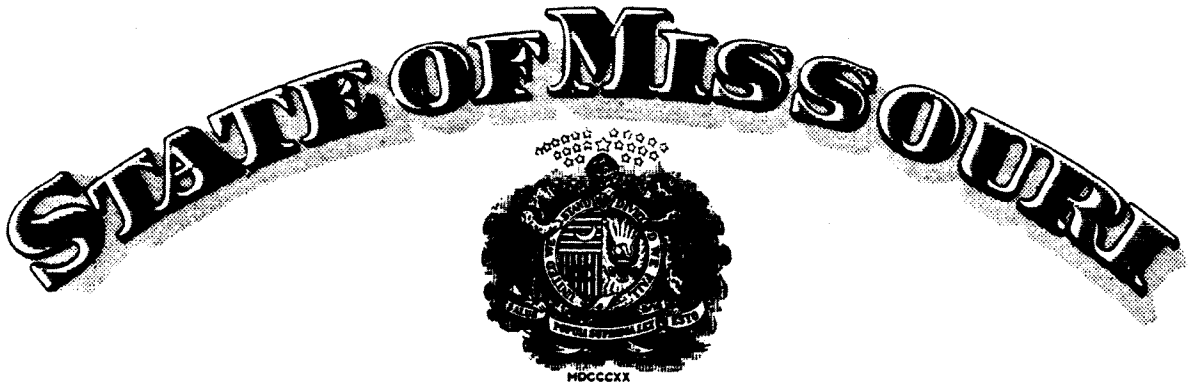

DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

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

In re:	)	
United Healthcare of the Midwest (NAIC #96385)	)	Examination No. 0603-18 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 of the Midwest (NAIC #96385), (hereafter referred to as "UHCMW") and ACN, Inc. report numbered 0603-18 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 UHCMW 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 UHCMW shall not engage in any of the violations of law and regulations set forth in the Stipulation and shall implement procedures to place UHCMW 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 UHCMW shall pay, and the Department of Insurance, Financial Institutions and Professional Registration, State of Missouri, shall accept, the Voluntary Forfeiture of $174,663.08, 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 of the Midwest
Office of the President
13655 Riverport Dr.
Maryland Heights, MO 63043

RE: Missouri Market Conduct Examination 0603-18 and -19-TGT
United Healthcare of the Midwest (NAIC #96385) 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 of the Midwest (NAIC #96385) and ACN, Inc., (hereafter collectively referred to as "UHCMW"), 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, UHCMW 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 UHCMW and prepared report number 0603-18 and -19-TGT; and

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

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

6. In some instances, UHCMW denied chiropractic claims by improperly coding the denials of the claims.

7. UHCMW failed to timely and completely respond to one of the examiners' requests for information and criticisms, thereby violating §374.205, RSMo.

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

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

2. UHCMW 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 re-file 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. UHCMW 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 any claims as described in the exam report. For those claims improperly denied, UHCMW 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. UHCMW 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; and

4. UHCMW 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. UHCMW 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, UHCMW 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, UHCMW, 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, UHCMW hereby agrees to the imposition of the ORDER of the Director and as a result of Market Conduct Examination #0603-18 and -19-TGT further agrees, voluntarily and knowingly to surrender and forfeit the sum of $174,663.08.

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 UHCMW to transact the business of insurance in the State of Missouri or the imposition of other sanctions, UHCMW 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 $174,663.08, such sum payable to the Missouri State School Fund, in accordance with §374.280, RSMo.

DATED: 7/29/09

President
United Healthcare of the Midwest, Inc.

EXHIBIT A

UHCMW 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. UHCMW 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, UHCMW 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. UHCMW may deny a claim for failure to provide the requested medical information.

7. UHCMW 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. UHCMW 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 OF THE MIDWEST

NAIC NUMBER: 96385

And

ACN, INC.

13655 Riverport Drive
Maryland Heights, Missouri 63043

May 29, 2009

DIFP EXAMINATON REPORT NUMBERS: 0603-18, 19-TGT

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FOREWORD

This market conduct report regarding the operations of the United Healthcare of the Midwest, Inc. and ACN, Inc. is in general, a report by exception. The examiners, in writing this report, cited errors made by the Companies. 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, Inc. (formerly, American Chiropractic Network);

"CCN" refers to Complete Clinical Notification;

"Company" refers to United Healthcare of the Midwest, 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;

"NR" refers to Notification Response Letter;

"RSMo" refers to Revised Statutes of Missouri;

"UHCMW" refers to United Healthcare of the Midwest, Inc.;

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

"UR" refers to Utilization Review;

"URC" refers to Usual, Reasonable, and Customary; and

"TPA" refers to Third Party Administrator

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 UHCMW and ACN, in their respective handling of claims and utilization review of chiropractic services provided to members, complied with Missouri's Insurance Laws and with DIFP regulations. In addition, the examiners reviewed the operations of the companies to determine if these were consistent with the public interest.

The examination focused upon the general business practices of the companies, while the examination team cited errors found in individual files. The DIFP 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 is 5% for prompt pay issues. 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 of the Midwest, Inc.
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 the network provider 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 one large group 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. As a consequence, 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 UHCMW'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 pages 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 licenses to manage its chiropractic network and perform utilization review and claims processing as a TPA in the State of Missouri.

Regarding these companies' operations in Missouri, the examiners determined that UHCMW complies with its Certificates of Authority, and ACN complies with its licenses to operate in its capacities as a UR agents and .as a TPA.

B. Advertising

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

The examiners noted no issues with regard to advertising material generated by UHCMW. The examiners note that within the context of utilization review and network management, ACN Inc. leaves the determination of medical necessity up 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 violated 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 unfairly limited coverage to 20 visits in a calendar year.
Reference: Section 376.1230, RSMo

Group Policy Number	Rider Identification Number
000705697	98CHIRO/NETPLS (CHP152.DOC) (CHP2030.DOC)

2. The Company's group policies or chiropractic riders describe the coverage afforded enrollees of group health plans as defined by section 376.1350, RSMo. The policies or 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 83 patients and 431 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

Choice – H.01.MO/IL
Choice Plus – H.01.MO/IL
Select – H.01.MO/IL
Select Plus – H.01.MO/IL

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:	34,414
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:	29,239
Sample Size:	50
Type of Sample:	ACL Random
Number of Errors:	8
Error Ratio:	16%
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 000407704, effective 05/01/2004. 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's denial 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, UHCMW 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 payment to the network provider for $34.00.
Reference: Sections 375.1007(1), (3), and (4), and 376.1230, RSMo

Claim Number	Member ID #
102473962201	312720404

b) The Company afforded the insured patient coverage under group policy number 000705697 effective, 07/01/2005. The Company unfairly denied payment of benefits for chiropractic care for the 10/04/2005 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, UHCMW 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 for $24.00 for the 10/04/05 DOS. In addition, the Company owes interest on this electronically filed claim submitted on 10/11/2005 at the rate of one percent per month from the 46 day after submission of the claim to the date of payment. Reference: Sections 375.1007(1), (3), and (4), 376.383, and 376.1230, RSMo

Claim Number	Member ID #
102240852501	488605686

c) The Company afforded the insured patient coverage under group policy number 000269018, effective 09/01/2004. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 07/12/2005 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, UHCMW and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violates the requirements of Missouri law.

