS per denial code "M0", that states "This date exceeds the number of visits indicated in the ACN notification response; re-notification was required. The patient may not be billed for amounts declined when administrative requirements are not followed."

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification or a re-notification. Part of the CCN included the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to re-submit a CCN grounds for denial of the claim. This practice violates the requirements of Missouri law.

The chiropractor who provided medical services to the member contracted with the ACN network. ACN's network policy leaves the determination of medical necessity up to the provider and the patient. UHIC did not engage in utilization review of the services provided by ACN's network provider. According to both ACN and UHIC, ACN is not involved in the claim process. However, it appears ACN initiated use of the "M0" remark code. This action resulted in denial of payment. It does not appear that UHIC made any determination on the issue of medical necessity, nor did it investigate the recovery milestone's applicability to the specific patient under care. UHIC conducted neither utilization review nor an investigation to make a determination about the issue of medical necessity.

According to UHIC and ACN, the notification process requires a treating provider to submit a CCN that contains data about the patient under care. Once ACN receives notification from the provider, ACN establishes a milestone for the treatment and re-notification. If the patient's condition requires treatment beyond the established milestone, ACN requires the provider to re-submit a CCN. The CCN refers to the network's standardized medical forms. The CCN includes the provider's description of the patient's condition, a treatment plan, and a health questionnaire completed by the patient. During the period under review, ACN considered the CCN incomplete without the patient's health questionnaire. The provider's failure to resubmit a follow-up CCN could, and in this case did result in denial of payment for the services rendered.

The notification process is not a "pre-certification" or "pre-authorization" of the treatment according to ACN. According to the Company, application of the "M0" code does not deny services as non-covered or medically unnecessary. However, the Company's use of the "M0" remark code did result in denial of benefits to the provider for services already performed.

UHIC did not receive a copy of the CCN submitted by the provider to ACN. UHIC only received the CMS 1500 claim form. Without conducting an investigation, UHIC could not make a determination about the medical necessity of the treatment provided by the chiropractor. The date of service was the 21st visit in the 2004 policy period. The statute prohibits the notification requirement within the first 26 visits in a policy period. Unless UHIC bases its denial on a lack of medical necessity, the Company should pay for services already provided to this patient.

The examiners requested the Company issue a benefit payment to the network provider for $24.00.
Reference: Sections 375.1007(1), (3), (4), and (6), and 376.1230, RSMo

Claim Number	Member ID #
105503625101	476643849

Company Response:

The Denied Claims deficiency noted involves the administrative claims denial of services for which a chiropractor did not submit a Complete Clinical Notification (CCN), and the Department's interpretation that 376.1230, RSMo does not permit any form of prospective utilization review of the necessity of chiropractic treatment during the first 26 visits in a calendar or policy year

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Through this annual review and approval process ACN believed that it was in full compliance with all Missouri statutes, including provisions of 376.1230, RSMo.

The examination report states:

> "The CCN includes the provider's description of the patient's condition, a treatment plan, and a health questionnaire completed by the patient. During the period under review, ACN considered the CCN incomplete without the patient's health questionnaire. Failure to re-submit a CCN could and did result in denial of payment for services rendered."

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In addition to recommending the use of standardized patient intake forms to collect initial data regarding the patient's condition, and to monitor the patient's response to treatment at 4 to 6 week intervals, these same guidelines provide details regarding the specific data to be collected from patients using these standardized patient intake forms.

The patient data reported using the ACN Patient Health Questionnaire is very well aligned with the recommendations of these international chiropractic guidelines. In fact the majority of the questions on the PHQ are public domain questions as opposed to being proprietary to ACN Group. For those Tier 2 chiropractors who voluntarily choose to use the PHQ to report patient historical data, the PHQ is not associated with the requirement to capture any data beyond that routinely collected by chiropractors initially and at 4 to 6 week intervals as required by chiropractic documentation and record keeping.

Recording Keeping Practices of Individual Chiropractors

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Thus those Tier 2 chiropractors who voluntarily choose to submit patient historical data using the PHQ do not require that their patients engage in a separate and distinct patient intake process from what is performed as a matter of standard chiropractic practice.

2. Standardized Chiropractic Patient Intake Used by Missouri Chiropractors

Standardized patient intake forms posted by Missouri chiropractors on their publicly available clinic website were obtained and reviewed. A summary of the data collected by the standardized patient intake forms used by Missouri chiropractors yields several observations:

a. the record keeping practices of Missouri chiropractors are highly variable
b. the standard intake forms used by a majority of Missouri chiropractors already include many of the data elements required by chiropractic record keeping guidelines
c. For those Tier 2 chiropractors who voluntarily choose to report patient intake data using the ACN PHQ the provider can do so without having to obtain any additional data to that already collected using the provider's intake forms.

Summary: 376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. 376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees.*** Although the PHQ form requires information from the patient, it is the standard information the provider should be obtaining from the patient anyway in order to effectively treat the person. The patient has no obligation to fill out the form or submit the form. The obligation rests completely with the Chiropractor.

While 376.1230, RSMo acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by 376.1230, RSMo.

Through obtaining Missouri Department of Insurance approval of UHIC Certificates of Coverage and of the ACN UR Application and ACN UM Program UHIC and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHIC and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHIC and ACN can take to comply with the Department's current interpretation of the provisions of 376.1230, RSMo.

Compliance With 375.1007(1)(3)(4)(6) R.S.Mo.

This finding also refers to Section 375.1007(1)(3)(4)(6) R.S.Mo., which provides:

"375.1007. Any of the following acts by an insurer, if committed in violation of section 375.1005, constitutes an improper claims practice:
1. Misrepresenting to claimants and insured relevant facts or policy provisions relating to coverages at issue;
3. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;
4. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;
6. Refusing to pay claims without conducting a reasonable investigation;"

Unfair Claims Settlement Practices is listed as a reference and the Company seeks to clarify that it has not committed any improper claims practices under 375.1007(1)(3)(4)(6) R.S.Mo. The Company has not utilized any business practices or conducted itself in conscious disregard of the Unfair Claims Settlement Practices provisions as outlined in 375.1005(1) R.S.Mo.

The Company has not misrepresented relevant facts or provisions to claimants and insureds. As indicated previously, enrollees received the services and the Company does not require the enrollee to seek prior authorization or notification in order to receive the 26 visits. In addition, the enrollee is not financially responsible for the claims since the provider failed to follow the administrative guidelines within the provider contract.

UHIC has implemented reasonable standards for the prompt investigation and settlement of claims. Since the denial is an administrative denial related to an ACN contracted provider not following the provisions of the signed ACN provider agreement, this administrative denial does not require any further investigation by the organization.

In addition, the Company is making good faith efforts to effectuate prompt, fair and equitable settlement of claims submitted where liability has become reasonably clear in compliance with 375.1007(4). If the provider follows the

notification process outlined in the agreement, the Company promptly settles those claims in which liability is reasonably clear. Until the proper administrative process is followed, the Company's liability is not reasonably clear.

c) The Company afforded the insured patient coverage under group policy number 000991911 effective March 1, 2004. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 01/05/2005 DOS on the basis that the insured and provider failed to submit a CCN. The Company did not contemplate the issue of medical necessity with its denial.

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification. Part of the CCN includes the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violates the requirements of Missouri law.

According to records provided by the Company, the provider submitted the claim in question (01/05/05) on 01/14/05. This is the same date the Company received notice of three other claims for the 01/6/05, 01/7/05, and 01/8/05 dates of service. While the Company initially denied these three dates of service, it did so on the basis that the dates exceeded the number of visits indicated on ACN's notification response. The reference to the notification response relative to dates of service in such close proximity to the 01/05/05, DOS indicates the provider submitted a notification that would have addressed all of the dates of service noted. It appears a series of processing errors resulted in non-payment of the claims. Though not a part of the sample of claims, the examiners noted that the Company received notice of the 01/04/05 DOS at the same time as the other claims and the Company also denied this claim per the "J0" remark code.

The examiners requested that the Company reprocess the claims for 01/04/05 and 01/05/05 and issue a benefit check to the network provider. Because of a number of inconsistencies in the processing of this insured's claims, the examiners could not readily ascertain the correct amounts payable. The examiners understand the Company makes payment to network providers based upon a "Day Rate" that allows $60 for the initial visit and $44.00 for subsequent visits in the geographic area where the enrollee incurred the expense. The claim records showed the allowed amounts for the 01/6/05, 01/7/05, and 01/8/05 DOS equaled $45.00, $60.00, and $60.00 respectively. The examiners requested an explanation for these inconsistencies. The Company may make corrections to previously paid claims when it re-adjudicates the claim in question. The Company overstated the allowed amount on one claim by $16.00 and another by $1.00, while the Company should base the payment due for the 01/04/05 and 01/05 DOS on a $44.00 "Day Rate".

Reference: Sections 375.1007(1), (3), and (4), and 376.1230, RSMo

Claim Number	Member ID #
102875715401	486708750

Company Response:

The deficiency noted involves the administrative claims denial of services for which a chiropractor did not submit a Complete Clinical Notification (CCN), and the Department's interpretation that 376.1230, RSMo does not permit any form of prospective utilization review of the necessity of chiropractic treatment during the first 26 visits in a calendar or policy year.

376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees***.

376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. While the statute acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by the statute. The notification process does not inhibit an enrollee's access to 26 clinically appropriate and medically necessary chiropractic visits during the policy period as required by the statute and allowed by the enrollee's Certificate of Coverage.

UHIC and ACN have both interpreted 376.1230, RSMo as specific to the issue of enrollee notification requirements in the first 26 chiropractic visits. The UHIC Certificate of Coverage filed with and approved by the Missouri Department of Insurance clearly states that enrollees do not have a notification requirement when accessing chiropractic services. As described in both the ACN Group provider agreement filed with and approved by the Missouri Department of Insurance and in the ACN Group UR program filed with and approved by the Missouri Department of Insurance the ACN Group Notification process is a provider requirement, not an enrollee requirement. To follow is a history of the Missouri Department of Insurance review and approval of the ACN UR application, UM program, Provider Manual and ACN forms.

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1999	UR Application UM Plan - REV3/15/99 Provider Manual Response Template	3/15/99	3/22/99
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2002	UR Application UM Plan REV 9/04/01 ACN Forms Packet Provider Manual	3/08/02	4/4/02
2003	UR Application UM Plan REV9/16/02	2/27/03	3/11/03
2004	UR Application UM Program – REV11/13/03 ACN Locations	3/08/04	3/30/04

2005	UR Application UM Program – 2005 ACN Location Changes Officers and Directors Fine Information	3/15/05	3/30/05
2006	UR Application Change to NY 800 Number	1/27/06	8/1/06
2007	UR Application UM Program - 2007 ACN Group Locations Fine Information	2/2/07	3/23/07

Through this annual review and approval process ACN believed that it was in full compliance with all Missouri statutes, including provisions of 376.1230, RSMo.

The examination report states:

> "The CCN includes the provider's description of the patient's condition, a treatment plan, and a health questionnaire completed by the patient. During the period under review, ACN considered the CCN incomplete without the patient's health questionnaire. Failure to re-submit a CCN could and did result in denial of payment for services rendered."

The examiners have misinterpreted the definition of a CCN to include a requirement that the enrollee complete the ACN Patient Health Questionnaire. The definition of a complete clinical notification (CCN) does not include the completion and submission of the ACN Group Patient Health Questionnaire (PHQ).

- Tier 1 providers are not required to use or submit the PHQ
- Tier 2 providers who submit the Provider Notification electronically report patient historical data derived from the provider's standardized patient intake and are not required to use the ACN Patient Health Questionnaire.

Tier 2 providers who voluntarily choose to submit the Provider Notification via paper as opposed to electronically via the ACN Group provider portal are required to attach the PHQ to the ACN Provider Notification. For these providers:

- Not all PHQ questions must be completed in order to satisfy the requirements of a complete clinical notification.

- The PHQ data that is submitted is not proprietary to ACN Group, does not represent a separate and distinct ACN Group requirement, is aligned with public domain chiropractic record keeping guidelines and is already routinely collected by Missouri chiropractors.
- If a patient cannot or refuses to complete the PHQ form, the provider can make a notation to that effect on the submission, and it would not be considered an incomplete submission.

The following information is provided to illustrate that, for those Tier 2 providers who voluntarily choose to submit patient intake data using the PHQ, the PHQ does not represent the collection of additional patient information that is not already routinely collected by chiropractors consistent with international chiropractic record keeping guidelines and standards of care. Additionally, the requirement is completely the obligation of the Chiropractor, not the patient. There should be no adverse impact on the patient if the PHQ form is not submitted.

Chiropractic Record Keeping Guidelines

1. Collection of Patient Data

The collection of patient historical data using a standard history form at the time of the initial evaluation, and at 4 to 6 week intervals during treatment, represents standard chiropractic practice recommended/required by; public domain guidelines regarding chiropractic practice, chiropractic professional associations, and state chiropractic licensing boards. To follow are some selected excerpts from these documents

a. The American Chiropractic Associations Clinical Documentation Manual states:

An admittance/new patient intake form(s) is typically used to collect and record subjective information. The patient initially completes the form(s) which the Doctor of Chiropractic then reviews prior to examining the patient. Any sections of the form(s) that are unclear or incomplete are then completed, clarified, and detailed. Periodic re-examinations may be completed at approximately 30-day intervals or as needed for new injury, new complaints, acute exacerbations, etc. Outcome assessment tools and pertinent data must be used to quantify progress and to set further treatment goals.

b. The American Chiropractic Association's Medical Review Benchmarks states:

> Documentation for the initial (new patient) visit, new injury or exacerbation should consist of the history and physical and the anticipated patient treatment plan. The initial treatment plan, except in chronic cases, should not extend beyond a 30-45 day interval.

c. The Guidelines for Chiropractic Quality Assurance and Practice Parameters states:

> When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation.

d. The Council on Chiropractic Practice states:

> Questionnaires may be used in the assessment of the performance of activities of daily living, pain perception, patient satisfaction, general health outcomes, patient perception outcomes, mental health outcomes, and overall quality of life, throughout a course of chiropractic care. Determination of the patient's progress must be made on a per-visit and periodic basis.

e. The International Chiropractors Association Recommended Clinical Protocols and Guidelines for the Practice of Chiropractic states:

> The organization of the patient chart may be enhanced by using pre-printed forms and by having proper identifying information on each page. When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation. The use of forms can assist in tasks such as obtaining case history, noting examination findings and charting case progress.

f. The Canadian Chiropractic Association Glenerin Guidelines states:

> Pre-printed history questionnaires that contain much of the above and other information may be used at the time of initial documentation.

The use of standardized intake forms, including measures used to evaluate patient progress, initially and at 4 to 6 week intervals is internationally recognized as standard chiropractic practice. The ACN Group Notification process is aligned with standard chiropractic

practice which includes obtaining an initial patient history and performing periodic re-evaluations to document a patient's response to treatment.

2. Elements of Standardized Chiropractic Patient Intake

In addition to recommending the use of standardized patient intake forms to collect initial data regarding the patient's condition, and to monitor the patient's response to treatment at 4 to 6 week intervals, these same guidelines provide details regarding the specific data to be collected from patients using these standardized patient intake forms.

The patient data reported using the ACN Patient Health Questionnaire is very well aligned with the recommendations of these international chiropractic guidelines. In fact the majority of the questions on the PHQ are public domain questions as opposed to being proprietary to ACN Group. For those Tier 2 chiropractors who voluntarily choose to use the PHQ to report patient historical data, the PHQ is not associated with the requirement to capture any data beyond that routinely collected by chiropractors initially and at 4 to 6 week intervals as required by chiropractic documentation and record keeping.

Recording Keeping Practices of Individual Chiropractors

1. Collection of Patient Data by Missouri Chiropractors

Missouri chiropractors that post patient intake forms and policies on publicly available clinic websites uniformly follow chiropractic record keeping guidelines in that these chiropractors;

a. use standardized patient intake forms
b. have patients complete these forms prior to seeing the chiropractor on the first visit

Thus those Tier 2 chiropractors who voluntarily choose to submit patient historical data using the PHQ do not require that their patients engage in a separate and distinct patient intake process from what is performed as a matter of standard chiropractic practice.

2. Standardized Chiropractic Patient Intake Used by Missouri Chiropractors

Standardized patient intake forms posted by Missouri chiropractors on their publicly available clinic website were obtained and reviewed. A summary of the data collected by the standardized patient intake forms used by Missouri chiropractors yields several observations:

a. the record keeping practices of Missouri chiropractors are highly variable
b. the standard intake forms used by a majority of Missouri chiropractors already include many of the data elements required by chiropractic record keeping guidelines
c. For those Tier 2 chiropractors who voluntarily choose to report patient intake data using the ACN PHQ the provider can do so without having to obtain any additional data to that already collected using the provider's intake forms.

Summary: 376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. 376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees.*** Although the PHQ form requires information from the patient, it is the standard information the provider should be obtaining from the patient anyway in order to effectively treat the person. The patient has no obligation to fill out the form or submit the form. The obligation rests completely with the Chiropractor.

While 376.1230, RSMo acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by 376.1230, RSMo.

Through obtaining Missouri Department of Insurance approval of UHIC Certificates of Coverage and of the ACN UR Application and ACN UM Program UHIC and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHIC and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHIC and ACN can take to comply with the Department's current interpretation of the provisions of 376.1230, RSMo.