The examiners believe the allowed amount should be the "Day Rate" of $40. However, the examiners could not readily ascertain the appropriate amount payable because of the varied payments made by the Company on previously processed claims. For the 02/17/05 DOS, the Company allowed $40.00, deducted $15.00 for a co-payment and paid $25.00. For the next two dates of service (04/26/05 and 05/18/05), the Company allowed $35.00, applied $7.00 coinsurance and paid $28.00. The examiners requested an explanation for the inconsistent payments. The examiners requested a copy of the member's benefit schedule or other documentation to support the correct allowed amount and the correct amount for the member's portion of the claim.

The examiners requested the Company issue a benefit payable to the network provider for the appropriate amount for the 07/12/2005 DOS. In addition, the Company owes interest on this electronically filed claim at the rate of one percent per month from the 46 day after submission of the claim to the date of payment. Reference: Sections 375.1007(1), (3), and (4), 376.383, and 376.1230, RSMo

Claim Number	Member ID #
114615384501	494584819

d) The Company afforded the insured patient coverage under group policy number 000705697, effective 07/01/2005. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 01/07/2005 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, UHCMW 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 for $29.00 for the 01/07/05 DOS.
Reference: Sections 375.1007(1), (3), and (4), 376.1230, RSMo

Claim Number	Member ID #
102477299701	494640268

e) The Company afforded the insured patient coverage under group policy number 000325732, effective 09/01/2004. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 05/17/2005 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, UHCMW and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violates the requirements of Missouri law.

The examiners believe the allowed amount should be the "Day Rate" of $40. The examiners could not readily ascertain the appropriate amount payable because of the varied payments made by the Company on previously processed claims. The

Company processed claims for the 05/10/05 and 05/12/05 dates of service under one claim number, (111108096401). The claim records show no payment was made for the 05/12/05 DOS. The claim record shows two separate allowed amounts for the 05/10/05 DOS ($25 and $55). Neither of these allowed amounts reflects the "Day Rate" of $40.00. However, the combined amount equals $80.00 which could have been intended to account for two separate "Day Rate" amounts of $40.00. However, the adjustment on the entry of $25.00 allowed for the 05/10/05 DOS shows the Company applied $2.50 as co-insurance while the other entry of $55.00 shows a co-payment of $10.00. The Company paid a total of $67.50 for the 05/10/05 DOS. The examiners requested the Company to provide an explanation for the inconsistent payments and a copy of the member's benefit schedule to support the correct allowed amount and the correct amount for the member's portion of the claim.

The examiners asked the Company to issue a benefit payable to the network provider for the appropriate amount for the 05/17/05 DOS.
Reference: Sections 375.1007(1), (3), (4) and 376.1230, RSMo

Claim Number	Member ID #
111996237901	495786275

f) The Company afforded the insured patient coverage under group policy number 000705812, effective 07/01/2004. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 06/15/2005 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, UHCMW and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violates the requirements of Missouri law.

The examiners asked the Company to issue a benefit payable to the network provider for $24.00 for the 10/04/05 DOS. In addition, the Company owes interest on this electronically filed claim submitted on 10/11/2005 at the rate of one percent per month from 46 day after the claim was submitted to the date paid.
Reference: Sections 375.1007(1), (3) and (4), 376.383, and 376.1230, RSMo

Claim Number	Member ID #
113535665101	496801247

g) The Company afforded the insured patient coverage under group policy number 000705697, effective 07/01/2004. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 06/15/2005 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."

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. By its own admission, UHCMW does not engage in utilization review of the services provided by ACN's network providers. According to both ACN and UHCMW, ACN is not involved in the claim process. However, ACN initiated application of the "M0" remark code that resulted in denial of payment. It does not appear that UHCMW made any determination on the issue of medical necessity, nor did it investigate the recovery milestone's applicability to the specific patient under care.

According to UHCMW and ACN, the notification process requires a provider to submit a standardized medical record form that contains data about the patient under care. After its review of the CCN, ACN establishes a duration-based 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 new notification. The "CCN" refers to ACN'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 did result in denial of payment for the services rendered.

Both ACN and UHCMW take 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. 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.

UHCMW does not receive a copy of the CCN submitted by the provider to ACN. UHCMW only received the CMS 1500 claim form. Without conducting an investigation, UHCMW could not make a determination about the medical necessity of the treatment provided by the chiropractor. The DOS was the 12th visit in 2005. The Company may not require notification within the first 26 visits in a policy period as a condition of coverage. Unless UHCMW bases its denial of payment 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 check payable to the network provider for $24.00.

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

Claim Number	Member ID #
104975313801	500922728

h) The Company afforded the insured patient coverage under group policy number 000705697, effective 07/01/2004. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 05/02/2005 DOS per denial code "H0" that states, "ACN received the Healthcare provider's notification for this date or service shown. We were unable to approve this service or length of time requested. Please refer to our response to the health care provider's notification for an explanation of the denial. The patient may not be billed for amounts declined when administrative requirements are not followed." While the Company used a standardized EOB, it did not provide a description of the reason for the denial.

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. UHCMW does not engage in utilization review of the services provided by ACN's network providers. According to both ACN and UHCMW, ACN is not involved in the claim process. However, ACN initiated application of the "H0" remark code that resulted in denial of payment. It does not appear that UHCMW made any determination on the issue of medical necessity, nor did it investigate the recovery milestone's applicability to the specific patient under care. UHCMW conducted neither utilization review nor an investigation to make a determination on the issue of medical necessity. As such, UHCMW cannot deny the claim on the basis that it cannot approve the service or length of time requested.

According to UHCMW and ACN, the notification process requires a provider to submit a standardized medical form that contains data about the patient under care. Once ACN receives notification from the provider, it establishes a duration-based milestone for the treatment. If the patient's condition requires treatment beyond the established milestone, ACN requires the provider to re-submit a follow-up CCN. The CCN refers to ACN's standardized medical form which 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 the services already 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 "H0" code does not deny services as non-covered or medically unnecessary. However, the Company's use of the "H0" remark code resulted in denial of benefits to the provider for services already performed.

The Company's explanation for the denial of this claim failed to satisfy the requirements of Section 376.1400, RSMo. The language in the EOB gives the impression that UHCMW reviewed the provider's notification and made the determination that it could not approve the service or length of time requested. UHCMW does not receive a copy of the CCN submitted by the provider to ACN. UHCMW only received the CMS 1500 claim form. Without conducting an investigation, UHCMW could not make a determination about the medical necessity of the treatment provided by the chiropractor. The DOS was the third visit in the policy year. The statute prohibits the notification requirement within the first 26 visits in a policy period. Unless UHCMW's bases it denial on a lack of medical necessity, the Company should pay for services already provided to this patient.

The examiners could not readily ascertain the correct amount payable to the provider because of the variance in other claims paid for this patient. Subsequent to

the claim in question the Company made payment for services provided on 08/17/05 and 10/05/05. The allowed amount for the 08/17/05 DOS equaled $40, while the amount shown for the 10/05/05 DOS equaled $44.00. The examiners believe the "Day Rate" should be $44.00 based upon the location of the provider.