Compliance With 375.1007(1)(3)(4) R.S.Mo.

This finding also refers to Section 375.1007(1)(3)(4) R.S.Mo., which provides:

"375.1007. Any of the following acts by an insurer, if committed in violation of section 375.1005, constitutes an improper claims practice:
1. Misrepresenting to claimants and insured relevant facts or policy provisions relating to coverages at issue;
3. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;
4. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;"

Unfair Claims Settlement Practices is listed as a reference and the Company seeks to clarify that it has not committed any improper claims practices under 375.1007(1)(3)(4) R.S.Mo. The Company has not utilized any business practices or conducted itself in conscious disregard of the Unfair Claims Settlement Practices provisions as outlined in 375.1005(1) R.S.Mo.

The Company has not misrepresented relevant facts or provisions to claimants and insureds. As indicated previously, enrollees received the services and the Company does not require the enrollee to seek prior authorization or notification in order to receive the 26 visits. In addition, the enrollee is not financially responsible for the claims since the provider failed to follow the administrative guidelines within the provider contract.

UHIC has implemented reasonable standards for the prompt investigation and settlement of claims. Since the denial is an administrative denial related to an ACN contracted provider not following the provisions of the signed ACN provider agreement, this administrative denial does not require any further investigation by the organization.

In addition, the Company is making good faith efforts to effectuate prompt, fair and equitable settlement of claims submitted where liability has become reasonably clear in compliance with 375.1007(4). If the provider follows the notification process outlined in the agreement, the Company promptly settles those claims in which liability is reasonably clear. Until the proper

administrative process is followed, the Company's liability is not reasonably clear.

d) The Company afforded the insured patient coverage under group policy number 000707768 effective February 1, 2005. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 06/27/2005 DOS per denial code "M0", that states "This date exceeds the number of visits indicated in the ACN Group notification response; re-notification was required. The patient may not be billed for amounts declined when administrative requirements are not followed."

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification or a re-notification. Part of the CCN included the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to re-submit a CCN grounds for denial of the claim. This practice violated the requirements of Missouri law.

The chiropractor who provided medical services to the member contracted with the ACN network. The managed care policy of ACN leaves the determination of medical necessity up to the provider and the patient. UHIC does not engage in utilization review of the services provided by ACN's network providers. According to both ACN and UHIC, ACN is not involved in the claim process. However, it appears that ACN initiated use of the "M0" remark code. This action resulted in denial of payment. It does not appear that UHIC made any determination on the issue of medical necessity, nor did it investigate the recovery milestone applicable to the patient under care. UHIC conducted neither utilization review nor an investigation to make a determination about the issue of medical necessity.

According to UHIC and ACN, the notification process requires a treating provider to submit standardized medical forms containing data about the patient under care. Once ACN receives notification from the provider, ACN establishes a milestone for the treatment and re-notification. If the patient's condition requires treatment beyond the established milestone, ACN requires the provider to re-submit a CCN. The CCN refers to the standardized medical forms required of ACN's network providers. The CCN includes the provider's description of the patient's condition, a treatment plan, and a health questionnaire completed by the patient. During the period under review, ACN considered the CCN incomplete without the patient's health questionnaire. The provider's failure to resubmit a follow-up CCN could and in this case did result in denial of payment for the services rendered.

The notification process is not a "pre-certification" or "pre-authorization" of the treatment. According to the Company, application of the "M0" code does not deny services as non-covered or medically unnecessary. However, the Company's use of the "M0" remark code did result in denial of benefits to the provider for services already performed

UHIC does not receive a copy of the CCN submitted by the provider to ACN. UHIC only received the CMS 1500 claim form. Without conducting an investigation, UHIC could not make a determination about the medical necessity of the treatment provided by the chiropractor. The DOS was the 10th visit in the 2005 policy period. The statute prohibits the notification requirement within the first 26 visits in a policy period. Unless UHIC bases its denial on a lack of medical necessity, the Company should pay for services already provided to this patient.

The examiners requested the Company issue a benefit payment to the network provider for $39.00 for the 6/27/05 DOS. In addition, the Company owes interest on this electronically filed claim submitted on 07/01/05 at the rate of 1 percent per month from 45 days after the date submitted to the date paid.

Reference: Sections 375.1007(1), (3), (4), and (6), 376.1230, and 376.1361(13), RSMo

Claim Number	Member ID #
113760128701	486928585

Inexplicably, the Company paid for the following dates of service: 07/06/05, 07/07/05, 07/11/05, 07/20/05, 07/25/05, and 07/27/05. These dates of service fell between and subsequent to dates of service for which the Company denied benefits. This inconsistent claim payment activity demonstrates the Company deemed the treatment received during this period medically necessary on some occasions while it refused to pay for other dates of service occurring within this 28-day period. Nothing indicates the Company had been prejudiced in any way by the provider's actions.

Note: Though not a part of the sample, the examiners requested the Company pay benefits on related claims for treatment received on the following dates: (The circumstances for these claims mirrored the claim in question)

Claim Number	Date of Service - Visit Number	
1133844510010	6/23/05	9th
1137601287010	6/27/05	10th
1137601288010	6/29/05	11th
1138540709010	6/30/05	12th
1149026108010	7/14/05	16th
1149026108010	7/18/05	17th

Company Response:

The deficiency noted involves the administrative claims denial of services for which a chiropractor did not submit a Complete Clinical Notification (CCN), and the Department's interpretation that 376.1230, RSMo does not permit any form of prospective utilization review of the necessity of chiropractic treatment during the first 26 visits in a calendar or policy year.

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2. Elements of Standardized Chiropractic Patient Intake

In addition to recommending the use of standardized patient intake forms to collect initial data regarding the patient's condition, and to monitor the patient's response to treatment at 4 to 6 week intervals, these same guidelines provide details regarding the specific data to be collected from patients using these standardized patient intake forms.

The patient data reported using the ACN Patient Health Questionnaire is very well aligned with the recommendations of these international chiropractic guidelines. In fact the majority of the questions on the PHQ are public domain questions as opposed to being proprietary to ACN Group. For those Tier 2 chiropractors who voluntarily choose to use the PHQ to report patient historical data, the PHQ is not associated with the requirement to capture any data beyond that routinely collected by chiropractors initially and at 4 to 6 week intervals as required by chiropractic documentation and record keeping.

Recording Keeping Practices of Individual Chiropractors

1. Collection of Patient Data by Missouri Chiropractors

Missouri chiropractors that post patient intake forms and policies on publicly available clinic websites uniformly follow chiropractic record keeping guidelines in that these chiropractors;

a. use standardized patient intake forms
b. have patients complete these forms prior to seeing the chiropractor on the first visit

Thus those Tier 2 chiropractors who voluntarily choose to submit patient historical data using the PHQ do not require that their patients engage in a separate and distinct patient intake process from what is performed as a matter of standard chiropractic practice.

2. Standardized Chiropractic Patient Intake Used by Missouri Chiropractors

Standardized patient intake forms posted by Missouri chiropractors on their publicly available clinic website were obtained and reviewed. A summary of the data collected by the standardized patient intake forms used by Missouri chiropractors yields several observations:

a. the record keeping practices of Missouri chiropractors are highly variable
b. the standard intake forms used by a majority of Missouri chiropractors already include many of the data elements required by chiropractic record keeping guidelines

c. For those Tier 2 chiropractors who voluntarily choose to report patient intake data using the ACN PHQ the provider can do so without having to obtain any additional data to that already collected using the provider's intake forms.

Summary: 376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. 376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees.*** Although the PHQ form requires information from the patient, it is the standard information the provider should be obtaining from the patient anyway in order to effectively treat the person. The patient has no obligation to fill out the form or submit the form. The obligation rests completely with the Chiropractor.

While 376.1230, RSMo acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by 376.1230, RSMo.

Through obtaining Missouri Department of Insurance approval of UHIC Certificates of Coverage and of the ACN UR Application and ACN UM Program UHIC and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHIC and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHIC and ACN can take to comply with the Department's current interpretation of the provisions of 376.1230, RSMo.

Compliance With 375.1007(1)(3)(4)(6) R.S.Mo.

This finding also refers to Section 375.1007(1)(3)(4)(6) R.S.Mo., which provides:

"375.1007. Any of the following acts by an insurer, if committed in violation of section 375.1005, constitutes an improper claims practice:
1. Misrepresenting to claimants and insured relevant facts or policy provisions relating to coverages at issue;
3. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;
4. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;
6. Refusing to pay claims without conducting a reasonable investigation;"

Unfair Claims Settlement Practices is listed as a reference and the Company seeks to clarify that it has not committed any improper claims practices under 375.1007(1)(3)(4)(6) R.S.Mo. The Company has not utilized any business practices or conducted itself in conscious disregard of the Unfair Claims Settlement Practices provisions as outlined in 375.1005(1) R.S.Mo.

The Company has not misrepresented relevant facts or provisions to claimants and insureds. As indicated previously, enrollees received the services and the Company does not require the enrollee to seek prior authorization or notification in order to receive the 26 visits. In addition, the enrollee is not financially responsible for the claims since the provider failed to follow the administrative guidelines within the provider contract.

UHIC has implemented reasonable standards for the prompt investigation and settlement of claims. Since the denial is an administrative denial related to an ACN contracted provider not following the provisions of the signed ACN provider agreement, this administrative denial does not require any further investigation by the organization.

In addition, the Company is making good faith efforts to effectuate prompt, fair and equitable settlement of claims submitted where liability has become reasonably clear in compliance with 375.1007(4). If the provider follows the notification process outlined in the agreement, the Company promptly settles those claims in which liability is reasonably clear. Until the proper administrative process is followed, the Company's liability is not reasonably clear.

Compliance with MO stat. 376.1361

The Criticism also refers to Section 376.1361 (13) R.S. Mo., which provides:

> If an authorized representative of a health carrier authorizes the provision of health care services, the health carrier shall not subsequently retract its authorization after the health care services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless
>
> (1) Such authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or
> (2) The health benefit plan terminates before the health care services are provided; or
> (3) The covered person's coverage under the health benefit plan terminates before the health care services are provided.

Although no specific violations are noted in the Criticism, Section 376.1361 (13) is listed as a reference and the Company seeks to clarify that it has not only not authorized the provision of health care services, it has not retracted an authorization that never took place. The Company has not utilized any business practices or conducted itself in conscious disregard of the provisions as outlined in 376.1361 (13) R.S.Mo.

The ACN Group provider notification requirement is a contractual obligation of a provider pursuant to the provider agreement between the provider and ACN. The notification process requires a treating provider to submit a standardized medical record containing data about the patient under care. Once ACN receives notification from the provider, ACN establishes a duration based milestone for the treatment. All treatment provided within the established re-evaluation milestone is reimbursed. If the patient's condition requires treatment beyond the established milestone, the provider is required to re-notify ACN.

e) The Company afforded the insured patient coverage under group policy number 000274147 effective December 1, 2004. The Company unfairly denied payment of benefits for chiropractic care for the 01/04/2005 DOS (first visit in 2004 policy period) on the basis that the insured and provider failed to submit a CCN. The Company did not contemplate the issue of medical necessity with its denial.

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification. Part of the CCN includes the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violated the requirements of Missouri law.

The examiners requested the Company issue a benefit payable to the network provider based on the $40.00 "Day Rate" for the Raymore, MO area, less the appropriate co-payment for the 01/04/05 DOS. In addition, the Company owes interest on this electronically filed claim submitted on 01/21/2005 at the rate of one percent per month from 45 days after the date submitted to the date paid.
Reference: Sections 375.1007(1), (3) and (4), 376.383, and 376.1230, RSMo

Claim Number	Member ID #
103258157701	488729635

Company Response:

The deficiency noted involves the administrative claims denial of services for which a chiropractor did not submit a Complete Clinical Notification (CCN), and the Department's interpretation that 376.1230, RSMo does not permit any form of prospective utilization review of the necessity of chiropractic treatment during the first 26 visits in a calendar or policy year.

376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees***.

376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. While the statute acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by the statute. The notification process does not inhibit an enrollee's access to 26 clinically appropriate and medically necessary chiropractic visits during the policy period as required by the statute and allowed by the enrollee's Certificate of Coverage.

UHIC and ACN have both interpreted 376.1230, RSMo as specific to the issue of enrollee notification requirements in the first 26 chiropractic visits. The UHIC Certificate of Coverage filed with and approved by the Missouri Department of Insurance clearly states that enrollees do not have a notification requirement when accessing chiropractic services. As described in both the ACN Group provider agreement filed with and approved by the Missouri Department of Insurance and in the ACN Group UR program filed with and approved by the Missouri Department of Insurance the ACN Group Notification process is a provider requirement, not an enrollee requirement. To follow is a history of the Missouri Department of Insurance review and approval of the ACN UR application, UM program, Provider Manual and ACN forms.

Filing Year	**What Submitted**	**Date Submitted**	**Date Approved**
1999	UR Application UM Plan - REV3/15/99 Provider Manual Response Template	3/15/99	3/22/99
2000	UR Application	Unknown	2/07/00
2001	UR Application Evidence of URAC Accreditation	1/08/01	2/1/01
2002	UR Application UM Plan REV 9/04/01 ACN Forms Packet Provider Manual	3/08/02	4/4/02

2003	UR Application UM Plan REV9/16/02	2/27/03	3/11/03
2004	UR Application UM Program – REV11/13/03 ACN Locations	3/08/04	3/30/04
2005	UR Application UM Program – 2005 ACN Location Changes Officers and Directors Fine Information	3/15/05	3/30/05
2006	UR Application Change to NY 800 Number	1/27/06	8/1/06
2007	UR Application UM Program - 2007 ACN Group Locations Fine Information	2/2/07	3/23/07

Through this annual review and approval process ACN believed that it was in full compliance with all Missouri statutes, including provisions of 376.1230, RSMo.

The examination report states:

> "The CCN includes the provider's description of the patient's condition, a treatment plan, and a health questionnaire completed by the patient. During the period under review, ACN considered the CCN incomplete without the patient's health questionnaire. Failure to re-submit a CCN could and did result in denial of payment for services rendered."

The examiners have misinterpreted the definition of a CCN to include a requirement that the enrollee complete the ACN Patient Health Questionnaire. The definition of a complete clinical notification (CCN) does not include the completion and submission of the ACN Group Patient Health Questionnaire (PHQ).

- Tier 1 providers are not required to use or submit the PHQ
- Tier 2 providers who submit the Provider Notification electronically report patient historical data derived from the provider's standardized patient intake and are not required to use the ACN Patient Health Questionnaire.

Tier 2 providers who voluntarily choose to submit the Provider Notification via paper as opposed to electronically via the ACN Group provider portal are required to attach the PHQ to the ACN Provider Notification. For these providers:

- Not all PHQ questions must be completed in order to satisfy the requirements of a complete clinical notification.
- The PHQ data that is submitted is not proprietary to ACN Group, does not

represent a separate and distinct ACN Group requirement, is aligned with public domain chiropractic record keeping guidelines and is already routinely collected by Missouri chiropractors.

- If a patient cannot or refuses to complete the PHQ form, the provider can make a notation to that effect on the submission, and it would not be considered an incomplete submission.

The following information is provided to illustrate that, for those Tier 2 providers who voluntarily choose to submit patient intake data using the PHQ, the PHQ does not represent the collection of additional patient information that is not already routinely collected by chiropractors consistent with international chiropractic record keeping guidelines and standards of care. Additionally, the requirement is completely the obligation of the Chiropractor, not the patient. There should be no adverse impact on the patient if the PHQ form is not submitted.

Chiropractic Record Keeping Guidelines

1. Collection of Patient Data

The collection of patient historical data using a standard history form at the time of the initial evaluation, and at 4 to 6 week intervals during treatment, represents standard chiropractic practice recommended/required by; public domain guidelines regarding chiropractic practice, chiropractic professional associations, and state chiropractic licensing boards. To follow are some selected excerpts from these documents

a. The American Chiropractic Associations Clinical Documentation Manual states:

An admittance/new patient intake form(s) is typically used to collect and record subjective information. The patient initially completes the form(s) which the Doctor of Chiropractic then reviews prior to examining the patient. Any sections of the form(s) that are unclear or incomplete are then completed, clarified, and detailed. Periodic re-examinations may be completed at approximately 30-day intervals or as needed for new injury, new complaints, acute exacerbations, etc. Outcome assessment tools and pertinent data must be used to quantify progress and to set further treatment goals.

b. The American Chiropractic Association's Medical Review Benchmarks states:

Documentation for the initial (new patient) visit, new injury or exacerbation should consist of the history and physical and the anticipated patient treatment plan. The initial treatment plan, except in chronic cases, should not extend beyond a 30-45 day interval.

c. The Guidelines for Chiropractic Quality Assurance and Practice Parameters states:

When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation.

d. The Council on Chiropractic Practice states:

Questionnaires may be used in the assessment of the performance of activities of daily living, pain perception, patient satisfaction, general health outcomes, patient perception outcomes, mental health outcomes, and overall quality of life, throughout a course of chiropractic care. Determination of the patient's progress must be made on a per-visit and periodic basis.

e. The International Chiropractors Association Recommended Clinical Protocols and Guidelines for the Practice of Chiropractic states:

The organization of the patient chart may be enhanced by using pre-printed forms and by having proper identifying information on each page. When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation. The use of forms can assist in tasks such as obtaining case history, noting examination findings and charting case progress.

f. The Canadian Chiropractic Association Glenerin Guidelines states:

Pre-printed history questionnaires that contain much of the above and other information may be used at the time of initial documentation.

The use of standardized intake forms, including measures used to evaluate patient progress, initially and at 4 to 6 week intervals is internationally recognized as standard chiropractic practice. The ACN Group Notification process is aligned with standard chiropractic practice which includes obtaining an initial patient history and performing periodic re-evaluations to document a patient's response to treatment.

2. Elements of Standardized Chiropractic Patient Intake

In addition to recommending the use of standardized patient intake forms to collect initial data regarding the patient's condition, and to monitor the patient's response to treatment at 4 to 6 week intervals, these same guidelines provide details regarding the specific data to be collected from patients using these standardized patient intake forms.

The patient data reported using the ACN Patient Health Questionnaire is very well aligned with the recommendations of these international chiropractic guidelines. In fact the majority of the questions on the PHQ are public domain questions as opposed to being proprietary to ACN Group. For those Tier 2 chiropractors who voluntarily choose to use the PHQ to report patient historical data, the PHQ is not associated with the requirement to capture any data beyond that routinely collected by chiropractors initially and at 4 to 6 week intervals as required by chiropractic documentation and record keeping.

Recording Keeping Practices of Individual Chiropractors

1. Collection of Patient Data by Missouri Chiropractors

Missouri chiropractors that post patient intake forms and policies on publicly available clinic websites uniformly follow chiropractic record keeping guidelines in that these chiropractors;

a. use standardized patient intake forms
b. have patients complete these forms prior to seeing the chiropractor on the first visit

Thus those Tier 2 chiropractors who voluntarily choose to submit patient historical data using the PHQ do not require that their patients engage in a separate and distinct patient intake process from what is performed as a matter of standard chiropractic practice.

2. Standardized Chiropractic Patient Intake Used by Missouri Chiropractors

Standardized patient intake forms posted by Missouri chiropractors on their publicly available clinic website were obtained and reviewed. A summary of the data collected by the standardized patient intake forms used by Missouri chiropractors yields several observations:

a. the record keeping practices of Missouri chiropractors are highly variable
b. the standard intake forms used by a majority of Missouri chiropractors already include many of the data elements required by chiropractic record keeping guidelines
c. For those Tier 2 chiropractors who voluntarily choose to report patient intake data using the ACN PHQ the provider can do so without having to obtain any additional data to that already collected using the provider's intake forms.

Summary: 376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. 376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees.*** Although the PHQ form requires information from the patient, it is the standard information the provider should be obtaining from the patient anyway in order to effectively treat the person. The patient has no obligation to fill out the form or submit the form. The obligation rests completely with the Chiropractor.

While 376.1230, RSMo acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by 376.1230, RSMo.

Through obtaining Missouri Department of Insurance approval of UHIC Certificates of Coverage and of the ACN UR Application and ACN UM Program UHIC and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHIC and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHIC and ACN can take to comply with the Department's current interpretation of the provisions of 376.1230, RSMo.

Compliance With 375.1007(1)(3)(4) R.S.Mo.

This finding also refers to Section 375.1007(1)(3)(4) R.S.Mo., which provides:

"375.1007. Any of the following acts by an insurer, if committed in violation of section 375.1005, constitutes an improper claims practice:
1. Misrepresenting to claimants and insured relevant facts or policy provisions relating to coverages at issue;
3. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

4. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;"

Unfair Claims Settlement Practices is listed as a reference and the Company seeks to clarify that it has not committed any improper claims practices under 375.1007(1)(3)(4) R.S.Mo. The Company has not utilized any business practices or conducted itself in conscious disregard of the Unfair Claims Settlement Practices provisions as outlined in 375.1005(1) R.S.Mo.

The Company has not misrepresented relevant facts or provisions to claimants and insureds. As indicated previously, enrollees received the services and the Company does not require the enrollee to seek prior authorization or notification in order to receive the 26 visits. In addition, the enrollee is not financially responsible for the claims since the provider failed to follow the administrative guidelines within the provider contract.

UHIC has implemented reasonable standards for the prompt investigation and settlement of claims. Since the denial is an administrative denial related to an ACN contracted provider not following the provisions of the signed ACN provider agreement, this administrative denial does not require any further investigation by the organization.

In addition, the Company is making good faith efforts to effectuate prompt, fair and equitable settlement of claims submitted where liability has become reasonably clear in compliance with 375.1007(4). If the provider follows the notification process outlined in the agreement, the Company promptly settles those claims in which liability is reasonably clear. Until the proper administrative process is followed, the Company's liability is not reasonably clear.

g) The Company afforded the insured patient coverage under group policy number 0003N9496 effective July 1, 2004. The Company unfairly denied payment of benefits for chiropractic care for the 06/13/2005 (8th visit in 2004 policy period) on the basis that the insured and provider failed to submit a CCN. The Company did not contemplate the issue of medical necessity with its denial.

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification. Part of the CCN includes the insured/patient's completion of a health questionnaire.

During the period under review, UHIC and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violated the requirements of Missouri law.

The examiners requested the Company issue a benefit payable to the network provider based on the $40.00 "Day Rate" for the Holt, MO area, less the appropriate co-payment for the 06/13/2005 date of service.
Reference: Sections 375.1007(1), (3), and (4), and 376.1230, RSMo

Claim Number	Member ID #
113071597801	493647229

Company Response:

The deficiency noted involves the administrative claims denial of services for which a chiropractor did not submit a Complete Clinical Notification (CCN), and the Department's interpretation that 376.1230, RSMo does not permit any form of prospective utilization review of the necessity of chiropractic treatment during the first 26 visits in a calendar or policy year.

376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees***.

376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. While the statute acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by the statute. The notification process does not inhibit an enrollee's access to 26

clinically appropriate and medically necessary chiropractic visits during the policy period as required by the statute and allowed by the enrollee's Certificate of Coverage.

UHIC and ACN have both interpreted 376.1230, RSMo as specific to the issue of enrollee notification requirements in the first 26 chiropractic visits. The UHIC Certificate of Coverage filed with and approved by the Missouri Department of Insurance clearly states that enrollees do not have a notification requirement when accessing chiropractic services. As described in both the ACN Group provider agreement filed with and approved by the Missouri Department of Insurance and in the ACN Group UR program filed with and approved by the Missouri Department of Insurance the ACN Group Notification process is a provider requirement, not an enrollee requirement. To follow is a history of the Missouri Department of Insurance review and approval of the ACN UR application, UM program, Provider Manual and ACN forms.

Filing Year	**What Submitted**	**Date Submitted**	**Date Approved**
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2000	UR Application	Unknown	2/07/00
2001	UR Application Evidence of URAC Accreditation	1/08/01	2/1/01
2002	UR Application UM Plan REV 9/04/01 ACN Forms Packet Provider Manual	3/08/02	4/4/02
2003	UR Application UM Plan REV9/16/02	2/27/03	3/11/03
2004	UR Application UM Program – REV11/13/03 ACN Locations	3/08/04	3/30/04
2005	UR Application UM Program – 2005 ACN Location Changes Officers and Directors Fine Information	3/15/05	3/30/05
2006	UR Application Change to NY 800 Number	1/27/06	8/1/06
2007	UR Application UM Program - 2007 ACN Group Locations Fine Information	2/2/07	3/23/07

Through this annual review and approval process ACN believed that it was in full compliance with all Missouri statutes, including provisions of 376.1230, RSMo.

The examination report states:

The deficiency identified in (g) of this section of the examination report states:

> "The CCN includes the provider's description of the patient's condition, a treatment plan, and a health questionnaire completed by the patient. During the period under review, ACN considered the CCN incomplete without the patient's health questionnaire. Failure to re-submit a CCN could and did result in denial of payment for services rendered."

The examiners have misinterpreted the definition of a CCN to include a requirement that the enrollee complete the ACN Patient Health Questionnaire. The definition of a complete clinical notification (CCN) does not include the completion and submission of the ACN Group Patient Health Questionnaire (PHQ).

- Tier 1 providers are not required to use or submit the PHQ
- Tier 2 providers who submit the Provider Notification electronically report patient historical data derived from the provider's standardized patient intake and are not required to use the ACN Patient Health Questionnaire.

Tier 2 providers who voluntarily choose to submit the Provider Notification via paper as opposed to electronically via the ACN Group provider portal are required to attach the PHQ to the ACN Provider Notification. For these providers:

- Not all PHQ questions must be completed in order to satisfy the requirements of a complete clinical notification.
- The PHQ data that is submitted is not proprietary to ACN Group, does not represent a separate and distinct ACN Group requirement, is aligned with public domain chiropractic record keeping guidelines and is already routinely collected by Missouri chiropractors.
- If a patient cannot or refuses to complete the PHQ form, the provider can make a notation to that effect on the submission, and it would not be considered an incomplete submission.

The following information is provided to illustrate that, for those Tier 2 providers who voluntarily choose to submit patient intake data using the PHQ, the PHQ does not represent the collection of additional patient information that is not already routinely collected by chiropractors consistent with international

chiropractic record keeping guidelines and standards of care. Additionally, the requirement is completely the obligation of the Chiropractor, not the patient. There should be no adverse impact on the patient if the PHQ form is not submitted.

Chiropractic Record Keeping Guidelines

1. Collection of Patient Data

The collection of patient historical data using a standard history form at the time of the initial evaluation, and at 4 to 6 week intervals during treatment, represents standard chiropractic practice recommended/required by; public domain guidelines regarding chiropractic practice, chiropractic professional associations, and state chiropractic licensing boards. To follow are some selected excerpts from these documents

a. The American Chiropractic Associations Clinical Documentation Manual states:

An admittance/new patient intake form(s) is typically used to collect and record subjective information. The patient initially completes the form(s) which the Doctor of Chiropractic then reviews prior to examining the patient. Any sections of the form(s) that are unclear or incomplete are then completed, clarified, and detailed. Periodic re-examinations may be completed at approximately 30-day intervals or as needed for new injury, new complaints, acute exacerbations, etc. Outcome assessment tools and pertinent data must be used to quantify progress and to set further treatment goals.

b. The American Chiropractic Association's Medical Review Benchmarks states:

Documentation for the initial (new patient) visit, new injury or exacerbation should consist of the history and physical and the anticipated patient treatment plan. The initial treatment plan, except in chronic cases, should not extend beyond a 30-45 day interval.

c. The Guidelines for Chiropractic Quality Assurance and Practice Parameters states:

When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation.

d. The Council on Chiropractic Practice states:

Questionnaires may be used in the assessment of the performance of activities of daily living, pain perception, patient satisfaction, general health outcomes, patient perception outcomes, mental health outcomes, and overall quality of life, throughout a course of chiropractic care. Determination of the patient's progress must be made on a per-visit and periodic basis.

e. The International Chiropractors Association Recommended Clinical Protocols and Guidelines for the Practice of Chiropractic states:

The organization of the patient chart may be enhanced by using pre-printed forms and by having proper identifying information on each page. When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation. The use of forms can assist in tasks such as obtaining case history, noting examination findings and charting case progress.

f. The Canadian Chiropractic Association Glenerin Guidelines states:

Pre-printed history questionnaires that contain much of the above and other information may be used at the time of initial documentation.

The use of standardized intake forms, including measures used to evaluate patient progress, initially and at 4 to 6 week intervals is internationally recognized as standard chiropractic practice. The ACN Group Notification process is aligned with standard chiropractic practice which includes obtaining an initial patient history and performing periodic re-evaluations to document a patient's response to treatment.

2. Elements of Standardized Chiropractic Patient Intake

In addition to recommending the use of standardized patient intake forms to collect initial data regarding the patient's condition, and to monitor the patient's response to treatment at 4 to 6 week intervals, these same guidelines provide details regarding the specific data to be collected from patients using these standardized patient intake forms.

The patient data reported using the ACN Patient Health Questionnaire is very well aligned with the recommendations of these international chiropractic guidelines. In fact the majority of the questions on the PHQ are public domain questions as opposed to being proprietary to ACN Group. For those Tier 2 chiropractors who voluntarily choose to use the

PHQ to report patient historical data, the PHQ is not associated with the requirement to capture any data beyond that routinely collected by chiropractors initially and at 4 to 6 week intervals as required by chiropractic documentation and record keeping.

Recording Keeping Practices of Individual Chiropractors

1. Collection of Patient Data by Missouri Chiropractors

Missouri chiropractors that post patient intake forms and policies on publicly available clinic websites uniformly follow chiropractic record keeping guidelines in that these chiropractors;

a. use standardized patient intake forms
b. have patients complete these forms prior to seeing the chiropractor on the first visit

Thus those Tier 2 chiropractors who voluntarily choose to submit patient historical data using the PHQ do not require that their patients engage in a separate and distinct patient intake process from what is performed as a matter of standard chiropractic practice.

2. Standardized Chiropractic Patient Intake Used by Missouri Chiropractors

Standardized patient intake forms posted by Missouri chiropractors on their publicly available clinic website were obtained and reviewed. A summary of the data collected by the standardized patient intake forms used by Missouri chiropractors yields several observations:

a. the record keeping practices of Missouri chiropractors are highly variable
b. the standard intake forms used by a majority of Missouri chiropractors already include many of the data elements required by chiropractic record keeping guidelines
c. For those Tier 2 chiropractors who voluntarily choose to report patient intake data using the ACN PHQ the provider can do so without having to obtain any additional data to that already collected using the provider's intake forms.

Summary: 376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. 376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the

enrollee having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees.*** Although the PHQ form requires information from the patient, it is the standard information the provider should be obtaining from the patient anyway in order to effectively treat the person. The patient has no obligation to fill out the form or submit the form. The obligation rests completely with the Chiropractor.

While 376.1230, RSMo acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by 376.1230, RSMo.

Through obtaining Missouri Department of Insurance approval of UHIC Certificates of Coverage and of the ACN UR Application and ACN UM Program UHIC and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHIC and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHIC and ACN can take to comply with the Department's current interpretation of the provisions of 376.1230, RSMo.

Compliance With 375.1007(1)(3)(4) R.S.Mo.

This finding also refers to Section 375.1007(1)(3)(4) R.S.Mo., which provides:

"375.1007. Any of the following acts by an insurer, if committed in violation of section 375.1005, constitutes an improper claims practice:
1. Misrepresenting to claimants and insured relevant facts or policy provisions relating to coverages at issue;
3. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;
4. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;"

Unfair Claims Settlement Practices is listed as a reference and the Company seeks to clarify that it has not committed any improper claims practices under

375.1007(1)(3)(4) R.S.Mo. The Company has not utilized any business practices or conducted itself in conscious disregard of the Unfair Claims Settlement Practices provisions as outlined in 375.1005(1) R.S.Mo.

The Company has not misrepresented relevant facts or provisions to claimants and insureds. As indicated previously, enrollees received the services and the Company does not require the enrollee to seek prior authorization or notification in order to receive the 26 visits. In addition, the enrollee is not financially responsible for the claims since the provider failed to follow the administrative guidelines within the provider contract.

UHIC has implemented reasonable standards for the prompt investigation and settlement of claims. Since the denial is an administrative denial related to an ACN contracted provider not following the provisions of the signed ACN provider agreement, this administrative denial does not require any further investigation by the organization.

In addition, the Company is making good faith efforts to effectuate prompt, fair and equitable settlement of claims submitted where liability has become reasonably clear in compliance with 375.1007(4). If the provider follows the notification process outlined in the agreement, the Company promptly settles those claims in which liability is reasonably clear. Until the proper administrative process is followed, the Company's liability is not reasonably clear.

i) The Company afforded the insured patient coverage under group policy number 000706442 effective October 1, 2004. The Company unfairly denied payment of benefits for chiropractic care for the 08/04/2005 DOS (first visit in 2004 policy period) on the basis that the insured and provider failed to submit a CCN The Company did not contemplate the issue of medical necessity with its denial.

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification. Part of the CCN includes the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violated the requirements of Missouri law.

The examiners requested the Company issue a benefit payable to the network provider based on the $44.00 "Day Rate" for the St. Louis, MO area, less the appropriate deduction for the enrollee's portion for the 08/04/05 DOS. In addition, the Company owes interest on this electronically filed claim submitted on 08/08/2005 at the rate of one percent per month from 45 days after the date submitted to the date paid.

Reference: Sections 375.1007(1), (3), and (4), 376.383, and 376.1230, RSMo, and 20 CSR 300-2.200(2)(B)

Claim Number	Member ID #
116077073101	498668240

NOTE: Though not a part of the sample of the denied claims review and therefore not subject to the error ratio, the examiners noted the Company inappropriately denied the enrollee's 08/12/2005 DOS (2nd visit in policy period) per denial code "J0". The examiners asked the Company to re-process this claim.

Company Response:

The deficiency noted involves the administrative claims denial of services for which a chiropractor did not submit a Complete Clinical Notification (CCN), and the Department's interpretation that 376.1230, RSMo does not permit any form of prospective utilization review of the necessity of chiropractic treatment during the first 26 visits in a calendar or policy year.

376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees***.

376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. While the statute acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by the statute. The notification process does not inhibit an enrollee's access to 26 clinically appropriate and medically necessary chiropractic visits during the policy period as required by the statute and allowed by the enrollee's Certificate of Coverage.