The examiners requested the Company issue a benefit check payable to the network provider for $24.00. Claims filed electronically are subject to payment of interest. As such, the examiners request payment of interest at the rate of one percent per month from 46 day after submission of the claim to the date of payment. Reference: Sections 375.1007(1), (3), (4) and (6), 376.383, and 376.1230, and 376.1400, RSMo

Claim Number	Member ID #
110205005601	486542995

B. Target Review – H0 Denied Claims

Field Size:	1,089
Sample Size:	50
Type of Sample:	ACL Random
Number of Errors:	35
Error Ratio:	70%
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

(The examiners noted errors in the following 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	DOS/ Visit Number
487542983	000705697	114814816601	07/01/2005 - #1
490829536	000701916	112574720401	06/10/2005 -#17
229359280	000706963	120705305601	09/19/2005 - #1
492548792	000706787	120391337801	10/07/2005 -#11
313924680	000705697	116846361201	08/16/2005 -#19
500424647	000705697	123951165601	11/29/2005 -#19
493426121	000705697	114169761901	07/01/2005 - #1
393641778	000703818	113966203401	07/01/2005 - #1
498767577	000706962	120391344901	10/14/2005 - #9
498946948	000705697	123338050401	11/21/2005 -#24
498946948	000705697	123437741101	11/21/2005 -#25
494500920	000275196	108231500701	04/04/2005 -#18

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' Numbers	Group Number	Claims Number	DOS/ ID Visit Number
269507725	000705697	104433257001	02/07/2005 - #6
498881692	000705697	110455542001	04/26/2005 -#11
381746589	000705697	108097561101	03/29/2005 -#12
495741070	000705697	107089703601	03/18/2005 - #2
499527545	000705697	110798471701	05/14/2005 -#11
488706645	000705697	112365756601	06/08/2005 -#22
496826997	0001p8022	104986770801	02/17/2005 -#23
486542995	000705697	107578053001	03/14/2005 - #2
486542995	000705697	107578053001	05/02/2005 - #3
496569627	000438730	111494534101	05/24/2005 -#11
499824109	000274179	104125827001	01/24/2005 - #3

2. The insured/patients received chiropractic care on the dates indicated below. The Company denied payment of benefits for these patients' DOS per remark 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 law. The insured/patient shall have access to medically necessary chiropractic care for the first 26 visits in a policy period without the necessity of providing notification as a condition of coverage.

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

(The examiners noted errors in the following 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	DOS/ Visit Number
495786275	000325732	119599057001	09/21/2005 - #5
482987928	000705521	110237408101	04/29/2005 - #3
499682526	000706787	107354208401	03/24/2005 -#27
498767577	000706962	120754145401	10/14/2005 - #9
498946948	000705697	122397770101	11/08/2005 -#21
495940258	000705697	119048890101	09/19/2005 - #4

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	DOS/ Visit Number
134401017	000705697	102372568801	01/04/2005 - #5
493426121	000705697	112712654901	06/04/2005 -#18
486523067	000705697	112092449101	04/12/2005 - #1
486768382	000346399	115613495701	07/21/2005 - #1
490885861	000385631	102804162301	01/05/2005 -#12
488700614	000705697	103650989803	01/13/2005 - #1

C. Target Review – J0 Denied Claims

Field Size:	3,954
Sample Size:	50
Type of Sample:	ACL Random
Number of Errors:	41
Error Ratio:	82%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

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 CCN's 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 a total of 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.

Both ACN and UHCMW 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 the claims on the question of medical necessity, but relied upon administrative requirements. Per the Company's EOB explanation, the claims denied because ACN did not receive 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

(The examiners noted errors in the following 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	DOS/ Visit Number
447446736 (EE)	000705697	116038544201(Z)	08/02/2005 - #1
404700518 (EE)	000701916	109412280901(Y)	03/29/2005 -#17
492823111 (EE)	000705697	118415851701(Z)	09/07/2005 - #6
492800704 (EE)	000705697	115587241401(Z)	07/15/2005 - #4
337461512 (EE)	000705697	116360964301(Z)	08/05/2005 - #9
499825691 (SP)	000706850	112502721201(W)	06/01/2005 - #4
492042164 (EE)	000705697	124504266301 (Z)	11/17/2005 -#10
338403183 (EE)	000705697	123584894001(Z)	11/23/2005 - #1

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	DOS/ Visit Number
570642288 (EE)	000705697	103950487801(Z)	01/31/2005 -#12
493941636 (SP)	000705697	104517237401(Z)	02/03/2005 - #1
493681738 (SP)	000438109	118421108301(U)	08/31/2005 - #5
329540101 (EE)	000705697	113688549701(Z)	05/18/2005 - #1
499726677 (EE)	000705697	102504807201(Z)	01/07/2005 - #5
498723035 (EE)	000705697	102739245501(Z)	01/11/2005 - #1
571669925 (EE)	000705696	112748666101(Z)	06/13/2005 -#11

(The examiners noted errors in the following 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	DOS/ Visit Number
487541089 (CH)	000705697	118471914301(Z)	07/11/2005 - #1
496980094 (EE)	0001S0979	111404825201(U)	05/19/2005 - #4
492823111 (EE)	000705697	117104921601(Z)	08/16/2005 - #4
486587556 (SP)	000707721	111191191401(W)	05/18/2005 - #9
487462231 (CH)	000706917	125152466601(W)	10/03/2005 - #2
498624907 (EE)	000705815	115055129901(Z)	07/19/2005 - #1
500945448 (EE)	000701648	124788338701(C)	09/14/2005 - #2
499825691 (SP)	000706850	114151220901(W)	06/27/2005 -#14
444808691 (EE)	0005R4008	115002924601(U)	07/13/2005 -#19
400003554 (EE)	0005R5595	113926298501(U)	06/10/2005 - #3
276602785 (EE)	000703818	11560659501(M)	07/15/2005 - #1
500607999 (SP)	000707027	118528200001(W)	09/13/2005 - #1

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	DOS/ Visit Number
498665977 (SP)	000705812	113925632501(Z)	06/24/2005 - #4
497522585 (EE)	000705697	107813157201(Z)	03/28/2005 - #5
487135658 (CH)	000319642	105191050401(S)	01/05/2005 - #3
489649002 (EE)	000703818	111106500501(M)	04/15/2005 - #3
498669402 (EE)	000705697	105381870901(Z)	02/17/2005 - #1
496567397 (EE)	000385798	106398656201(U)	01/18/2005 - #4
495504039 (EE)	000705697	102904118301(Z)	01/05/2005 - #9
500789471 (EE)	000706621	112508749601(W)	04/28/2005 - #1
412962866 (EE)	000705697	102504840701(Z)	01/07/2005 - #2
512722627 (SP)	000448760	113309161401(U)	03/14/2005 - #2
487603189 (EE)	000705697	105249836701(Z)	02/21/2005 - #1
500461555 (SP)	000705697	103897719401(Z)	01/07/2005 - #2
500461555 (SP)	000705697	103897719701(Z)	01/14/2005 - #5
497526417 (EE)	000705697	103779871401(Z)	01/20/2005 - #4

D. Target Review – M0 Denied Claims

Field Size:	1,105
Sample Size:	50
Type of Sample:	ACL Random
Number of Errors:	23
Error Ratio:	46%
Within DIFP Guidelines?	No