UHIC and ACN have both interpreted 376.1230, RSMo as specific to the issue of enrollee notification requirements in the first 26 chiropractic visits. The UHIC Certificate of Coverage filed with and approved by the Missouri Department of Insurance clearly states that enrollees do not have a notification requirement when accessing chiropractic services. As described in both the ACN Group provider agreement filed with and approved by the Missouri Department of Insurance and in the ACN Group UR program filed with and approved by the Missouri Department of Insurance the ACN Group Notification process is a provider requirement, not an enrollee requirement. To follow is a history of the Missouri Department of Insurance review and approval of the ACN UR application, UM program, Provider Manual and ACN forms.

Filing Year	**What Submitted**	**Date Submitted**	**Date Approved**
1999	UR Application UM Plan - REV3/15/99 Provider Manual Response Template	3/15/99	3/22/99
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2003	UR Application UM Plan REV9/16/02	2/27/03	3/11/03

2004	UR Application UM Program – REV11/13/03 ACN Locations	3/08/04	3/30/04
2005	UR Application UM Program – 2005 ACN Location Changes Officers and Directors Fine Information	3/15/05	3/30/05
2006	UR Application Change to NY 800 Number	1/27/06	8/1/06
2007	UR Application UM Program - 2007 ACN Group Locations Fine Information	2/2/07	3/23/07

Through this annual review and approval process ACN believed that it was in full compliance with all Missouri statutes, including provisions of 376.1230, RSMo.

The examination report states:

> "The CCN includes the provider's description of the patient's condition, a treatment plan, and a health questionnaire completed by the patient. During the period under review, ACN considered the CCN incomplete without the patient's health questionnaire. Failure to re-submit a CCN could and did result in denial of payment for services rendered."

The examiners have misinterpreted the definition of a CCN to include a requirement that the enrollee complete the ACN Patient Health Questionnaire. The definition of a complete clinical notification (CCN) does not include the completion and submission of the ACN Group Patient Health Questionnaire (PHQ).

- Tier 1 providers are not required to use or submit the PHQ
- Tier 2 providers who submit the Provider Notification electronically report patient historical data derived from the provider's standardized patient intake and are not required to use the ACN Patient Health Questionnaire.

Tier 2 providers who voluntarily choose to submit the Provider Notification via paper as opposed to electronically via the ACN Group provider portal are required to attach the PHQ to the ACN Provider Notification. For these providers:

- Not all PHQ questions must be completed in order to satisfy the requirements of a complete clinical notification.
- The PHQ data that is submitted is not proprietary to ACN Group, does not represent a separate and distinct ACN Group requirement, is aligned with public domain chiropractic record keeping guidelines and is already routinely collected by Missouri chiropractors.
- If a patient cannot or refuses to complete the PHQ form, the provider can make a notation to that effect on the submission, and it would not be considered an incomplete submission.

The following information is provided to illustrate that, for those Tier 2 providers who voluntarily choose to submit patient intake data using the PHQ, the PHQ does not represent the collection of additional patient information that is not already routinely collected by chiropractors consistent with international chiropractic record keeping guidelines and standards of care. Additionally, the requirement is completely the obligation of the Chiropractor, not the patient. There should be no adverse impact on the patient if the PHQ form is not submitted.

Chiropractic Record Keeping Guidelines

1. Collection of Patient Data

The collection of patient historical data using a standard history form at the time of the initial evaluation, and at 4 to 6 week intervals during treatment, represents standard chiropractic practice recommended/required by; public domain guidelines regarding chiropractic practice, chiropractic professional associations, and state chiropractic licensing boards. To follow are some selected excerpts from these documents

a. The American Chiropractic Associations Clinical Documentation Manual states:

An admittance/new patient intake form(s) is typically used to collect and record subjective information. The patient initially completes the form(s) which the Doctor of Chiropractic then reviews prior to examining the patient. Any sections of the form(s) that are unclear or incomplete are then completed, clarified, and detailed. Periodic re-examinations may be completed at approximately 30-day intervals or as needed for new injury, new complaints, acute exacerbations, etc. Outcome assessment tools and pertinent data must be used to quantify progress and to set further treatment goals.

b. The American Chiropractic Association's Medical Review Benchmarks states:

> Documentation for the initial (new patient) visit, new injury or exacerbation should consist of the history and physical and the anticipated patient treatment plan. The initial treatment plan, except in chronic cases, should not extend beyond a 30-45 day interval.

c. The Guidelines for Chiropractic Quality Assurance and Practice Parameters states:

> When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation.

d. The Council on Chiropractic Practice states:

> Questionnaires may be used in the assessment of the performance of activities of daily living, pain perception, patient satisfaction, general health outcomes, patient perception outcomes, mental health outcomes, and overall quality of life, throughout a course of chiropractic care. Determination of the patient's progress must be made on a per-visit and periodic basis.

e. The International Chiropractors Association Recommended Clinical Protocols and Guidelines for the Practice of Chiropractic states:

> The organization of the patient chart may be enhanced by using pre-printed forms and by having proper identifying information on each page. When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation. The use of forms can assist in tasks such as obtaining case history, noting examination findings and charting case progress.

f. The Canadian Chiropractic Association Glenerin Guidelines states:

> Pre-printed history questionnaires that contain much of the above and other information may be used at the time of initial documentation.

The use of standardized intake forms, including measures used to evaluate patient progress, initially and at 4 to 6 week intervals is internationally recognized as standard chiropractic practice. The ACN Group Notification process is aligned with standard chiropractic practice which includes obtaining an initial patient history and performing periodic re-evaluations to document a patient's response to treatment.

2. Elements of Standardized Chiropractic Patient Intake

In addition to recommending the use of standardized patient intake forms to collect initial data regarding the patient's condition, and to monitor the patient's response to treatment at 4 to 6 week intervals, these same guidelines provide details regarding the specific data to be collected from patients using these standardized patient intake forms.

The patient data reported using the ACN Patient Health Questionnaire is very well aligned with the recommendations of these international chiropractic guidelines. In fact the majority of the questions on the PHQ are public domain questions as opposed to being proprietary to ACN Group. For those Tier 2 chiropractors who voluntarily choose to use the PHQ to report patient historical data, the PHQ is not associated with the requirement to capture any data beyond that routinely collected by chiropractors initially and at 4 to 6 week intervals as required by chiropractic documentation and record keeping.

Recording Keeping Practices of Individual Chiropractors

1. Collection of Patient Data by Missouri Chiropractors

Missouri chiropractors that post patient intake forms and policies on publicly available clinic websites uniformly follow chiropractic record keeping guidelines in that these chiropractors;

a. use standardized patient intake forms
b. have patients complete these forms prior to seeing the chiropractor on the first visit

Thus those Tier 2 chiropractors who voluntarily choose to submit patient historical data using the PHQ do not require that

their patients engage in a separate and distinct patient intake process from what is performed as a matter of standard chiropractic practice.

2. Standardized Chiropractic Patient Intake Used by Missouri Chiropractors

Standardized patient intake forms posted by Missouri chiropractors on their publicly available clinic website were obtained and reviewed. A summary of the data collected by the standardized patient intake forms used by Missouri chiropractors yields several observations:

a. the record keeping practices of Missouri chiropractors are highly variable
b. the standard intake forms used by a majority of Missouri chiropractors already include many of the data elements required by chiropractic record keeping guidelines
c. For those Tier 2 chiropractors who voluntarily choose to report patient intake data using the ACN PHQ the provider can do so without having to obtain any additional data to that already collected using the provider's intake forms.

Summary: 376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. 376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees.*** Although the PHQ form requires information from the patient, it is the standard information the provider should be obtaining from the patient anyway in order to effectively treat the person. The patient has no obligation to fill out the form or submit the form. The obligation rests completely with the Chiropractor.

While 376.1230, RSMo acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification

requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by 376.1230, RSMo.

Through obtaining Missouri Department of Insurance approval of UHIC Certificates of Coverage and of the ACN UR Application and ACN UM Program UHIC and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHIC and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHIC and ACN can take to comply with the Department's current interpretation of the provisions of 376.1230, RSMo.

Compliance With 375.1007(1)(3)(4) R.S.Mo.

This finding also refers to Section 375.1007(1)(3)(4) R.S.Mo., which provides:

"375.1007. Any of the following acts by an insurer, if committed in violation of section 375.1005, constitutes an improper claims practice:
1. Misrepresenting to claimants and insured relevant facts or policy provisions relating to coverages at issue;
3. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;
4. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;"

Unfair Claims Settlement Practices is listed as a reference and the Company seeks to clarify that it has not committed any improper claims practices under 375.1007(1)(3)(4) R.S.Mo. The Company has not utilized any business practices or conducted itself in conscious disregard of the Unfair Claims Settlement Practices provisions as outlined in 375.1005(1) R.S.Mo.

The Company has not misrepresented relevant facts or provisions to claimants and insureds. As indicated previously, enrollees received the services and the Company does not require the enrollee to seek prior authorization or notification in order to receive the 26 visits. In

addition, the enrollee is not financially responsible for the claims since the provider failed to follow the administrative guidelines within the provider contract.

UHIC has implemented reasonable standards for the prompt investigation and settlement of claims. Since the denial is an administrative denial related to an ACN contracted provider not following the provisions of the signed ACN provider agreement, this administrative denial does not require any further investigation by the organization.

In addition, the Company is making good faith efforts to effectuate prompt, fair and equitable settlement of claims submitted where liability has become reasonably clear in compliance with 375.1007(4). If the provider follows the notification process outlined in the agreement, the Company promptly settles those claims in which liability is reasonably clear. Until the proper administrative process is followed, the Company's liability is not reasonably clear.

20 CSR 300-2.200(2)(B)

This finding also refers to 20 CSR 300-2.200(2)(B). We are unable to identify the particular provision (2)(B); however, it is clear that 20 CSR 300-2.200 pertains to records required to be maintained for the purpose of market conduct examinations. Although no specific records are listed in the Report allegation, the Company seeks to clarify that all records were maintained in a manner that allowed the Examiners to sufficiently ascertain the claims handling practices of the Company as demonstrated by the allegation noted in the Report.

j) The Company afforded the insured patient coverage under group policy number 000308398 effective July 1, 2004. The Company unfairly denied payment of benefits for chiropractic care for the 04/25/2005 DOS (7th visit in 2004 policy period) on the basis that the insured and provider failed to submit a CCN. The Company did not contemplate the issue of medical necessity with its denial.

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification. Part

of the CCN includes the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violates the requirements of Missouri law.

The examiners requested the Company issue a benefit payable to the network provider based on the $40.00 "Day Rate" for the Liberty, MO area, less the appropriate co-payment for the 04/25/05 DOS. In addition, the Company owes interest on this electronically filed claim submitted on 04/27/2005 at the rate of one percent per month from 45 days after the date submitted to the date paid. Reference: Sections 375.1007(1), (3), and (4), 376.383, and 376.1230, RSMo

Claim Number	Member ID #
109420119701	499788107

Company Response:

The deficiency noted involves the administrative claims denial of services for which a chiropractor did not submit a Complete Clinical Notification (CCN), and the Department's interpretation that 376.1230, RSMo does not permit any form of prospective utilization review of the necessity of chiropractic treatment during the first 26 visits in a calendar or policy year.

376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees***.

376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. While the statute acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements

related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by the statute. The notification process does not inhibit an enrollee's access to 26 clinically appropriate and medically necessary chiropractic visits during the policy period as required by the statute and allowed by the enrollee's Certificate of Coverage.

UHIC and ACN have both interpreted 376.1230, RSMo as specific to the issue of enrollee notification requirements in the first 26 chiropractic visits. The UHIC Certificate of Coverage filed with and approved by the Missouri Department of Insurance clearly states that enrollees do not have a notification requirement when accessing chiropractic services. As described in both the ACN Group provider agreement filed with and approved by the Missouri Department of Insurance and in the ACN Group UR program filed with and approved by the Missouri Department of Insurance the ACN Group Notification process is a provider requirement, not an enrollee requirement. To follow is a history of the Missouri Department of Insurance review and approval of the ACN UR application, UM program, Provider Manual and ACN forms.

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2007	UR Application UM Program - 2007 ACN Group Locations Fine Information	2/2/07	3/23/07

Through this annual review and approval process ACN believed that it was in full compliance with all Missouri statutes, including provisions of 376.1230, RSMo.

The examination report states:

> "The CCN includes the provider's description of the patient's condition, a treatment plan, and a health questionnaire completed by the patient. During the period under review, ACN considered the CCN incomplete without the patient's health questionnaire. Failure to re-submit a CCN could and did result in denial of payment for services rendered."

The examiners have misinterpreted the definition of a CCN to include a requirement that the enrollee complete the ACN Patient Health Questionnaire. The definition of a complete clinical notification (CCN) does not include the completion and submission of the ACN Group Patient Health Questionnaire (PHQ).

- Tier 1 providers are not required to use or submit the PHQ
- Tier 2 providers who submit the Provider Notification electronically report patient historical data derived from the provider's standardized patient intake and are not required to use the ACN Patient Health Questionnaire.

Tier 2 providers who voluntarily choose to submit the Provider Notification via paper as opposed to electronically via the ACN Group provider portal are required to attach the PHQ to the ACN Provider Notification. For these providers:

- Not all PHQ questions must be completed in order to satisfy the requirements of a complete clinical notification.
- The PHQ data that is submitted is not proprietary to ACN Group, does not represent a separate and distinct ACN Group requirement, is aligned with public domain chiropractic record keeping guidelines and is already routinely collected by Missouri chiropractors.

- If a patient cannot or refuses to complete the PHQ form, the provider can make a notation to that effect on the submission, and it would not be considered an incomplete submission.

The following information is provided to illustrate that, for those Tier 2 providers who voluntarily choose to submit patient intake data using the PHQ, the PHQ does not represent the collection of additional patient information that is not already routinely collected by chiropractors consistent with international chiropractic record keeping guidelines and standards of care. Additionally, the requirement is completely the obligation of the Chiropractor, not the patient. There should be no adverse impact on the patient if the PHQ form is not submitted.

Chiropractic Record Keeping Guidelines

1. Collection of Patient Data

The collection of patient historical data using a standard history form at the time of the initial evaluation, and at 4 to 6 week intervals during treatment, represents standard chiropractic practice recommended/required by; public domain guidelines regarding chiropractic practice, chiropractic professional associations, and state chiropractic licensing boards. To follow are some selected excerpts from these documents

a. The American Chiropractic Associations Clinical Documentation Manual states:

An admittance/new patient intake form(s) is typically used to collect and record subjective information. The patient initially completes the form(s) which the Doctor of Chiropractic then reviews prior to examining the patient. Any sections of the form(s) that are unclear or incomplete are then completed, clarified, and detailed. Periodic re-examinations may be completed at approximately 30-day intervals or as needed for new injury, new complaints, acute exacerbations, etc. Outcome assessment tools and pertinent data must be used to quantify progress and to set further treatment goals.

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Documentation for the initial (new patient) visit, new injury or exacerbation should consist of the history and physical and the anticipated patient treatment plan. The initial treatment plan, except in chronic cases, should not extend beyond a 30-45 day interval.

c. The Guidelines for Chiropractic Quality Assurance and Practice Parameters states:

When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation.

d. The Council on Chiropractic Practice states:

Questionnaires may be used in the assessment of the performance of activities of daily living, pain perception, patient satisfaction, general health outcomes, patient perception outcomes, mental health outcomes, and overall quality of life, throughout a course of chiropractic care. Determination of the patient's progress must be made on a per-visit and periodic basis.

e. The International Chiropractors Association Recommended Clinical Protocols and Guidelines for the Practice of Chiropractic states:

The organization of the patient chart may be enhanced by using pre-printed forms and by having proper identifying information on each page. When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation. The use of forms can assist in tasks such as obtaining case history, noting examination findings and charting case progress.

f. The Canadian Chiropractic Association Glenerin Guidelines states:

Pre-printed history questionnaires that contain much of the above and other information may be used at the time of initial documentation.

The use of standardized intake forms, including measures used to evaluate patient progress, initially and at 4 to 6 week intervals is internationally recognized as standard chiropractic practice. The ACN Group Notification process is aligned with standard chiropractic practice which includes obtaining an initial patient history and performing periodic re-evaluations to document a patient's response to treatment.

2. Elements of Standardized Chiropractic Patient Intake

In addition to recommending the use of standardized patient intake forms to collect initial data regarding the patient's condition, and to

monitor the patient's response to treatment at 4 to 6 week intervals, these same guidelines provide details regarding the specific data to be collected from patients using these standardized patient intake forms.

The patient data reported using the ACN Patient Health Questionnaire is very well aligned with the recommendations of these international chiropractic guidelines. In fact the majority of the questions on the PHQ are public domain questions as opposed to being proprietary to ACN Group. For those Tier 2 chiropractors who voluntarily choose to use the PHQ to report patient historical data, the PHQ is not associated with the requirement to capture any data beyond that routinely collected by chiropractors initially and at 4 to 6 week intervals as required by chiropractic documentation and record keeping.

Recording Keeping Practices of Individual Chiropractors

1. Collection of Patient Data by Missouri Chiropractors

Missouri chiropractors that post patient intake forms and policies on publicly available clinic websites uniformly follow chiropractic record keeping guidelines in that these chiropractors;

a. use standardized patient intake forms
b. have patients complete these forms prior to seeing the chiropractor on the first visit

Thus those Tier 2 chiropractors who voluntarily choose to submit patient historical data using the PHQ do not require that their patients engage in a separate and distinct patient intake process from what is performed as a matter of standard chiropractic practice.