The examiners noted the following error 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 clinical-notification form to ACN Inc. 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 a total of 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 UHCMW 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 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 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

(The examiners noted errors in the following 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	DOS/ Visit Number
490808599 (EE)	000701648	116842570201(C)	08/01/2005 - #9
294448854 (EE)	000705697	123034644201(Z)	11/11/2005 - #6
492629166 (EE)	000707027	108478279901(W)	04/06/2005 -#12
500505977 (SP)	000705697	110738261301(W)	05/12/2005 -#18

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	DOS/ Visit Number
500823552 (EE)	000705697	105420621101(Z)	02/22/2005 -#17
500602765 (SP)	000433916	106704096601(U)	03/16/2005 -#16
486520054 (EE)	000705697	107868741901(Z)	03/31/2005 -#16

(The examiners noted errors in the following 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	DOS/ Visit Number
536281049 (SP)	000418682	116079277301(U)	08/04/2005 -#16
490808599 (EE)	000701648	116845898501(C)	08/04/2005 -#11
490808599 (EE)	000701648	116845898501(C)	08/11/2005 -#13
169547588 (EE)	000705697	117770862701(Z)	08/27/2005 - #9
444808691 (EE)	0005R4008	111941933801(U)	05/20/2005 -#13
490602779 (CH)	000705697	114872421201(Z)	07/13/2005 - #3
486602158 (SP)	000366791	124419807301(S)	11/01/2005 -#10
490740450 (SP)	000706787	113162198001(W)	06/13/2006 - #6
497940799 (EE)	000706787	124585151401(W)	11/12/2005 -#23

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	DOS/ Visit Number
487583289 (EE)	000705697	110841083401(Z)	05/13/2005 -#21
500602765 (SP)	000433916	109030635201(U)	04/18/2005 -#23
493941636 (SP)	000705697	107271896801(Z)	03/22/2005 - #8
493849282 (EE)	000705697	110740761301(Z)	05/09/2005 -#19
486520054 (EE)	000705697	109057495101(Z)	04/18/2005 -#18
500700434 (EE)	000705697	109815116601(Z)	04/27/2005 -#26
451684630 (EE)	000705697	107985735601(Z)	03/30/2005 -#14

E. Target Review – 9L Denied Claims

Field Size:	411
Sample Size:	30
Type of Sample:	ACL Random
Number of Errors:	22
Error Ratio:	73.3%
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".The examiners determined the Company improperly denied the following claims. 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."

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 without pre-authorization. The Company did not deny the claims listed below for reasons of medical necessity. Rather the Company based its denial of benefits on the basis that the insured/patient had exceeded the number of visits allowed by the policy. The Company calculated its policy benefits based upon utilization within the calendar year as opposed to the benefit period of the policy year. In every 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. UHCMW should review these claims and issue benefits on the basis of the applicable "Day Rate". The payments should be made to the respective network providers who provided the chiropractic care.

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 six claims that would be subject to payment of interest.
Reference: Sections 375.1007(1), (3), (4), and (6), 376.383, and 376.1230, RSMo

(The examiners noted errors in the following based upon analysis of ACL claim data provided by the Company)

(*Six of the following claims marked with an asterisk represent claims filed electronically and are subject to payment of interest.)

SECTION ONE – 2005-2006 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	DOS/ Visit Number
487541089 (CH)	000705697	118471914301(Z)	08/08/05 - #5
386562178 (EE)	000705697	123065077601(Z)	10/19/05 - #11
491509504 (EE)	000705697	122478105301(Z)	10/17/05 - #9
487541089 (SP)	000705697	118471862302(Z)	07/29/05 - #11
498721824 (EE)	000334563	121304486801(S)	10/19/05 - #3
492767059 (EE)	000705815	118415851401(Z)	09/07/05 - #11
487642142 (EE)	000705697	120856509301(Z)	10/17/05 - #9
491744543 (EE)	000366791	111294531801(S)	02/28/05 - #21
495629768 (EE)	000705697	116476441401(Z)	08/10/05 - #11
490705452 (SP)	000308935	125515720801(S)	12/16/05 - #21
500904879 (EE)	000705697	125030783501(Z)	12/02/05 - #12
496463729 (RR)	000705697	124513143401(Z)	12/09/05 - #15
386562178 (EE)	000705697	125547859101(Z)	12/14/05 - #22
492529600 (RR)	000705697	123727594101(Z)	11/29/05 - #18
487541089 (SP)	000705697	118471901501(Z)	09/01/05 - #25
498721824 (EE)	000334563	123600590701(S)	11/15/05 - #11

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	DOS/ Visit Number
487135658 (ST)	000319642	111245882701(S)	05/18/05 - #15*
008344750 (EE)	000274434	104622425502(S)	02/10/05 - #4*
488968046 (EE)	000705697	105433177204(Z)	01/28/05 - #2*
489159461 (EE)	000325724	108136063901(S)	03/17/05 - #21*
489159461 (EE)	000325724	108136063901(S)	03/24/05 - #23*
489159461 (EE)	000325724	108136063901(S)	03/29/05 - #24*

F. Target Review – JO Denied Claims

Field Size:	16
Sample Size:	16
Type of Sample:	Census
Number of Errors:	8
Error Ratio:	50%
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 34 claim records, 11 enrollees and 16 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), and (4), and 376.1230, RSMo

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

Member ID #	Group Pol. #	DOS	Claim Number
342362749 (EE)	000705812	04/25/05	110714180501
342362749 (EE)	000705812	05/04/05	110714180501
424500249 (EE)	000705697	01/11/05	102903650001

Member ID #	Group Pol. #	DOS	Claim Number
490861957 (CH)	000705697	01/05/05	103097635101
493908303 (EE)	000705812	06/13/05	118191384402
493908303 (EE)	000705812	06/29/05	118191384402
493908303 (EE)	000705812	06/30/05	118191384402
497921475 (EE)	000705697	01/13/05	102903650201

III. COMPLAINTS APPEALS 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 Company recorded 51 complaints during 2004 and 2005. These included 18 provider complaints, 23 MDI complaint inquiries and 9 additional consumer complaints. The examiners reviewed all Consumer (non DIFP) grievances/appeals and all DIFP Complaint inquiries.

The examiners noted the following errors in this review:

1. The Company failed to maintain a copy of an acknowledgement letter sent to the complainant that confirmed it received the complaint.

Case Number	Member ID #
200636	494680716

2. The enrollee submitted a claim for chiropractic services received from 05/25/2004 through 07/29/2004. Prior to treatment customer service stated that the policy provided coverage. Subsequent to receiving treatment the Company denied the claim on the basis of a policy exclusion (Section 11.1), which stated that except as specifically provided in Section 10 or through a Rider to the Policy, the following are not covered: (sub-section A1) "Services and supplies for analysis and adjustment of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure, or for muscle stimulation by any means (except treatment of fractures and dislocations of the extremities.)" Upon appeal, the Company agreed to

pay benefits, but only as a one time exception because its customer service representative misquoted coverage. However, while the Company paid the claims on appeal, its letter to the enrollee contained a misleading statement on the issue of coverage. The Company's letter reinforced the idea that the policy did not provide coverage for chiropractic care, when in fact chiropractic care is a mandated benefit as opposed to a one time exception.

Reference: Section 375.1007(1), RSMo, and 20 CSR 100-1.020

Case Number	Member ID #
304385	526506538

3. The enrollee submitted a claim for chiropractic services received on 02/02/2004. The enrollee received confirmation of coverage from customer service prior to treatment. Subsequent to treatment, the Company denied coverage based upon exclusions in the policy, however, on appeal the Company paid the claim as a one time exception because customer service misquoted coverage. However, the company's payment of the claim as a one-time exception inappropriately reinforced the notion that the policy did not provide chiropractic benefits when in fact chiropractic care is a mandated benefit.

Reference: Section 375.1007(1), RSMo, and 20 CSR 100-1.020

Case Number	Member ID #
164946	389523314

4. Under case number 323578 in reference to member # 499685510, the Company denied a claim for chiropractic care on the basis that the DOS exceeded the policies limit of 20 visits in a calendar year, when in fact the policy allowed for 26 visits.

Reference: 375.1007(1), RSMo, and 20 CSR 100-1.020

IV. 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	14	100%
10 to 20	09*	
Totals	23	100%

FORMAL REQUEST TIME STUDY

Number of Days	Number of Requests	Percentage
0 to10	19	51.4%
11 to 20	12*	32.4%
21 to 30	05*	13.5%
Over 30	01	02.7%
Totals	37	100%

* (The examiners granted the Company's requests for extensions of time to respond to some requests and criticisms. The examiners received all criticisms and all, but one request within the revised time-period.)

EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of United Healthcare of the Midwest (NAIC #96385), Examination # (0603-18, 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 of the Midwest, Inc.

The Company has structured the responses as follows:

- Exam Report Allegation
- Company Response

FORMS AND FILINGS

2. The Company's group policies or chiropractic riders describe the coverage afforded enrollees of group health plans as defined by section 376.1350, RSMo. The policies or 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 83 patients and 431 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

Choice – H.01.MO/IL
Choice Plus – H.01.MO/IL
Select – H.01.MO/IL
Select Plus – H.01.MO/IL

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 UHCMW to provide greater coverage for chiropractic treatment than other payors would create a competitive disadvantage for UHCMW.

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 UHCMW 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 UHCMW believed that the policies were in compliance with the provisions of 376.1230, RSMo. UHCMW 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 UHCMW 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.

2. **Denied Claims**

Field Size:	29,239
Sample Size:	50
Type of Sample:	ACL Random
Number of Errors:	8
Error Ratio:	16%
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 000407704 effective, 05/01/2004. 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's denial 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, UHCMW 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 payment to the network provider for $34.00.
Reference: Sections 375.1007(1), (3), and (4), and 376.1230, RSMo

Claim Number	Member ID #
102473962201	312720404

Company Response:

The Denied Claims deficiencies noted in (a) through (h) all involve 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.

UHCMW and ACN have both interpreted 376.1230, RSMo as specific to the issue of enrollee notification requirements in the first 26 chiropractic visits. The UHCMW 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.

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 UHCMW Certificates of Coverage and of the ACN UR Application and ACN UM Program UHCMW and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHCMW and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHCMW 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.

UHCMW 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 000705697 effective, 07/01/2005. The Company unfairly denied payment of

benefits for chiropractic care for the 10/04/2005 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, UHCMW 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 for $24.00 for the 10/04/05 DOS. In addition, the Company owes interest on this electronically filed claim submitted on 10/11/2005 at the rate of one percent per month from the 46 day after submission of the claim to the date of payment. Reference: Sections 375.1007(1), (3), and (4), 376.383, and 376.1230, RSMo

Claim Number	Member ID #
102240852501	488605686

Company Response:

The Denied Claims deficiencies noted in (a) through (h) all involve 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.

UHCMW and ACN have both interpreted 376.1230, RSMo as specific to the issue of enrollee notification requirements in the first 26 chiropractic visits. The UHCMW 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.

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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	3/08/04	3/30/04

	ACN Locations		
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.

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 UHCMW Certificates of Coverage and of the ACN UR Application and ACN UM Program UHCMW and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHCMW and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHCMW 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.

UHCMW 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 000269018 effective, 09/01/2004. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 07/12/2005 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, UHCMW and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violates the requirements of Missouri law.

The examiners believe the allowed amount should be the "Day Rate" of $40. However, the examiners could not readily ascertain the appropriate amount payable because of the varied payments made by the Company on previously processed claims. For the 02/17/05 DOS, the Company allowed $40.00, deducted $15.00 for a co-payment and paid $25.00. For the next two dates of service (04/26/05 and 05/18/05), the Company allowed $35.00, applied $7.00 coinsurance and paid $28.00. The examiners requested an explanation for the inconsistent payments. The examiners requested a copy of the member's benefit schedule or other documentation to support the correct allowed amount and the correct amount for the member's portion of the claim.

The examiners requested the Company issue a benefit payable to the network provider for the appropriate amount for the 07/12/2005 DOS. In addition, the Company owes interest on this electronically filed claim at the rate of one percent per month from the 46 day after submission of the claim to the date of payment. Reference: Sections 375.1007(1), (3), and (4), 376.383, and 376.1230, RSMo

Claim Number	Member ID #
114615384501	494584819

Company Response:

The Denied Claims deficiencies noted in (a) through (h) all involve 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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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.

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

UHCMW and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHCMW 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.

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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.

UHCMW 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 000705697 effective, 07/01/2005. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 01/07/2005 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, UHCMW 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 for $29.00 for the 01/07/05 DOS.

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

Claim Number	Member ID #
102477299701	494640268

Company Response:

The Denied Claims deficiencies noted in (a) through (h) all involve 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.

UHCMW and ACN have both interpreted 376.1230, RSMo as specific to the issue of enrollee notification requirements in the first 26 chiropractic visits. The UHCMW 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.

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 UHCMW Certificates of Coverage and of the ACN UR Application and ACN UM Program UHCMW and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHCMW and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHCMW 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.

UHCMW 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.

e) The Company afforded the insured patient coverage under group policy number 000325732 effective, 09/01/2004. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 05/17/2005 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, UHCMW and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violates the requirements of Missouri law.

The examiners believe the allowed amount should be the "Day Rate" of $40. The examiners could not readily ascertain the appropriate amount payable because of the varied payments made by the Company on previously processed claims. The Company processed claims for the 05/10/05 and 05/12/05 dates of service under one claim number, (111108096401). The claim records show no payment was made for the 05/12/05 DOS. The claim record shows two separate allowed amounts for the 05/10/05 DOS ($25 and $55). Neither of these allowed amounts reflects the "Day Rate" of $40.00. However, the combined amount equals $80.00 which could have been intended to account for two separate "Day Rate" amounts of $40.00. However, the adjustment on the entry of $25.00 allowed for the 05/10/05 DOS shows the Company applied $2.50 as co-insurance while the other entry of $55.00 shows a co-payment of $10.00. The Company paid a total of $67.50 for the 05/10/05 DOS. The examiners requested the Company to provide an explanation for the inconsistent payments and a copy of the member's benefit schedule to support the correct allowed amount and the correct amount for the member's portion of the claim.