2. Standardized Chiropractic Patient Intake Used by Missouri Chiropractors

Standardized patient intake forms posted by Missouri chiropractors on their publicly available clinic website were obtained and reviewed. A summary of the data collected by the standardized patient intake forms used by Missouri chiropractors yields several observations:

a. the record keeping practices of Missouri chiropractors are highly variable
b. the standard intake forms used by a majority of Missouri chiropractors already include many of the data elements required by chiropractic record keeping guidelines

c. For those Tier 2 chiropractors who voluntarily choose to report patient intake data using the ACN PHQ the provider can do so without having to obtain any additional data to that already collected using the provider's intake forms.

Summary: 376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. 376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees.*** Although the PHQ form requires information from the patient, it is the standard information the provider should be obtaining from the patient anyway in order to effectively treat the person. The patient has no obligation to fill out the form or submit the form. The obligation rests completely with the Chiropractor.

While 376.1230, RSMo acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by 376.1230, RSMo.

Through obtaining Missouri Department of Insurance approval of UHIC Certificates of Coverage and of the ACN UR Application and ACN UM Program UHIC and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHIC and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHIC and ACN can take to comply with the Department's current interpretation of the provisions of 376.1230, RSMo.

Compliance With 375.1007(1)(3)(4) R.S.Mo.

This finding also refers to Section 375.1007(1)(3)(4) R.S.Mo., which provides:

"375.1007. Any of the following acts by an insurer, if committed in violation of section 375.1005, constitutes an improper claims practice:

1. Misrepresenting to claimants and insured relevant facts or policy provisions relating to coverages at issue;
3. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;
4. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;"

Although no specific violations are noted in the Report, Unfair Claims Settlement Practices is listed as a reference and the Company seeks to clarify that it has not committed any improper claims practices under 375.1007(1)(3)(4) R.S.Mo. The Company has not utilized any business practices or conducted itself in conscious disregard of the Unfair Claims Settlement Practices provisions as outlined in 375.1005(1) R.S.Mo.

Unfair Claims Settlement Practices is listed as a reference and the Company seeks to clarify that it has not committed any improper claims practices under 375.1007(1)(3)(4)(6) R.S.Mo. The Company has not utilized any business practices or conducted itself in conscious disregard of the Unfair Claims Settlement Practices provisions as outlined in 375.1005(1) R.S.Mo.

The Company has not misrepresented relevant facts or provisions to claimants and insureds. As indicated previously, enrollees received the services and the Company does not require the enrollee to seek prior authorization or notification in order to receive the 26 visits. In addition, the enrollee is not financially responsible for the claims since the provider failed to follow the administrative guidelines within the provider contract.

In addition, the Company is making good faith efforts to effectuate prompt, fair and equitable settlement of claims submitted where liability has become reasonably clear in compliance with 375.1007(4). If the provider follows the notification process outlined in the agreement, the Company promptly settles those claims in which liability is reasonably clear. Until the proper administrative process is followed, the Company's liability is not reasonably clear.

k) The Company afforded the insured patient coverage under group policy number 000704440 effective October 1, 2004. The Company unfairly denied payment of benefits for chiropractic care for the 01/05/2005 DOS (5th visit in 2004 policy

period) on the basis that the insured and provider failed to submit a CCN. The Company did not contemplate the issue of medical necessity with its denial.

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification. Part of the CCN includes the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violates the requirements of Missouri law.

The examiners requested the Company issue a benefit payable to the network provider based on the $44.00 "Day Rate" for the O'Fallon, MO area, less the appropriate co-payment for the 01/05/05 DOS.
Reference: Sections 375.1007(1), (3), and (4), and 376.1230, RSMo

Claim Number	Member ID #
103475436101	499823985

Company Response:

The deficiency noted involves the administrative claims denial of services for which a chiropractor did not submit a Complete Clinical Notification (CCN), and the Department's interpretation that 376.1230, RSMo does not permit any form of prospective utilization review of the necessity of chiropractic treatment during the first 26 visits in a calendar or policy year.

376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees***.

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UHIC and ACN have both interpreted 376.1230, RSMo as specific to the issue of enrollee notification requirements in the first 26 chiropractic visits. The UHIC Certificate of Coverage filed with and approved by the Missouri Department of Insurance clearly states that enrollees do not have a notification requirement when accessing chiropractic services. As described in both the ACN Group provider agreement filed with and approved by the Missouri Department of Insurance and in the ACN Group UR program filed with and approved by the Missouri Department of Insurance the ACN Group Notification process is a provider requirement, not an enrollee requirement. To follow is a history of the Missouri Department of Insurance review and approval of the ACN UR application, UM program, Provider Manual and ACN forms.

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Through this annual review and approval process ACN believed that it was in full compliance with all Missouri statutes, including provisions of 376.1230, RSMo.

The examination report states:

> "The CCN includes the provider's description of the patient's condition, a treatment plan, and a health questionnaire completed by the patient. During the period under review, ACN considered the CCN incomplete without the patient's health questionnaire. Failure to re-submit a CCN could and did result in denial of payment for services rendered."

The examiners have misinterpreted the definition of a CCN to include a requirement that the enrollee complete the ACN Patient Health Questionnaire. The definition of a complete clinical notification (CCN) does not include the completion and submission of the ACN Group Patient Health Questionnaire (PHQ).

- Tier 1 providers are not required to use or submit the PHQ
- Tier 2 providers who submit the Provider Notification electronically report patient historical data derived from the provider's standardized patient intake and are not required to use the ACN Patient Health Questionnaire.

Tier 2 providers who voluntarily choose to submit the Provider Notification via paper as opposed to electronically via the ACN Group provider portal are required to attach the PHQ to the ACN Provider Notification. For these providers:

- Not all PHQ questions must be completed in order to satisfy the requirements of a complete clinical notification.

- The PHQ data that is submitted is not proprietary to ACN Group, does not represent a separate and distinct ACN Group requirement, is aligned with public domain chiropractic record keeping guidelines and is already routinely collected by Missouri chiropractors.
- If a patient cannot or refuses to complete the PHQ form, the provider can make a notation to that effect on the submission, and it would not be considered an incomplete submission.

The following information is provided to illustrate that, for those Tier 2 providers who voluntarily choose to submit patient intake data using the PHQ, the PHQ does not represent the collection of additional patient information that is not already routinely collected by chiropractors consistent with international chiropractic record keeping guidelines and standards of care. Additionally, the requirement is completely the obligation of the Chiropractor, not the patient. There should be no adverse impact on the patient if the PHQ form is not submitted.

Chiropractic Record Keeping Guidelines

1. Collection of Patient Data

The collection of patient historical data using a standard history form at the time of the initial evaluation, and at 4 to 6 week intervals during treatment, represents standard chiropractic practice recommended/required by; public domain guidelines regarding chiropractic practice, chiropractic professional associations, and state chiropractic licensing boards. To follow are some selected excerpts from these documents

a. The American Chiropractic Associations Clinical Documentation Manual states:

An admittance/new patient intake form(s) is typically used to collect and record subjective information. The patient initially completes the form(s) which the Doctor of Chiropractic then reviews prior to examining the patient. Any sections of the form(s) that are unclear or incomplete are then completed, clarified, and detailed. Periodic re-examinations may be completed at approximately 30-day intervals or as needed for new injury, new complaints, acute exacerbations, etc. Outcome assessment tools and pertinent data must be used to quantify progress and to set further treatment goals.

b. The American Chiropractic Association's Medical Review Benchmarks states:

> Documentation for the initial (new patient) visit, new injury or exacerbation should consist of the history and physical and the anticipated patient treatment plan. The initial treatment plan, except in chronic cases, should not extend beyond a 30-45 day interval.

c. The Guidelines for Chiropractic Quality Assurance and Practice Parameters states:

> When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation.

d. The Council on Chiropractic Practice states:

> Questionnaires may be used in the assessment of the performance of activities of daily living, pain perception, patient satisfaction, general health outcomes, patient perception outcomes, mental health outcomes, and overall quality of life, throughout a course of chiropractic care. Determination of the patient's progress must be made on a per-visit and periodic basis.

e. The International Chiropractors Association Recommended Clinical Protocols and Guidelines for the Practice of Chiropractic states:

> The organization of the patient chart may be enhanced by using pre-printed forms and by having proper identifying information on each page. When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation. The use of forms can assist in tasks such as obtaining case history, noting examination findings and charting case progress.

f. The Canadian Chiropractic Association Glenerin Guidelines states:

> Pre-printed history questionnaires that contain much of the above and other information may be used at the time of initial documentation.

The use of standardized intake forms, including measures used to evaluate patient progress, initially and at 4 to 6 week intervals is internationally recognized as standard chiropractic practice. The ACN

Group Notification process is aligned with standard chiropractic practice which includes obtaining an initial patient history and performing periodic re-evaluations to document a patient's response to treatment.

2. Elements of Standardized Chiropractic Patient Intake

In addition to recommending the use of standardized patient intake forms to collect initial data regarding the patient's condition, and to monitor the patient's response to treatment at 4 to 6 week intervals, these same guidelines provide details regarding the specific data to be collected from patients using these standardized patient intake forms.

The patient data reported using the ACN Patient Health Questionnaire is very well aligned with the recommendations of these international chiropractic guidelines. In fact the majority of the questions on the PHQ are public domain questions as opposed to being proprietary to ACN Group. For those Tier 2 chiropractors who voluntarily choose to use the PHQ to report patient historical data, the PHQ is not associated with the requirement to capture any data beyond that routinely collected by chiropractors initially and at 4 to 6 week intervals as required by chiropractic documentation and record keeping.

Recording Keeping Practices of Individual Chiropractors

1. Collection of Patient Data by Missouri Chiropractors

Missouri chiropractors that post patient intake forms and policies on publicly available clinic websites uniformly follow chiropractic record keeping guidelines in that these chiropractors;

a. use standardized patient intake forms
b. have patients complete these forms prior to seeing the chiropractor on the first visit

Thus those Tier 2 chiropractors who voluntarily choose to submit patient historical data using the PHQ do not require that their patients engage in a separate and distinct patient intake process from what is performed as a matter of standard chiropractic practice.

2. Standardized Chiropractic Patient Intake Used by Missouri Chiropractors

Standardized patient intake forms posted by Missouri chiropractors on their publicly available clinic website were obtained and reviewed. A summary of the data collected by the standardized patient intake forms used by Missouri chiropractors yields several observations:

a. the record keeping practices of Missouri chiropractors are highly variable
b. the standard intake forms used by a majority of Missouri chiropractors already include many of the data elements required by chiropractic record keeping guidelines
c. For those Tier 2 chiropractors who voluntarily choose to report patient intake data using the ACN PHQ the provider can do so without having to obtain any additional data to that already collected using the provider's intake forms.

Summary: 376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. 376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees.*** Although the PHQ form requires information from the patient, it is the standard information the provider should be obtaining from the patient anyway in order to effectively treat the person. The patient has no obligation to fill out the form or submit the form. The obligation rests completely with the Chiropractor.

While 376.1230, RSMo acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by 376.1230, RSMo.

Through obtaining Missouri Department of Insurance approval of UHIC Certificates of Coverage and of the ACN UR Application and ACN UM Program UHIC and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHIC and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHIC and ACN can take to comply with the Department's current interpretation of the provisions of 376.1230, RSMo.

Compliance With 375.1007(1)(3)(4) R.S.Mo.

This finding also refers to Section 375.1007(1)(3)(4) R.S.Mo., which provides:

"375.1007. Any of the following acts by an insurer, if committed in violation of section 375.1005, constitutes an improper claims practice:
1. Misrepresenting to claimants and insured relevant facts or policy provisions relating to coverages at issue;
3. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;
4. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;"

Unfair Claims Settlement Practices is listed as a reference and the Company seeks to clarify that it has not committed any improper claims practices under 375.1007(1)(3)(4) R.S.Mo. The Company has not utilized any business practices or conducted itself in conscious disregard of the Unfair Claims Settlement Practices provisions as outlined in 375.1005(1) R.S.Mo.

The Company has not misrepresented relevant facts or provisions to claimants and insureds. As indicated previously, enrollees received the services and the Company does not require the enrollee to seek prior authorization or notification in order to receive the 26 visits. In addition, the enrollee is not financially responsible for the claims since the provider failed to follow the administrative guidelines within the provider contract.

UHIC has implemented reasonable standards for the prompt investigation and settlement of claims. Since the denial is an administrative denial related to an ACN contracted provider not following the provisions of the signed ACN provider agreement, this administrative denial does not require any further investigation by the organization.

In addition, the Company is making good faith efforts to effectuate prompt, fair and equitable settlement of claims submitted where liability has become reasonably clear in compliance with 375.1007(4). If the provider follows the

notification process outlined in the agreement, the Company promptly settles those claims in which liability is reasonably clear. Until the proper administrative process is followed, the Company's liability is not reasonably clear.

l) The Company afforded the insured patient coverage under group policy number 000382719 effective January 15, 2005. The Company unfairly denied payment of benefits for chiropractic care for the 10/04/2005 DOS (4th visit in 2005 policy period) on the basis that the insured and provider failed to submit a CCN The Company did not contemplate the issue of medical necessity with its denial.

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification. Part of the CCN includes the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violated the requirements of Missouri law.

The examiners requested the Company issue a benefit payable to the network provider based on the $40.00 "Day Rate" for the Kansas City, MO area, less the appropriate co-payment for the 10/04/05 date of service. In addition, the Company owes interest on this electronically filed claim submitted on 10/13/2005 at the rate of one percent per month from 45 days after the date submitted to the date paid. Reference: Sections 375.1007(1), (3), and (4), 376.383, and 376.1230, RSMo

Claim Number	Member ID #
120417650501	515984907

Company Response:

The deficiency noted involves the administrative claims denial of services for which a chiropractor did not submit a Complete Clinical Notification (CCN), and the Department's interpretation that 376.1230, RSMo does not permit any form of prospective utilization review of the necessity of chiropractic treatment during the first 26 visits in a calendar or policy year.

376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees***.

376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. While the statute acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by the statute. The notification process does not inhibit an enrollee's access to 26 clinically appropriate and medically necessary chiropractic visits during the policy period as required by the statute and allowed by the enrollee's Certificate of Coverage.

UHIC and ACN have both interpreted 376.1230, RSMo as specific to the issue of enrollee notification requirements in the first 26 chiropractic visits. The UHIC Certificate of Coverage filed with and approved by the Missouri Department of Insurance clearly states that enrollees do not have a notification requirement when accessing chiropractic services. As described in both the ACN Group provider agreement filed with and approved by the Missouri Department of Insurance and in the ACN Group UR program filed with and approved by the Missouri Department of Insurance the ACN Group Notification process is a provider requirement, not an enrollee requirement. To follow is a history of the Missouri Department of Insurance review and approval of the ACN UR application, UM program, Provider Manual and ACN forms.

Filing Year	What Submitted	Date Submitted	Date Approved
1999	UR Application UM Plan - REV3/15/99 Provider Manual Response Template	3/15/99	3/22/99
2000	UR Application	Unknown	2/07/00
2001	UR Application Evidence of URAC Accreditation	1/08/01	2/1/01
2002	UR Application UM Plan REV 9/04/01 ACN Forms Packet Provider Manual	3/08/02	4/4/02
2003	UR Application UM Plan REV9/16/02	2/27/03	3/11/03
2004	UR Application UM Program – REV11/13/03 ACN Locations	3/08/04	3/30/04
2005	UR Application UM Program – 2005 ACN Location Changes Officers and Directors Fine Information	3/15/05	3/30/05
2006	UR Application Change to NY 800 Number	1/27/06	8/1/06
2007	UR Application UM Program - 2007 ACN Group Locations Fine Information	2/2/07	3/23/07

Through this annual review and approval process ACN believed that it was in full compliance with all Missouri statutes, including provisions of 376.1230, RSMo.

The examination report states:

> "The CCN includes the provider's description of the patient's condition, a treatment plan, and a health questionnaire completed by the patient. During the period under review, ACN considered the CCN incomplete without the patient's health questionnaire. Failure to re-submit a CCN could and did result in denial of payment for services rendered."

The examiners have misinterpreted the definition of a CCN to include a requirement that the enrollee complete the ACN Patient Health Questionnaire. The definition of a complete clinical notification (CCN) does not include the completion and submission of the ACN Group Patient Health Questionnaire (PHQ).

- Tier 1 providers are not required to use or submit the PHQ
- Tier 2 providers who submit the Provider Notification electronically report patient historical data derived from the provider's standardized patient intake and are not required to use the ACN Patient Health Questionnaire.

Tier 2 providers who voluntarily choose to submit the Provider Notification via paper as opposed to electronically via the ACN Group provider portal are required to attach the PHQ to the ACN Provider Notification. For these providers:

- Not all PHQ questions must be completed in order to satisfy the requirements of a complete clinical notification.
- The PHQ data that is submitted is not proprietary to ACN Group, does not represent a separate and distinct ACN Group requirement, is aligned with public domain chiropractic record keeping guidelines and is already routinely collected by Missouri chiropractors.
- If a patient cannot or refuses to complete the PHQ form, the provider can make a notation to that effect on the submission, and it would not be considered an incomplete submission.

The following information is provided to illustrate that, for those Tier 2 providers who voluntarily choose to submit patient intake data using the PHQ, the PHQ does not represent the collection of additional patient information that is not already routinely collected by chiropractors consistent with international chiropractic record keeping guidelines and standards of care. Additionally, the requirement is completely the obligation of the Chiropractor, not the patient. There should be no adverse impact on the patient if the PHQ form is not submitted.