The examiners asked the Company to issue a benefit payable to the network provider for the appropriate amount for the 05/17/05 DOS.
Reference: Sections 375.1007(1), (3), (4) and 376.1230, RSMo

Claim Number	Member ID #
111996237901	495786275

Company Response:

The Denied Claims deficiencies noted in (a) through (h) all involve 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.

UHCMW and ACN have both interpreted 376.1230, RSMo as specific to the issue of enrollee notification requirements in the first 26 chiropractic visits. The UHCMW 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.

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 UHCMW Certificates of Coverage and of the ACN UR Application and ACN UM Program UHCMW and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHCMW and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHCMW 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.

UHCMW 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.

f) The Company afforded the insured patient coverage under group policy number 000705812 effective, 07/01/2004. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 06/15/2005 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, UHCMW and ACN considered failure to submit a CCN grounds for denial of the claim. This practice violates the requirements of Missouri law.

The examiners asked the Company to issue a benefit payable to the network provider for $24.00 for the 10/04/05 DOS. In addition, the Company owes interest on this electronically filed claim submitted on 10/11/2005 at the rate of one percent per month from 46 day after the claim was submitted to the date paid.
Reference: Sections 375.1007(1), (3) and (4), 376.383, and 376.1230, RSMo

Claim Number	Member ID #
113535665101	496801247

Company Response:

The Denied Claims deficiencies noted in (a) through (h) all involve 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.

UHCMW and ACN have both interpreted 376.1230, RSMo as specific to the issue of enrollee notification requirements in the first 26 chiropractic visits. The UHCMW 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.

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 UHCMW Certificates of Coverage and of the ACN UR Application and ACN UM Program UHCMW and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHCMW and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHCMW 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.

UHCMW 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 000705697 effective, 07/01/2004. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 06/15/2005 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."

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. By its own admission, UHCMW does not engage in utilization review of the services provided by ACN's network providers. According to both ACN and UHCMW, ACN is not involved in the claim process. However, ACN initiated application of the "M0" remark code that resulted in denial of payment. It does not appear that UHCMW made any determination on the issue of medical necessity, nor did it investigate the recovery milestone's applicability to the specific patient under care.

According to UHCMW and ACN, the notification process requires a provider to submit a standardized medical record form that contains data about the patient

under care. After its review of the CCN, ACN establishes a duration-based 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 new notification. The "CCN" refers to ACN'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 did result in denial of payment for the services rendered.

Both ACN and UHCMW take 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. 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.

UHCMW does not receive a copy of the CCN submitted by the provider to ACN. UHCMW only received the CMS 1500 claim form. Without conducting an investigation, UHCMW could not make a determination about the medical necessity of the treatment provided by the chiropractor. The DOS was the 12th visit in 2005. The Company may not require notification within the first 26 visits in a policy period as a condition of coverage. Unless UHCMW bases its denial of payment 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 check payable to the network provider for $24.00.
Reference: Sections 375.1007(1), (3), (4) and (6), 376.1230, and 376.1361(13), RSMo

Claim Number	Member ID #
104975313801	500922728

Company Response:

The Denied Claims deficiencies noted in (a) through (h) all involve 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.

UHCMW and ACN have both interpreted 376.1230, RSMo as specific to the issue of enrollee notification requirements in the first 26 chiropractic visits. The UHCMW 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.

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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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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 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 UHCMW Certificates of Coverage and of the ACN UR Application and ACN UM Program UHCMW and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHCMW and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHCMW 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.

UHCMW 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.

h) The Company afforded the insured patient coverage under group policy number 000705697 effective, 07/01/2004. In the absence of documentation to the contrary, the Company unfairly denied payment of benefits for chiropractic care for the 05/02/2005 DOS per denial code "H0" that states, "ACN received the Healthcare provider's notification for this date or service shown. We were unable to approve this service or length of time requested. Please refer to our response to the health care provider's notification for an explanation of the denial. The patient may not be billed for amounts declined when administrative requirements are not followed." While the Company used a standardized EOB, it did not provide a description of the reason for the denial.

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. UHCMW does not engage in utilization

review of the services provided by ACN's network providers. According to both ACN and UHCMW, ACN is not involved in the claim process. However, ACN initiated application of the "H0" remark code that resulted in denial of payment. It does not appear that UHCMW made any determination on the issue of medical necessity, nor did it investigate the recovery milestone's applicability to the specific patient under care. UHCMW conducted neither utilization review nor an investigation to make a determination on the issue of medical necessity. As such, UHCMW cannot deny the claim on the basis that it cannot approve the service or length of time requested.

According to UHCMW and ACN, the notification process requires a provider to submit a standardized medical form that contains data about the patient under care. Once ACN receives notification from the provider, it establishes a duration-based milestone for the treatment. If the patient's condition requires treatment beyond the established milestone, ACN requires the provider to re-submit a follow-up CCN. The CCN refers to ACN's standardized medical form which 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 the services already 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 "H0" code does not deny services as non-covered or medically unnecessary. However, the Company's use of the "H0" remark code resulted in denial of benefits to the provider for services already performed.

The Company's explanation for the denial of this claim failed to satisfy the requirements of Section 376.1400, RSMo. The language in the EOB gives the impression that UHCMW reviewed the provider's notification and made the determination that it could not approve the service or length of time requested.

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

The examiners could not readily ascertain the correct amount payable to the provider because of the variance in other claims paid for this patient. Subsequent to the claim in question the Company made payment for services provided on 08/17/05 and 10/05/05. The allowed amount for the 08/17/05 DOS equaled $40, while the amount shown for the 10/05/05 DOS equaled $44.00. The examiners believe the "Day Rate" should be $44.00 based upon the location of the provider.

The examiners requested the Company issue a benefit check payable to the network provider for $24.00. Claims filed electronically are subject to payment of interest. As such, the examiners request payment of interest at the rate of one percent per month from 46 day after submission of the claim to the date of payment. Reference: Sections 375.1007(1), (3), (4) and (6), 376.383, and 376.1230, and 376.1400, RSMo

Claim Number	Member ID #
110205005601	486542995

Company Response:

The Denied Claims deficiencies noted in (a) through (h) all involve 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.

UHCMW and ACN have both interpreted 376.1230, RSMo as specific to the issue of enrollee notification requirements in the first 26 chiropractic visits. The UHCMW 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 deficiency identified in (h) 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).

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Chiropractic Record Keeping Guidelines

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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.

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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 UHCMW Certificates of Coverage and of the ACN UR Application and ACN UM Program UHCMW and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHCMW and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHCMW 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.

UHCMW 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. Target Review – H0 Denied Claims

Field Size:	1,089
Sample Size:	50
Type of Sample:	ACL Random
Number of Errors:	35
Error Ratio:	70%
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

(The examiners noted errors in the following 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	DOS/ Visit Number
487542983	000705697	114814816601	07/01/2005 - #1
490829536	000701916	112574720401	06/10/2005 -#17
229359280	000706963	120705305601	09/19/2005 - #1
492548792	000706787	120391337801	10/07/2005 -#11
313924680	000705697	116846361201	08/16/2005 -#19

500424647	000705697	123951165601	11/29/2005 -#19
493426121	000705697	114169761901	07/01/2005 - #1
393641778	000703818	113966203401	07/01/2005 - #1
498767577	000706962	120391344901	10/14/2005 - #9
498946948	000705697	123338050401	11/21/2005 -#24
498946948	000705697	123437741101	11/21/2005 -#25
494500920	000275196	108231500701	04/04/2005 -#18

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' Numbers	Group Number	Claims Number	DOS/ ID Visit Number
269507725	000705697	104433257001	02/07/2005 - #6
498881692	000705697	110455542001	04/26/2005 -#11
381746589	000705697	108097561101	03/29/2005 -#12
495741070	000705697	107089703601	03/18/2005 - #2
499527545	000705697	110798471701	05/14/2005 -#11
488706645	000705697	112365756601	06/08/2005 -#22
496826997	0001p8022	104986770801	02/17/2005 -#23
486542995	000705697	107578053001	03/14/2005 - #2
486542995	000705697	107578053001	05/02/2005 - #3
496569627	000438730	111494534101	05/24/2005 -#11
499824109	000274179	104125827001	01/24/2005 - #3

2. The insured/patients received chiropractic care on the dates indicated below. The Company denied payment of benefits for these patients' DOS per remark 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 law. The insured/patient shall have access to medically necessary chiropractic care for the first 26 visits in a policy period without the necessity of providing notification as a condition of coverage.

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

(The examiners noted errors in the following 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	DOS/ Visit Number
495786275	000325732	119599057001	09/21/2005 - #5
482987928	000705521	110237408101	04/29/2005 - #3
499682526	000706787	107354208401	03/24/2005 -#27
498767577	000706962	120754145401	10/14/2005 - #9
498946948	000705697	122397770101	11/08/2005 -#21
495940258	000705697	119048890101	09/19/2005 - #4

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	DOS/ Visit Number
134401017	000705697	102372568801	01/04/2005 - #5
493426121	000705697	112712654901	06/04/2005 -#18
486523067	000705697	112092449101	04/12/2005 - #1
486768382	000346399	115613495701	07/21/2005 - #1
490885861	000385631	102804162301	01/05/2005 -#12
488700614	000705697	103650989803	01/13/2005 - #1

Company Response:

The deficiencies noted in (1) and (2) both involve the same issue. 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, this targeted review simply provides a more detailed review of the deficiencies and rebuttals already described in III.A.2.(a)-(h) 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 UHCMW Certificates of Coverage and of the ACN UR Application and ACN UM Program UHCMW and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHCMW and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHCMW 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.

UHCMW 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:	3,954
Sample Size:	50
Type of Sample:	ACL Random
Number of Errors:	41
Error Ratio:	82%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

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 CCN's 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 a total of 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.

Both ACN and UHCMW 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 the claims on the question of medical necessity, but relied upon administrative requirements. Per the Company's EOB explanation, the claims denied because ACN did not receive 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

(The examiners noted errors in the following 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	DOS/ Visit Number
447446736 (EE)	000705697	116038544201(Z)	08/02/2005 - #1
404700518 (EE)	000701916	109412280901(Y)	03/29/2005 -#17
492823111 (EE)	000705697	118415851701(Z)	09/07/2005 - #6
492800704 (EE)	000705697	115587241401(Z)	07/15/2005 - #4
337461512 (EE)	000705697	116360964301(Z)	08/05/2005 - #9
499825691 (SP)	000706850	112502721201(W)	06/01/2005 - #4
492042164 (EE)	000705697	124504266301 (Z)	11/17/2005 -#10
338403183 (EE)	000705697	123584894001(Z)	11/23/2005 - #1

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	DOS/ Visit Number
570642288 (EE)	000705697	103950487801(Z)	01/31/2005 -#12
493941636 (SP)	000705697	104517237401(Z)	02/03/2005 - #1
493681738 (SP)	000438109	118421108301(U)	08/31/2005 - #5
329540101 (EE)	000705697	113688549701(Z)	05/18/2005 - #1
499726677 (EE)	000705697	102504807201(Z)	01/07/2005 - #5
498723035 (EE)	000705697	102739245501(Z)	01/11/2005 - #1
571669925 (EE)	000705696	112748666101(Z)	06/13/2005 -#11

(The examiners noted errors in the following 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	DOS/ Visit Number
487541089 (CH)	000705697	118471914301(Z)	07/11/2005 - #1
496980094 (EE)	0001S0979	111404825201(U)	05/19/2005 - #4
492823111 (EE)	000705697	117104921601(Z)	08/16/2005 - #4
486587556 (SP)	000707721	111191191401(W)	05/18/2005 - #9
487462231 (CH)	000706917	125152466601(W)	10/03/2005 - #2
498624907 (EE)	000705815	115055129901(Z)	07/19/2005 - #1
500945448 (EE)	000701648	124788338701(C)	09/14/2005 - #2
499825691 (SP)	000706850	114151220901(W)	06/27/2005 -#14
444808691 (EE)	0005R4008	115002924601(U)	07/13/2005 -#19
400003554 (EE)	0005R5595	113926298501(U)	06/10/2005 - #3
276602785 (EE)	000703818	11560659501(M)	07/15/2005 - #1

500607999 (SP)	000707027	118528200001(W)	09/13/2005 - #1

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	DOS/ Visit Number
498665977 (SP)	000705812	113925632501(Z)	06/24/2005 - #4
497522585 (EE)	000705697	107813157201(Z)	03/28/2005 - #5
487135658 (CH)	000319642	105191050401(S)	01/05/2005 - #3
489649002 (EE)	000703818	111106500501(M)	04/15/2005 - #3
498669402 (EE)	000705697	105381870901(Z)	02/17/2005 - #1
496567397 (EE)	000385798	106398656201(U)	01/18/2005 - #4
495504039 (EE)	000705697	102904118301(Z)	01/05/2005 - #9
500789471 (EE)	000706621	112508749601(W)	04/28/2005 - #1
412962866 (EE)	000705697	102504840701(Z)	01/07/2005 - #2
512722627 (SP)	000448760	113309161401(U)	03/14/2005 - #2
487603189 (EE)	000705697	105249836701(Z)	02/21/2005 - #1
500461555 (SP)	000705697	103897719401(Z)	01/07/2005 - #2
500461555 (SP)	000705697	103897719701(Z)	01/14/2005 - #5
497526417 (EE)	000705697	103779871401(Z)	01/20/2005 - #4

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, this targeted review simply provides a more detailed review of the deficiencies and rebuttals already described in III.A.2.(a)-(h) 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 UHCMW Certificates of Coverage and of the ACN UR Application and ACN UM Program UHCMW and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHCMW and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHCMW 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.