Chiropractic Record Keeping Guidelines

1. Collection of Patient Data

The collection of patient historical data using a standard history form at the time of the initial evaluation, and at 4 to 6 week intervals during treatment, represents standard chiropractic practice

recommended/required by; public domain guidelines regarding chiropractic practice, chiropractic professional associations, and state chiropractic licensing boards. To follow are some selected excerpts from these documents

a. The American Chiropractic Associations Clinical Documentation Manual states:

An admittance/new patient intake form(s) is typically used to collect and record subjective information. The patient initially completes the form(s) which the Doctor of Chiropractic then reviews prior to examining the patient. Any sections of the form(s) that are unclear or incomplete are then completed, clarified, and detailed. Periodic re-examinations may be completed at approximately 30-day intervals or as needed for new injury, new complaints, acute exacerbations, etc. Outcome assessment tools and pertinent data must be used to quantify progress and to set further treatment goals.

b. The American Chiropractic Association's Medical Review Benchmarks states:

Documentation for the initial (new patient) visit, new injury or exacerbation should consist of the history and physical and the anticipated patient treatment plan. The initial treatment plan, except in chronic cases, should not extend beyond a 30-45 day interval.

c. The Guidelines for Chiropractic Quality Assurance and Practice Parameters states:

When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation.

d. The Council on Chiropractic Practice states:

Questionnaires may be used in the assessment of the performance of activities of daily living, pain perception, patient satisfaction, general health outcomes, patient perception outcomes, mental health outcomes, and overall quality of life, throughout a course of chiropractic care. Determination of the patient's progress must be made on a per-visit and periodic basis.

e. The International Chiropractors Association Recommended Clinical Protocols and Guidelines for the Practice of Chiropractic states:

The organization of the patient chart may be enhanced by using pre-printed forms and by having proper identifying information on each page. When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation. The use of forms can assist in tasks such as obtaining case history, noting examination findings and charting case progress.

f. The Canadian Chiropractic Association Glenerin Guidelines states:

Pre-printed history questionnaires that contain much of the above and other information may be used at the time of initial documentation.

The use of standardized intake forms, including measures used to evaluate patient progress, initially and at 4 to 6 week intervals is internationally recognized as standard chiropractic practice. The ACN Group Notification process is aligned with standard chiropractic practice which includes obtaining an initial patient history and performing periodic re-evaluations to document a patient's response to treatment.

2. Elements of Standardized Chiropractic Patient Intake

In addition to recommending the use of standardized patient intake forms to collect initial data regarding the patient's condition, and to monitor the patient's response to treatment at 4 to 6 week intervals, these same guidelines provide details regarding the specific data to be collected from patients using these standardized patient intake forms.

The patient data reported using the ACN Patient Health Questionnaire is very well aligned with the recommendations of these international chiropractic guidelines. In fact the majority of the questions on the PHQ are public domain questions as opposed to being proprietary to ACN Group. For those Tier 2 chiropractors who voluntarily choose to use the PHQ to report patient historical data, the PHQ is not associated with the requirement to capture any data beyond that routinely collected by chiropractors initially and at 4 to 6 week intervals as required by chiropractic documentation and record keeping.

Recording Keeping Practices of Individual Chiropractors

1. Collection of Patient Data by Missouri Chiropractors

Missouri chiropractors that post patient intake forms and policies on publicly available clinic websites uniformly follow chiropractic record keeping guidelines in that these chiropractors;

a. use standardized patient intake forms
b. have patients complete these forms prior to seeing the chiropractor on the first visit

Thus those Tier 2 chiropractors who voluntarily choose to submit patient historical data using the PHQ do not require that their patients engage in a separate and distinct patient intake process from what is performed as a matter of standard chiropractic practice.

2. Standardized Chiropractic Patient Intake Used by Missouri Chiropractors

Standardized patient intake forms posted by Missouri chiropractors on their publicly available clinic website were obtained and reviewed. A summary of the data collected by the standardized patient intake forms used by Missouri chiropractors yields several observations:

a. the record keeping practices of Missouri chiropractors are highly variable
b. the standard intake forms used by a majority of Missouri chiropractors already include many of the data elements required by chiropractic record keeping guidelines
c. For those Tier 2 chiropractors who voluntarily choose to report patient intake data using the ACN PHQ the provider can do so without having to obtain any additional data to that already collected using the provider's intake forms.

Summary: 376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. 376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees.*** Although the PHQ form requires information from the patient, it is

the standard information the provider should be obtaining from the patient anyway in order to effectively treat the person. The patient has no obligation to fill out the form or submit the form. The obligation rests completely with the Chiropractor.

While 376.1230, RSMo acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by 376.1230, RSMo.

Through obtaining Missouri Department of Insurance approval of UHIC Certificates of Coverage and of the ACN UR Application and ACN UM Program UHIC and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHIC and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHIC and ACN can take to comply with the Department's current interpretation of the provisions of 376.1230, RSMo.

Compliance With 375.1007(1)(3)(4) R.S.Mo.

This finding also refers to Section 375.1007(1)(3)(4) R.S.Mo., which provides:

"375.1007. Any of the following acts by an insurer, if committed in violation of section 375.1005, constitutes an improper claims practice:
1. Misrepresenting to claimants and insured relevant facts or policy provisions relating to coverages at issue;
3. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;
4. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;"

Unfair Claims Settlement Practices is listed as a reference and the Company seeks to clarify that it has not committed any improper claims practices under 375.1007(1)(3)(4) R.S.Mo. The Company has not utilized any business practices or conducted itself in conscious disregard of the Unfair Claims Settlement Practices provisions as outlined in 375.1005(1) R.S.Mo.

The Company has not misrepresented relevant facts or provisions to claimants and insureds. As indicated previously, enrollees received the services and the Company does not require the enrollee to seek prior authorization or notification in order to receive the 26 visits. In addition, the enrollee is not financially responsible for the claims since the provider failed to follow the administrative guidelines within the provider contract.

UHIC has implemented reasonable standards for the prompt investigation and settlement of claims. Since the denial is an administrative denial related to an ACN contracted provider not following the provisions of the signed ACN provider agreement, this administrative denial does not require any further investigation by the organization.

In addition, the Company is making good faith efforts to effectuate prompt, fair and equitable settlement of claims submitted where liability has become reasonably clear in compliance with 375.1007(4). If the provider follows the notification process outlined in the agreement, the Company promptly settles those claims in which liability is reasonably clear. Until the proper administrative process is followed, the Company's liability is not reasonably clear.

m) The Company afforded the insured patient coverage under group policy number 000707056 effective January 1, 2005. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 05/16/2005 DOS per denial code "M0" which states, "This date exceeds the number of visits indicated in the ACN notification response; re-notification was required. The patient may not be billed for amounts declined when administrative requirements are not followed."

Missouri law mandates access to medically necessary chiropractic care for the first 26 visits in the policy period without the necessity of providing a notification or a re-notification. Part of the CCN included the insured/patient's completion of a health questionnaire. During the period under review, UHIC and ACN considered failure to re-submit a CCN grounds for denial of the claim. This practice violated the requirements of Missouri law.

The chiropractor who provided medical services to the member contracted with the ACN network. The ACN network policy leaves the determination of medical necessity up to the provider and the patient. By its own admission, UHIC does not engage in utilization review of the services provided by ACN's network providers. According to both ACN and UHIC, ACN is not involved in the claim process. However, ACN initiated application of the "M0" remark code that resulted in denial of payment. UHIC conducted neither utilization review nor an investigation to make a determination on the issue of medical necessity.

According to UHIC and ACN, the notification process requires a treating provider to submit a standardized medical record containing data about the patient under care. After ACN receives notification from the provider, ACN establishes a milestone for the treatment and re-notification. If the patient's condition requires treatment beyond the established milestone, the provider is required to re-notify ACN. The CCN refers to the standardized medical forms required of ACN's network providers. The CCN includes the provider's description of the patient's condition, a treatment plan, and a health questionnaire completed by the patient. During the period under review, UHIC and ACN considered the CCN incomplete without the patient's health questionnaire. The provider's failure to resubmit a follow-up CCN could and did result in denial of payment for the services rendered.

Both ACN and UHIC have taken the position that the notification response letter issued by ACN is not used for utilization review of the specific patient's condition and is not intended to be an authorization or a determination of medical necessity. According to the Company, application of the "M0" code does not deny services as non-covered or medically unnecessary. However, the Company's use of the "M0" remark code resulted in denial of benefits to the provider for services already performed.

UHIC does not receive a copy of the CCN that the provider submitted to ACN. UHIC only received the CMS 1500 claim form. Without conducting an

investigation, UHIC could not make a determination about the medical necessity of the treatment provided by the chiropractor. The DOS represented the 18th visit in the 2005 policy period. The Company may not require notification or re-notification within the first 26 visits in a policy period as a condition of coverage. Unless UHIC bases its denial on a lack of medical necessity, the Company should pay for services already provided to this patient.

The examiners requested the Company issue a benefit payment to the network provider for $29.00 for the 5/16/05 DOS.
Reference: Sections 375.1007(1), (3), and (4), (6), and 376.1230, RSMo

Claim Number	Member ID #
116038554801	559931586

Company Response:

The deficiency noted involves the administrative claims denial of services for which a chiropractor did not submit a Complete Clinical Notification (CCN), and the Department's interpretation that 376.1230, RSMo does not permit any form of prospective utilization review of the necessity of chiropractic treatment during the first 26 visits in a calendar or policy year.

376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees***.

376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. While the statute acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements,

including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by the statute. The notification process does not inhibit an enrollee's access to 26 clinically appropriate and medically necessary chiropractic visits during the policy period as required by the statute and allowed by the enrollee's Certificate of Coverage.

UHIC and ACN have both interpreted 376.1230, RSMo as specific to the issue of enrollee notification requirements in the first 26 chiropractic visits. The UHIC Certificate of Coverage filed with and approved by the Missouri Department of Insurance clearly states that enrollees do not have a notification requirement when accessing chiropractic services. As described in both the ACN Group provider agreement filed with and approved by the Missouri Department of Insurance and in the ACN Group UR program filed with and approved by the Missouri Department of Insurance the ACN Group Notification process is a provider requirement, not an enrollee requirement. To follow is a history of the Missouri Department of Insurance review and approval of the ACN UR application, UM program, Provider Manual and ACN forms.

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2003	UR Application UM Plan REV9/16/02	2/27/03	3/11/03
2004	UR Application UM Program – REV11/13/03 ACN Locations	3/08/04	3/30/04

2005	UR Application UM Program – 2005 ACN Location Changes Officers and Directors Fine Information	3/15/05	3/30/05
2006	UR Application Change to NY 800 Number	1/27/06	8/1/06
2007	UR Application UM Program - 2007 ACN Group Locations Fine Information	2/2/07	3/23/07

Through this annual review and approval process ACN believed that it was in full compliance with all Missouri statutes, including provisions of 376.1230, RSMo.

The examination report states:

> "The CCN includes the provider's description of the patient's condition, a treatment plan, and a health questionnaire completed by the patient. During the period under review, ACN considered the CCN incomplete without the patient's health questionnaire. Failure to re-submit a CCN could and did result in denial of payment for services rendered."

The examiners have misinterpreted the definition of a CCN to include a requirement that the enrollee complete the ACN Patient Health Questionnaire. The definition of a complete clinical notification (CCN) does not include the completion and submission of the ACN Group Patient Health Questionnaire (PHQ).

- Tier 1 providers are not required to use or submit the PHQ
- Tier 2 providers who submit the Provider Notification electronically report patient historical data derived from the provider's standardized patient intake and are not required to use the ACN Patient Health Questionnaire.

Tier 2 providers who voluntarily choose to submit the Provider Notification via paper as opposed to electronically via the ACN Group provider portal are required to attach the PHQ to the ACN Provider Notification. For these providers:

- Not all PHQ questions must be completed in order to satisfy the requirements of a complete clinical notification.

- The PHQ data that is submitted is not proprietary to ACN Group, does not represent a separate and distinct ACN Group requirement, is aligned with public domain chiropractic record keeping guidelines and is already routinely collected by Missouri chiropractors.
- If a patient cannot or refuses to complete the PHQ form, the provider can make a notation to that effect on the submission, and it would not be considered an incomplete submission.

The following information is provided to illustrate that, for those Tier 2 providers who voluntarily choose to submit patient intake data using the PHQ, the PHQ does not represent the collection of additional patient information that is not already routinely collected by chiropractors consistent with international chiropractic record keeping guidelines and standards of care. Additionally, the requirement is completely the obligation of the Chiropractor, not the patient. There should be no adverse impact on the patient if the PHQ form is not submitted.

Chiropractic Record Keeping Guidelines

1. Collection of Patient Data

The collection of patient historical data using a standard history form at the time of the initial evaluation, and at 4 to 6 week intervals during treatment, represents standard chiropractic practice recommended/required by; public domain guidelines regarding chiropractic practice, chiropractic professional associations, and state chiropractic licensing boards. To follow are some selected excerpts from these documents

a. The American Chiropractic Associations Clinical Documentation Manual states:

An admittance/new patient intake form(s) is typically used to collect and record subjective information. The patient initially completes the form(s) which the Doctor of Chiropractic then reviews prior to examining the patient. Any sections of the form(s) that are unclear or incomplete are then completed, clarified, and detailed. Periodic re-examinations may be completed at approximately 30-day intervals or as needed for new injury, new complaints, acute exacerbations, etc. Outcome assessment tools and pertinent data must be used to quantify progress and to set further treatment goals.

b. The American Chiropractic Association's Medical Review Benchmarks states:

> Documentation for the initial (new patient) visit, new injury or exacerbation should consist of the history and physical and the anticipated patient treatment plan. The initial treatment plan, except in chronic cases, should not extend beyond a 30-45 day interval.

c. The Guidelines for Chiropractic Quality Assurance and Practice Parameters states:

> When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation.

d. The Council on Chiropractic Practice states:

> Questionnaires may be used in the assessment of the performance of activities of daily living, pain perception, patient satisfaction, general health outcomes, patient perception outcomes, mental health outcomes, and overall quality of life, throughout a course of chiropractic care. Determination of the patient's progress must be made on a per-visit and periodic basis.

e. The International Chiropractors Association Recommended Clinical Protocols and Guidelines for the Practice of Chiropractic states:

> The organization of the patient chart may be enhanced by using pre-printed forms and by having proper identifying information on each page. When possible, history questionnaires, drawings and other information personally completed by the patient should be included in the initial documentation. The use of forms can assist in tasks such as obtaining case history, noting examination findings and charting case progress.

f. The Canadian Chiropractic Association Glenerin Guidelines states:

> Pre-printed history questionnaires that contain much of the above and other information may be used at the time of initial documentation.

The use of standardized intake forms, including measures used to evaluate patient progress, initially and at 4 to 6 week intervals is internationally recognized as standard chiropractic practice. The ACN Group Notification process is aligned with standard chiropractic practice which includes obtaining an initial patient history and performing periodic re-evaluations to document a patient's response to treatment.

2. Elements of Standardized Chiropractic Patient Intake

In addition to recommending the use of standardized patient intake forms to collect initial data regarding the patient's condition, and to monitor the patient's response to treatment at 4 to 6 week intervals, these same guidelines provide details regarding the specific data to be collected from patients using these standardized patient intake forms.

The patient data reported using the ACN Patient Health Questionnaire is very well aligned with the recommendations of these international chiropractic guidelines. In fact the majority of the questions on the PHQ are public domain questions as opposed to being proprietary to ACN Group. For those Tier 2 chiropractors who voluntarily choose to use the PHQ to report patient historical data, the PHQ is not associated with the requirement to capture any data beyond that routinely collected by chiropractors initially and at 4 to 6 week intervals as required by chiropractic documentation and record keeping.

Recording Keeping Practices of Individual Chiropractors

1. Collection of Patient Data by Missouri Chiropractors

Missouri chiropractors that post patient intake forms and policies on publicly available clinic websites uniformly follow chiropractic record keeping guidelines in that these chiropractors;

a. use standardized patient intake forms
b. have patients complete these forms prior to seeing the chiropractor on the first visit

Thus those Tier 2 chiropractors who voluntarily choose to submit patient historical data using the PHQ do not require that their patients engage in a separate and distinct patient intake process from what is performed as a matter of standard chiropractic practice.

2. Standardized Chiropractic Patient Intake Used by Missouri Chiropractors

Standardized patient intake forms posted by Missouri chiropractors on their publicly available clinic website were obtained and reviewed. A summary of the data collected by the standardized patient intake forms used by Missouri chiropractors yields several observations:

a. the record keeping practices of Missouri chiropractors are highly variable
b. the standard intake forms used by a majority of Missouri chiropractors already include many of the data elements required by chiropractic record keeping guidelines
c. For those Tier 2 chiropractors who voluntarily choose to report patient intake data using the ACN PHQ the provider can do so without having to obtain any additional data to that already collected using the provider's intake forms.

Summary: 376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. 376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees.*** Although the PHQ form requires information from the patient, it is the standard information the provider should be obtaining from the patient anyway in order to effectively treat the person. The patient has no obligation to fill out the form or submit the form. The obligation rests completely with the Chiropractor.

While 376.1230, RSMo acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by 376.1230, RSMo.

Through obtaining Missouri Department of Insurance approval of UHIC Certificates of Coverage and of the ACN UR Application and ACN UM Program UHIC and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHIC and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHIC and ACN can take to comply with the Department's current interpretation of the provisions of 376.1230, RSMo.

Compliance With 375.1007(1)(3)(4)(6) R.S.Mo.

This finding also refers to Section 375.1007(1)(3)(4)(6) R.S.Mo., which provides:

"375.1007. Any of the following acts by an insurer, if committed in violation of section 375.1005, constitutes an improper claims practice:

1. Misrepresenting to claimants and insured relevant facts or policy provisions relating to coverages at issue;
3. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;
4. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;
6. Refusing to pay claims without conducting a reasonable investigation;"

Unfair Claims Settlement Practices is listed as a reference and the Company seeks to clarify that it has not committed any improper claims practices under 375.1007(1)(3)(4)(6) R.S.Mo. The Company has not utilized any business practices or conducted itself in conscious disregard of the Unfair Claims Settlement Practices provisions as outlined in 375.1005(1) R.S.Mo.

The Company has not misrepresented relevant facts or provisions to claimants and insureds. As indicated previously, enrollees received the services and the Company does not require the enrollee to seek prior authorization or notification in order to receive the 26 visits. In addition, the enrollee is not financially responsible for the claims since the provider failed to follow the administrative guidelines within the provider contract.

UHIC has implemented reasonable standards for the prompt investigation and settlement of claims. Since the denial is an administrative denial related to an ACN contracted provider not following the provisions of the signed ACN provider agreement, this administrative denial does not require any further investigation by the organization.

In addition, the Company is making good faith efforts to effectuate prompt, fair and equitable settlement of claims submitted where liability has become reasonably clear in compliance with 375.1007(4). If the provider follows the notification process outlined in the agreement, the Company promptly settles those claims in which liability is reasonably clear. Until the proper administrative process is followed, the Company's liability is not reasonably clear.

TARGET REVIEW- HO Denied Claims

Field Size:	3,292
Sample Size:	50
Type of Sample:	ACL Random
Number of Errors:	38
Error Ratio:	76%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

1. The insured/patients received chiropractic care on the dates indicated below. The Company denied payment of benefits for these patients' dates of service per remarks code H0. In the absence of documentation to the contrary, the Company failed to pay benefits for medically necessary chiropractic care received by these patients on the dates indicated, contrary to the requirements of Missouri.

Section One reflects claims incurred in the 2005 – 2006 policy year. Section Two reflects claims incurred in the 2004 – 2005 policy year, but in the 2005 calendar year.

Reference: Sections 375.1007(1), (3), and (4), and 376.1230, RSMo

(Errors noted in the following are based upon analysis of ACL claim data provided by the Company)

SECTION ONE – 2005-2006 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
489941592 (EE)	000707768	107549618601(W)	03/23/2005 - #1
566418523 (EE)	000385318	111373214401(U)	05/20/2005 - #8
490549082 (EE)	000390687	123609980401(U)	11/18/2005 - #6
497785929 (EE)	000340411	125378905001(S)	12/22/2005 - #4
486541052 (EE)	000468002	124686265501(U)	12/13/2005 -#25
497789942 (EE)	000186567	109563511101(G)	04/22/2005 - #8
489848206 (CH)	000385835	116835050201(U)	08/16/2005 - #2
497526232 (CH)	000473384	108265243401(U)	04/01/2005 -#26
493602370 (EE)	000374896	125150128701(U)	12/14/2005 -#15
498924950 (EE)	0005R4078	115911529101(U)	07/01/2005 -#18
497809099 (CH)	000287650	111483563401(S)	05/24/2005 - #5
500665874 (EE)	000707031	114297983701(W)	04/06/2005 - #3
513880772 (EE)	000465074	107044405601(U)	03/14/2005 -#25
500748777 (SP)	000705671	114571933101(Z)	07/07/2005 -#24

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
345329499 (EE)	000345765	102852542901(S)	01/12/2005 - #5
490720738 (EE)	000463634	122385991501(U)	11/02/2005 -#21
513589971 (EE)	000448921	118294342501(U)	08/30/2005 -#19
487768378 (EE)	0001K8055	113031640201(S)	06/15/2005 - #8
487485100 (SP)	000704382	105980542801(Z)	01/25/2005 - #2
489889782 (EE)	000422070	109973205901(U)	04/26/2005 - #5
226908234 (SP)	000706901	110633806201(W)	05/10/2005 -#17
488747301 (SP)	000705680	109747545601(Z)	04/22/2005 -#12
497785929 (CH)	000340411	102368498301(S)	01/05/2005 -#13
167423656 (SP)	0005R3423	102647285001(U)	01/11/2005 - #2
498963919 (EE)	000705992	104020750201(Z)	01/26/2005 -#17
494666724 (EE)	000415884	106780123301(U)	01/04/2005 - #3

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number

497885575 (EE)	000705936	105698911401(Z)	01/05/2005 - #1
497800287 (SP)	000339313	109904286501(S)	04/29/2005 - #6
499787664 (SP)	0002P0431	117455564901(U)	08/19/2005 -#10
491661687 (EE)	000437955	106704102401(U)	02/25/2005 - #6

2. The insured/patients received chiropractic care on the dates indicated below. The Company denied payment of benefits for these patients' dates of service per remarks code H0. From a review of the documentation provided by the Company, the examiners determined that the Company failed to pay benefits for medically necessary chiropractic care received by these patients on the dates indicated, contrary to the requirements of Missouri Law.
Reference: Sections 375.1007(1), (3), and (4), and 376.1230, RSMo

(Errors noted in the following are based upon analysis of hard copy documentation provided by the Company.)

2005-2006 POLICY YEAR CLAIMS

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
400002154 (EE)	000275267	106703166801(S)	01/04/2005 - #1
355408229 (EE)	000706621	111462020101(W)	05/18/2005 -#14
499486261 (EE)	000707581	117981330001(W)	08/31/2005 -#11
491729871 (EE)	000474938	108934717801(U)	02/06/2005 - #1
488764704 (EE)	0001K8631	105132621001(S)	01/10/2005 - #1
336568995 (EE)	000418613	107695442701(U)	03/23/2005 -#12
489645640 (EE)	000276376	110200615701(S)	05/05/2005 -#13
490886937 (EE)	000704440	117443630001(Z)	08/09/2005 -#11

Company Response:

The H0 remark code is used during the claims adjudication process to administratively deny services in situations where the provider failed to participate in the ACN Notification process as described in the ACN Provider Agreement and ACN UR program filed with and approved by the Missouri Department of Insurance.

Rather than representing additional findings, these targeted reviews simply provide a more detailed review of the deficiencies and rebuttals already described in III.A.2.(a)-(e), (g), and (i)-(m) of the report, regarding denied claims.

Summary: 376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. 376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees.*** Although the PHQ form requires information from the patient, it is the standard information the provider should be obtaining from the patient anyway in order to effectively treat the person. The patient has no obligation to fill out the form or submit the form. The obligation rests completely with the Chiropractor.

While 376.1230, RSMo acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by 376.1230, RSMo.

Through obtaining Missouri Department of Insurance approval of UHIC Certificates of Coverage and of the ACN UR Application and ACN UM Program UHIC and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHIC and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHIC and ACN can take to comply with the Department's current interpretation of the provisions of 376.1230, RSMo.

Compliance With 375.1007(1)(3)(4) R.S.Mo.

This finding also refers to Section 375.1007(1)(3)(4) R.S.Mo., which provides:

"375.1007. Any of the following acts by an insurer, if committed in violation of section 375.1005, constitutes an improper claims practice:
1. Misrepresenting to claimants and insured relevant facts or policy provisions relating to coverages at issue;

3. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;
4. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;"

Unfair Claims Settlement Practices is listed as a reference and the Company seeks to clarify that it has not committed any improper claims practices under 375.1007(1)(3)(4) R.S.Mo. The Company has not utilized any business practices or conducted itself in conscious disregard of the Unfair Claims Settlement Practices provisions as outlined in 375.1005(1) R.S.Mo.

The Company has not misrepresented relevant facts or provisions to claimants and insureds. As indicated previously, enrollees received the services and the Company does not require the enrollee to seek prior authorization or notification in order to receive the 26 visits. In addition, the enrollee is not financially responsible for the claims since the provider failed to follow the administrative guidelines within the provider contract.

UHIC has implemented reasonable standards for the prompt investigation and settlement of claims. Since the denial is an administrative denial related to an ACN contracted provider not following the provisions of the signed ACN provider agreement, this administrative denial does not require any further investigation by the organization.

In addition, the Company is making good faith efforts to effectuate prompt, fair and equitable settlement of claims submitted where liability has become reasonably clear in compliance with 375.1007(4). If the provider follows the notification process outlined in the agreement, the Company promptly settles those claims in which liability is reasonably clear. Until the proper administrative process is followed, the Company's liability is not reasonably clear.

TARGET REVIEW- J0 Denied Claims

Field Size:	13,650
Sample Size:	50
Type of Sample:	ACL Random
Number of Errors:	45

Error Ratio:	90%
Within DIFP Guidelines?	No

The examiners' review of documentation provided by the Company, determined the following:

During their respective benefit periods, the enrollees listed below submitted claims for chiropractic care for specific dates of service under coverage afforded by their respective policies. The Company improperly denied payment of benefits for these claims on the basis that the network providers failed to submit CCNs to ACN as required by the providers' network agreements.

Section 376.1230.1, RSMo, provides mandatory coverage for chiropractic care. The coverage shall include initial diagnosis and clinically appropriate and medically necessary service to treat the diagnosed disorder, subject to the terms and conditions of the policy. According to the statute, an enrollee may access chiropractic care for a total of 26 chiropractic physician office visits per policy period, but may be required to provide notice prior to any additional visits. The insurance policies do not require notification or authorization prior to treatment.

Both ACN and UHIC have taken the position that the notification response letter issued by ACN is not used for utilization review of the specific patient's condition and is not intended to be an authorization or a determination of medical necessity. The Company did not deny the claims on the question of medical necessity, but relied upon administrative requirements. Per the Company's EOB, the Company denied the claims because ACN did not receive the required CCNs from the providers.

By definition, the participating provider, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health services to enrollees with an expectation of receiving payment, other than co-payments or

deductibles, directly or indirectly from the health carrier. Under the circumstances associated with the following list of claims, the enrollees received medically necessary care from the network providers. Each claim references a visit within the first 26 dates of service within the respective policy periods, and the providers should receive payment of benefits for the associated services.

Reference: Sections 375.1007(1), (3), and (4), 376.1230, and 376.1350, RSMo

(Errors noted in the following are based upon analysis of hard copy documentation provided by the Company.)

SECTION ONE – 2005-2006 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
491567994 (EE)	0005R4202	103495097701(U)	01/03/2005 - #1
497462268 (EE)	000466024	115645024201(U)	07/18/2005 - #1
330659905 (EE)	000705671	117995716201(Z)	08/29/2005 - #2
486869875 (EE)	000707567	107522023401(W)	03/09/2005 - #2
498909116 (EE)	000704873	104975466101(Z)	01/14/2005 - #3
491806958 (EE)	000364464	110524733201(S)	05/10/2005 - #3

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
513962753 (EE)	000194564	112401032501(Q)	06/02/2005 -#12
492906729 (EE)	000396890	103946986501(U)	01/19/2005 - #1
500601000 (EE)	000706579	116668492701(W)	08/10/2005 -#14
492680555 (EE)	0002P0431	103388143701(U)	01/06/2005 - #2
494543411 (SP)	000432598	102647253601(U)	01/07/2005 - #4
490843276 (EE)	0005R3035	106292780801(U)	03/07/2005 - #3
331546448 (EE)	000706161	105503492401(Z)	02/22/2005 - #8
Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
492948642 (EE)	000415866	110563139101(U)	05/04/2005 -#13
498481430 (EE)	000463183	105133004601(U)	01/27/2005 - #2

(Errors noted in the following are based upon analysis of ACL claim data provided by the Company)

SECTION ONE – 2005-2006 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
490767969 (EE)	0001P9001	103304894201(S+W)	01/17/2005 - #1
473728233 (EE)	000707955	112419715401(W)	05/03/2005 - #2
495669741 (EE)	0004N2024	119716126301(U)	06/03/2005 - #6

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
487408800 (SP)	000706790	104614132501(W)	02/01/2005 - #3
499684075 (EE)	0003N5564	115673162801(S)	07/28/2005 - #4
499684075 (EE)	0003N5564	119632095801(S)	09/26/2005 - #6
524902546 (EE)	000702017	109031920201(U+Y)	04/13/2005 - #2
478842520 (EE)	000458582	104435411401(U)	01/15/2005 - #2
490721784 (CH)	000374227	105671430701(U)	01/19/2005 - #1
490721784 (CH)	000374227	106907808201(U)	01/20/2005 - #2
489728162 (CH)	000397157	113530404801(U)	04/18/2005 - #6
500480032 (EE)	000707052	116723972601(W)	08/08/2005 -#13

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
494769780 (EE)	0002J0637	103857415101(S)	01/24/2005 - #5
486801045 (SP)	000706593	104219261301(W)	01/25/2005 - #5
489583496 (SP)	000705658	106900657101(z)	01/07/2005 -#11
500585127 (CH)	000444322	117200887301(U)	06/08/2005 - #3
493860773 (SP)	0005R1113	108297696501(U)	03/17/2005 -#16
503501708 (SP)	000341699	104592914501(S)	02/04/2005 -#13
226837476 (EE)	000706597	117493786101(W)	08/22/2005 -#10
430353750 (SP)	000274146	114014555401(S)	07/05/2005 -#23
330669978 (EE)	000318655	113509938001(S)	06/21/2005 -#23
496880366 (EE)	000441083	102401057701(U)	01/03/2005 - #3
493906096 (EE)	000342236	103258551301(S)	01/19/2005 - #2
490526627 (EE)	000458295	111549452301(U)	05/25/2005 - #3
496808650 (EE)	0004R7479	103229802401(S)	01/19/2005 - #4
496808650 (EE)	0004R7479	103945969201(S)	01/31/2005 - #8
488661855 (EE)	000407603	104703107901(U)	01/31/2005 - #5

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number

495629795 (EE)	000352284	108373649001(S)	01/19/2005 - #2
156685388 (SP)	000705671	105305698801(Z)	02/01/2005 - #1
493860773 (EE)	0005R1113	108297696401(U)	03/30/2005 -#24
500761269 (EE)	000194564	104116889701(Q)	01/27/2005 -#2*
500761269 (EE)	000194564	104116889801(Q)	01/31/2005 -#3*

* Reference: Criticism # 27(Not included in error ratio)

Company Response:

The J0 remark code is used during the claims adjudication process to administratively deny services in situations where the provider failed to participate in the ACN Notification process as described in the ACN Provider Agreement and ACN UR program filed with and approved by the Missouri Department of Insurance.

Rather than representing additional findings, these targeted reviews simply provide a more detailed review of the deficiencies and rebuttals already described in III.A.2.(a)-(e), (g), and (i)-(m) of the report, regarding denied claims.

Summary: 376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. 376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees.*** Although the PHQ form requires information from the patient, it is the standard information the provider should be obtaining from the patient anyway in order to effectively treat the person. The patient has no obligation to fill out the form or submit the form. The obligation rests completely with the Chiropractor.

While 376.1230, RSMo acknowledges the existence of provider networks that are created through provider contracts between the health carrier and the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated

by 376.1230, RSMo.

Through obtaining Missouri Department of Insurance approval of UHIC Certificates of Coverage and of the ACN UR Application and ACN UM Program UHIC and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHIC and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHIC and ACN can take to comply with the Department's current interpretation of the provisions of 376.1230, RSMo.

Compliance With 375.1007(1)(3)(4) R.S.Mo.

This finding also refers to Section 375.1007(1)(3)(4) R.S.Mo., which provides:

"375.1007. Any of the following acts by an insurer, if committed in violation of section 375.1005, constitutes an improper claims practice:
1. Misrepresenting to claimants and insured relevant facts or policy provisions relating to coverages at issue;
3. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;
4. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;"

Unfair Claims Settlement Practices is listed as a reference and the Company seeks to clarify that it has not committed any improper claims practices under 375.1007(1)(3)(4) R.S.Mo. The Company has not utilized any business practices or conducted itself in conscious disregard of the Unfair Claims Settlement Practices provisions as outlined in 375.1005(1) R.S.Mo.

The Company has not misrepresented relevant facts or provisions to claimants and insureds. As indicated previously, enrollees received the services and the Company does not require the enrollee to seek prior authorization or notification in order to receive the 26 visits. In addition, the enrollee is not financially responsible for the claims since the provider failed to follow the administrative guidelines within the provider contract.

UHIC has implemented reasonable standards for the prompt investigation

and settlement of claims. Since the denial is an administrative denial related to an ACN contracted provider not following the provisions of the signed ACN provider agreement, this administrative denial does not require any further investigation by the organization.

In addition, the Company is making good faith efforts to effectuate prompt, fair and equitable settlement of claims submitted where liability has become reasonably clear in compliance with 375.1007(4). If the provider follows the notification process outlined in the agreement, the Company promptly settles those claims in which liability is reasonably clear. Until the proper administrative process is followed, the Company's liability is not reasonably clear.

TARGET REVIEW- M0 Denied Claims

Field Size:	3,695
Sample Size:	50
Type of Sample:	ACL Random
Number of Errors:	29
Error Ratio:	58%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

1. During their respective benefit periods, the enrollees listed below submitted claims for chiropractic care for specific dates of service under coverage afforded by their respective policies. The Company improperly denied payment of benefits for these claims on the basis that the network providers failed to re-submit a CCN to ACN as required by the providers' network agreements.

Section 376.1230.1, RSMo, provides mandatory coverage for chiropractic care. The coverage shall include initial diagnosis and clinically appropriate and medically necessary services...to treat the diagnosed disorder, subject to the terms and conditions of the policy. According to the statute, an enrollee may access chiropractic care for 26 chiropractic physician office visits per policy period, but

may be required to provide notice prior to any additional visits. The policies do not require notification or authorization prior to treatment during the first 26 dates of service.

Both ACN and UHIC have taken the position that the notification response letter issued by ACN is not based upon utilization review of the specific patient's condition and is not intended to be an authorization or a determination of medical necessity. The Company did not deny these claims on the question of medical necessity, but relied upon administrative requirements of the providers' contracts. The Company issued its denial of benefits for these claims with remark code "M0". The EOBs' explanation of this code states, "This date exceeds the number of visits indicated in the ACN Group notification response; re-notification was required. The patient may not be billed for amounts declined when administrative requirements are not followed."

By definition, the participating provider, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health services to enrollees with an expectation of receiving payment, other than co-payments or deductibles, directly or indirectly from the health carrier. Under the circumstances associated with the following list of claims, the enrollees received medically necessary care from the network providers. Each claim references a visit within the first 26 dates of service within the respective policy periods and the providers should receive payment of benefits for the associated services.
Reference: Sections 375.1007(1), (3), and (4), 376.1230, and 376.1350, RSMo

(Errors noted in the following are based upon analysis of hard copy documentation provided by the Company.)

SECTION ONE – 2005-2006 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
487924723 (SP)	0001K8631	120661176001(S)	10/11/2005 -#17
498787125 (EE)	000396862	106704080501(U)	03/14/2005 -#13

547863506 (EE)	0003N9157	122073313901(U)	08/18/2005 -#11
514666662 (EE)	000704464	115413753101(Z)	07/13/2005 -#19
499582667 (EE)	000313131	115179927001(S)	07/11/2005 - #4
449981884 (EE)	000299050	115022785401(S)	07/18/2005 -#17

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
487602466 (SP)	000438696	106544724901(U)	02/28/2005 -#18
493945169 (EE)	000705793	106620378401(Z)	02/15/2005 - #7

(Errors noted in the following are based upon analysis of ACL claim data provided by the Company)

SECTION ONE – 2005-2006 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
355484115 (EE)	000385522	113078260001(U)	04/11/2005 - #5
355484115 (EE)	000385522	113078260001(U)	04/13/2005 - #6
510844095 (EE)	000488646	116390096601(U)	08/05/2005 -#14
421640250 (EE)	000410661	118409046101(U)	09/09/2005 -#21
488968240 (EE)	000375190	110172187501(U)	04/29/2005 -#18
487965131 (EE)	0003N7600	105326517801(U)	02/04/2005 - #2
490589009 (EE)	000468442	113616156401(U)	06/27/2005 -#11
487768635 (EE)	000392250	122171385201(U)	10/11/2005 -#13

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
488947409 (EE)	000319018	107404950701(S)	03/23/2005 -#15
513828901 (EE)	000701328	117736241901(Y)	06/09/2005 -#12
497548073 (EE)	000706057	111560516701(Z)	05/26/2005 -#12
498346522 (SP)	000323663	110736337401(S)	04/29/2005 - #9
488561290 (CH)	000325138	104491556301(S)	01/31/2005 -#10
492504659 (EE)	000703567	107420232901(M)	03/11/2005 -#15
492706255 (SP)	000323595	106992478101(S)	03/04/2005 -#17
551671653 (EE)	000442331	107074441301(U)	03/07/2005 -#10
511662282 (EE)	000357092	114558268801(S)	07/11/2005 -#18
488826870 (EE)	000700728	109673967501(F)	04/22/2005 -#22

488826870 (EE)	000700728	109673967601(F)	04/20/2005 -#21
488826870 (EE)	000700728	110701694801(F)	04/29/2005 -#23
498449206 (SP)	000346322	116230249101(S)	08/03/2005 -#19

Company Response:

The M0 remark code is used during the claims adjudication process to administratively deny services in situations where the provider failed to participate in the ACN Notification process as described in the ACN Provider Agreement and ACN UR program filed with and approved by the Missouri Department of Insurance.

Rather than representing additional findings, these targeted reviews simply provide a more detailed review of the deficiencies and rebuttals already described in III.A.2.(a)-(e), (g), and (i)-(m) of the report, regarding denied claims.

Summary: 376.1230, RSMo is a mandated benefits statute, not a provider relations or provider contracting statute. 376.1230, RSMo focuses on the benefits that an enrollee must receive under the carrier's certificate of coverage. It specifically refers to an enrollee's ability to access network services without the ***enrollee*** having to seek or provide prior authorization or notification. The enrollee is specifically referenced in the statute because the statute only pertains to the benefit design under a carrier's certificate of coverage. United Healthcare and ACN do not impose any prior notification requirements on ***enrollees.*** Although the PHQ form requires information from the patient, it is the standard information the provider should be obtaining from the patient anyway in order to effectively treat the person. The patient has no obligation to fill out the form or submit the form. The obligation rests completely with the Chiropractor.

While 376.1230, RSMo acknowledges the existence of provider networks that are created through provider contracts between the health carrier and

the provider, it is silent on the issue of a provider's ability to accept the carrier's administrative requirements, including requirements related to notification. Providers have accepted the prior notification requirement as a condition of doing business with the health carrier, just as they routinely accept other administrative requirements appearing in provider-health carrier agreements. None of that activity is prohibited or even contemplated by 376.1230, RSMo.

Through obtaining Missouri Department of Insurance approval of UHIC

Certificates of Coverage and of the ACN UR Application and ACN UM Program UHIC and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHIC and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHIC and ACN can take to comply with the Department's current interpretation of the provisions of 376.1230, RSMo.

Compliance With 375.1007(1)(3)(4) R.S.Mo.

This finding also refers to Section 375.1007(1)(3)(4) R.S.Mo., which provides:

"375.1007. Any of the following acts by an insurer, if committed in violation of section 375.1005, constitutes an improper claims practice:
1. Misrepresenting to claimants and insured relevant facts or policy provisions relating to coverages at issue;
3. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;
4. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;"

Unfair Claims Settlement Practices is listed as a reference and the Company seeks to clarify that it has not committed any improper claims practices under 375.1007(1)(3)(4) R.S.Mo. The Company has not utilized any business practices or conducted itself in conscious disregard of the Unfair Claims Settlement Practices provisions as outlined in 375.1005(1) R.S.Mo.

The Company has not misrepresented relevant facts or provisions to claimants and insureds. As indicated previously, enrollees received the

services and the Company does not require the enrollee to seek prior authorization or notification in order to receive the 26 visits. In addition, the enrollee is not financially responsible for the claims since the provider failed to follow the administrative guidelines within the provider contract.

UHIC has implemented reasonable standards for the prompt investigation and settlement of claims. Since the denial is an administrative denial related to an ACN contracted provider not following the provisions of the signed ACN provider agreement, this administrative denial does not

require any further investigation by the organization.

In addition, the Company is making good faith efforts to effectuate prompt, fair and equitable settlement of claims submitted where liability has become reasonably clear in compliance with 375.1007(4). If the provider follows the notification process outlined in the agreement, the Company promptly settles those claims in which liability is reasonably clear. Until the proper administrative process is followed, the Company's liability is not reasonably clear.

TARGET REVIEW- 9L Denied Claims

Field Size:	1,053
Sample Size:	30
Type of Sample:	ACL Random
Number of Errors:	11
Error Ratio:	36.66%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

Based upon data provided by the Company, the examiners made a random sample of claims denied per remark code "9L". This denial code states, "According to our records, your annual maximum benefit for this therapy service and/or associated expenses has been paid. Therefore, no further benefits are payable for this benefit period." The examiners determined that the Company improperly denied the following claims.

Missouri law mandates chiropractic benefits for the diagnosis and treatment of medically necessary and clinically appropriate chiropractic care for 26 visits in a policy period. The Company did not deny the claims listed below for reasons of medical necessity. Instead, the Company based its denial of benefits on the basis that the insured/patient had exceeded the number of visits allowed by the policy. It

appears that the Company calculated its policy benefits based upon utilization within the calendar year as opposed to the benefit period of the policy. In each instance, the DOS did not exceed the number of visits allowed by the plan or by Missouri's mandated chiropractic benefit statute.

The Company did not pay the claims within 45 days of receipt as required by statute. The examiners requested the Company review these claims and issue benefits based upon the applicable "Day Rate".

For those claims filed electronically, the Company is responsible for payment of interest according to the requirements of section 376.383, RSMo. Based upon the claim data provided by the company, the examiners identified two claims that subject to payment of interest (124923731001 and 123098638201). \
Reference: Sections 375.1007(1), (3), (4), and (6), 376.383, and 376.1230, RSMo

(Errors noted in the following are based upon analysis of ACL claim data provided by the Company)

SECTION ONE – 2005-2006 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
510662775 (EE)	000704440	122755702501(Z)	11/14/2005 - #8
508722467 (EE)	000326288	*124923731001(S)	12/13/2005 -#7
497704904 (EE)	000445507	123327247501(U)	11/17/2005 - #7
495820801 (EE)	000433902	123251431401(U)	11/02/2005 -#11
488503553 (EE)	000705812	114814867801(Z)	07/13/2005 - #3
488503553 (EE)	000705812	115909052401(Z)	07/29/2005 - #5
490647065 (SP)	000706065	125263203301(W)	12/21/2005 -#12
359563251 (EE)	000706065	123098638201(Z)	11/17/2005 -#19
953657745 (SP)	000375229	**124220222801(U)	11/30/2005 -#28
486708750 (EE)	000391911	122849498401(U)	11/04/2005 -#18

* NOTE: The Company underpaid this claim. The Company only allowed $25 as opposed to the $40 day rate. The Company applied $20 to the co-pay and only paid $5.00 as opposed to $20.00. $15.00 remains payable to the provider.

** NOTE: The Company did not deny any of the dates of service for this insured/patient based on lack of medical necessity. While this was the 28th visit in the 2005 policy year, the Company had only paid 20 visits to this point in the 2005 policy year. According to the terms of the chiropractic rider, the Company owed payment for an additional six visits. The Company failed to pay the six preceding (9/21/05, 9/27/05, 10/11/05, 10/26/05, 11/1/05, and 11/16/2005) dates of service. Consequently, this claim would be payable even under the terms of the rider as it would not exceed the limit of 26 visits.

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	Date of Service/ Visit Number
488966550 (EE)	0004R3497	102208530101(Z)	12/27/2004 - #3
500761269 (EE)	000194564	119631016801	09/28/2005 -#26

Company Response:

The Unfair Claims Settlement Practices is listed as a reference and the Company seeks to clarify that it has not committed any improper claims practices under 375.1007(1)(3)(4)(6) R.S.Mo. The Company has not utilized any business practices or conducted itself in conscious disregard of the Unfair Claims Settlement Practices provisions as outlined in 375.1005(1) R.S.Mo.

In reference to 376.1230, the Company has the following comments:

Relative to ID number 495620151, group number 704559, claim number 121854433101, the Company acknowledges that services were denied which exceeded the stated benefit limit of 12 visits per year. However, the Company respectfully disagrees that these denials were erroneous. As this policy is issued out of Arizona, the chiropractic benefits mandated by the State of Missouri are not applicable. Please refer to the print screens below which were extracted from UNET identifying the policy number and employee number (A) and the same policy number and state of issue (SOI field) as AZ (B).

A.

```
            CONSOLIDATED ELIGIBILITY SYSTEM SUMMARY MAINTENANCE
        3 DEPENDENTS                                    NO MORE COVERAGES
CUSTOMER 0704559 EE 00495620151 ALT-ID 00910649003 CORP            POL
UPD   DCN              IDC              PREFIX   LB Z
LAST NAME [redacted]            FIRST BRUCE        MI   SEX M M/S M
SSN              REL 0 SEQ 001 TIC: REL EE SEQ 00 RETIRE            LATE ENRL
BIRTH 09 01 1955 VIP    XREF EE                  EMPLOYMENT DATE 08 04 2003
```

B.

```
CUST 0704559 GROUP 0704559 DIVISION           COV M  BENEFIT SET ACIS0
START 01 01 2004 STOP 12 31 2006 LEGAL-ENT1 30100 LEGAL-ENT2       OI 01
OPTUM Y       NON-MEDICAL   RETRO: RESTRICT M TIME 060 ODN Y    PI
BEN-START 01 01 2006 BEN-STOP 12 31 2006    FBI T PT Q  PC PS1M0109999 F
COPAYS:  PCP        SPC        HOSP        ER 075.00 DRUG        OFF 01
         URG 035.00 PED        PRT: 006 IPLAN 1 P-LVL    SOI AZ CML 01 F
RIDERS: CHEM        VIS V1F    MH          CHIRO        DEN
        DRUG        SPH        RXMX          HMO                TRVL
```

TARGET REVIEW- JO Denied Claims

Field Size:	72
Sample Size:	72
Type of Sample:	Census
Number of Errors:	38
Error Ratio:	52.77%
Within DIFP Guidelines?	No

The examiners conducted a review of chiropractic claims that the Company denied with remark code "JO". The examiners analyzed the enrollees' claim histories to ensure that the dates of service in question were not subsequently paid or denied for another valid reason. The examiners listed only claims that would otherwise have been paid had the proper determination been made. The examiners excluded those claims denied with both a "JO" (alpha) remark code and a "J0" (numeric) remark code in order to avoid duplication of the issues relative to the "J0" denials addressed elsewhere in the report. The study involved 33 enrollees with 72 DOS.

It appears the Company inadvertently denied the following Chiropractic claims with remark code "JO". The interpretation for this code states, "Your supplemental executive plan has a dental benefit limit. Payment has been made based upon that limit." The code failed to reflect a proper claim determination relative to the circumstances of the claims in question.
Reference: Sections 375.1007(1), (3), (4), and (6), 376.383, and 376.1230, RSMo

The examiners requested the Company issue benefit payments to the network providers associated with the claims.

Member ID #	Group Pol. #	Date of Service	Claim Number
493844568 (EE)	000395709	04/06/05	109112116402
490767969 (EE)	0001P9001	01/19/05	103387724201
506749947 (CH)	0005R0655	02/28/05	105807657702
559825064 (EE)	000438718	01/26/05	106544690601
Member ID #	Group Pol. #	Date of Service	Claim Number
559825064 (EE)	000438718	01/27/05	106544690601
559825064 (EE)	000438718	01/28/05	106544690602
559825064 (EE)	000438718	01/31/05	106544690602
559825064 (EE)	000438718	02/02/05	106544690603
559825064 (EE)	000438718	02/04/05	106544690603
559825064 (EE)	000438718	02/14/05	106544690605
559825064 (EE)	000438718	02/17/05	106544690605
559825064 (EE)	000438718	02/24/05	106544690605
499909212 (EE)	000273445	06/02/05	112629004601
494445797 (EE)	000707599	05/02/05	112322545102
494445797 (EE)	000707599	05/09/05	112322545102
494445797 (EE)	000707599	05/16/05	112322545102
491780295 (SP)	000707170	04/12/05	110502538301
499781581 (EE)	000467905	07/13/05	114974127301
500525501 (EE)	000375190	01/31/05	104674189302
488747301 (SP)	000705680	02/02/05	104409787801
493908303 (EE)	000705812	07/13/05	118191384501
493908303 (EE)	000705812	07/14/05	118191384501
493908303 (EE)	000705812	07/18/05	118191384501
493908303 (EE)	000705812	07/20/05	118191384501
493908303 (EE)	000705812	07/25/05	118191384501
493908303 (EE)	000705812	07/05/05	118191384503

493908303 (EE)	000705812	07/06/05	118191384503
493908303 (EE)	000705812	07/07/05	118191384503
493908303 (EE)	000705812	08/24/05	118191384503
500584204 (EE)	000708003	07/11/05	114559813701
496981195 (SP)	000330999	10/25/05	123088558601
500608775 (EE)	000385495	01/26/05	103671229201
482566563 (EE)	000294849	02/22/05	107424183201
424820952 (EE)	000707321	11/07/05	125710341201
424820952 (EE)	000707321	11/14/05	125710341201
424820952 (EE)	000707321	11/21/05	125710341201
424820952 (EE)	000707321	11/28/05	125710341201
424820952 (EE)	000707321	12/05/05	125710341201

Company Response:

The Company agrees with the facts that the JO (alpha) remark code was utilized. These errors were due to a processor typing the wrong character and were not related to a systemic process. The Company will issue a communication to claims processors reminding them how to distinguish these codes and that chiropractic codes are zeroes and not O's.

The Company will review these claims with ACN to confirm whether the provider failed to submit the complete clinical notification as indicated in a J0 (numeric) remark code. The Company respectfully disagrees with issuing benefit payments at this time and with the Examiner statement that "would otherwise have been paid had the proper determination been made". The Company's position regarding "J0" denials has been outlined in the response to Criticism #9 for UHIC and the Company response to "Target Review – J0 Denied Claims". Both are incorporated into the response to this allegation.