UHCMW 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:	1,105
Sample Size:	50
Type of Sample:	ACL Random
Number of Errors:	23
Error Ratio:	46%
Within DIFP Guidelines?	No

The examiners noted the following error 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 clinical-notification form to ACN Inc. 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 a total of 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 UHCMW 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 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 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

(The examiners noted errors in the following 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	DOS/ Visit Number
490808599 (EE)	000701648	116842570201(C)	08/01/2005 - #9
294448854 (EE)	000705697	123034644201(Z)	11/11/2005 - #6
492629166 (EE)	000707027	108478279901(W)	04/06/2005 -#12
500505977 (SP)	000705697	110738261301(W)	05/12/2005 -#18

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	DOS/ Visit Number
500823552 (EE)	000705697	105420621101(Z)	02/22/2005 -#17
500602765 (SP)	000433916	106704096601(U)	03/16/2005 -#16
486520054 (EE)	000705697	107868741901(Z)	03/31/2005 -#16

(The examiners noted errors in the following 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	DOS/ Visit Number
536281049 (SP)	000418682	116079277301(U)	08/04/2005 -#16
490808599 (EE)	000701648	116845898501(C)	08/04/2005 -#11
490808599 (EE)	000701648	116845898501(C)	08/11/2005 -#13
169547588 (EE)	000705697	117770862701(Z)	08/27/2005 - #9
444808691 (EE)	0005R4008	111941933801(U)	05/20/2005 -#13
490602779 (CH)	000705697	114872421201(Z)	07/13/2005 - #3
486602158 (SP)	000366791	124419807301(S)	11/01/2005 -#10
490740450 (SP)	000706787	113162198001(W)	06/13/2006 - #6
497940799 (EE)	000706787	124585151401(W)	11/12/2005 -#23

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	DOS/ Visit Number

487583289 (EE)	000705697	110841083401(Z)	05/13/2005 -#21
500602765 (SP)	000433916	109030635201(U)	04/18/2005 -#23
493941636 (SP)	000705697	107271896801(Z)	03/22/2005 - #8
493849282 (EE)	000705697	110740761301(Z)	05/09/2005 -#19
486520054 (EE)	000705697	109057495101(Z)	04/18/2005 -#18
500700434 (EE)	000705697	109815116601(Z)	04/27/2005 -#26
451684630 (EE)	000705697	107985735601(Z)	03/30/2005 -#14

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, this targeted review simply provides a more detailed review of the deficiencies and rebuttals already described in III.A.2.(a)-(h) 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 UHCMW Certificates of Coverage and of the ACN UR Application and ACN UM Program

UHCMW and ACN believed we were operating in compliance with the provisions of 376.1230, RSMo.

UHCMW and ACN would appreciate the opportunity to meet with the Department to review the Department's current interpretation of this statute and discuss actions UHCMW 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.

UHCMW 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.

E. TARGET REVIEW- 9L Denied Claims

Field Size:	411
Sample Size:	30
Type of Sample:	ACL Random
Number of Errors:	22
Error Ratio:	73.3%
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".The examiners determined the Company improperly denied the following claims. 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."

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 without pre-authorization. The Company did not deny the claims listed below for reasons of medical necessity. Rather the Company based its denial of benefits on the basis that the insured/patient had exceeded the number of visits allowed by the policy. The Company calculated its policy benefits based upon utilization within the calendar year as opposed to the benefit period of the policy

year. In every 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. UHCMW should review these claims and issue benefits on the basis of the applicable "Day Rate". The payments should be made to the respective network providers who provided the chiropractic care.

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 six claims that would be subject to payment of interest.
Reference: Sections 375.1007(1), (3), (4), and (6), 376.383, and 376.1230, RSMo

(The examiners noted errors in the following based upon analysis of ACL claim data provided by the Company)

(*Six of the following claims marked with an asterisk represent claims filed electronically and are subject to payment of interest.)

SECTION ONE – 2005-2006 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	DOS/ Visit Number
487541089 (CH)	000705697	118471914301(Z)	08/08/05 - #5
386562178 (EE)	000705697	123065077601(Z)	10/19/05 - #11
491509504 (EE)	000705697	122478105301(Z)	10/17/05 - #9
487541089 (SP)	000705697	118471862302(Z)	07/29/05 - #11
498721824 (EE)	000334563	121304486801(S)	10/19/05 - #3
492767059 (EE)	000705815	118415851401(Z)	09/07/05 - #11
487642142 (EE)	000705697	120856509301(Z)	10/17/05 - #9
491744543 (EE)	000366791	111294531801(S)	02/28/05 - #21
495629768 (EE)	000705697	116476441401(Z)	08/10/05 - #11
490705452 (SP)	000308935	125515720801(S)	12/16/05 - #21
500904879 (EE)	000705697	125030783501(Z)	12/02/05 - #12
496463729 (RR)	000705697	124513143401(Z)	12/09/05 - #15

386562178 (EE)	000705697	125547859101(Z)	12/14/05 - #22
492529600 (RR)	000705697	123727594101(Z)	11/29/05 - #18
487541089 (SP)	000705697	118471901501(Z)	09/01/05 - #25
498721824 (EE)	000334563	123600590701(S)	11/15/05 - #11

SECTION TWO – 2004-2005 Policy Year Claims

Insured/Patients' ID Numbers	Group Number	Claims Number	DOS/ Visit Number
487135658 (ST)	000319642	111245882701(S)	05/18/05 - #15*
008344750 (EE)	000274434	104622425502(S)	02/10/05 - #4*
488968046 (EE)	000705697	105433177204(Z)	01/28/05 - #2*
489159461 (EE)	000325724	108136063901(S)	03/17/05 - #21*
489159461 (EE)	000325724	108136063901(S)	03/24/05 - #23*
489159461 (EE)	000325724	108136063901(S)	03/29/05 - #24*

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 the following, the Company respectfully disagrees:
SECTION ONE – 2005-2006 Policy Year Claims

487541089 (SP)	000705697	118471862302(Z)	07/29/05 - #11
487541089 (SP)	000705697	118471901501(Z)	09/01/05 - #25

These 2 claims were processed to incorrectly reflect a denial code of 9L rather than J0. Although the benefits were not exhausted at the time the claims were processed, payment remains unavailable as authorization was not obtained. However, the claims will be reprocessed to reflect the correct denial reason.

Relative to the following, the Company respectfully disagrees:
SECTION ONE – 2005-2006 Policy Year Claims

514601954 (EE)	000308996	118108132901(S)	08/22/05 - #7

SECTION TWO – 2004-2005 Policy Year Claims

031508758 (EE)	000273976	117385647001(S)	07/19/05 - #20

Although the Company acknowledges that these claims were denied to reflect a limited benefit had been exhausted, the Company respectfully disagrees that these denials were erroneous. In both cases, the policy was issued out of Kansas. Therefore, the chiropractic benefits mandated by the State of Missouri are not applicable. Please refer to the print screens below which identify the policy number and employee number (A) and the same policy number and state of issue (SOI field) as KS.

A.

```
            CONSOLIDATED ELIGIBILITY SYSTEM SUMMARY MAINTENANCE          AUTO=N
        1 DEPENDENTS                                    NO MORE COVERAGES
CUSTOMER 1308996 EE 00514601954 ALT-ID 00861137299 CORP              POL 0308996
UPD   DCN              IDC                PREFIX S
LAST NAME [redacted]              FIRST DAVID        MI L SEX M M/S U
SSN 00514601954 REL 0 SEQ 001 TIC: REL EE SEQ 00 RETIRE              LATE ENRL A
BIRTH 03 15 1954 VIP    XREF EE                    EMPLOYMENT DATE 09 01 1988
```

B.

```
                    INFORCE CONTROL BENEFIT SET MAINTENANCE W/P

CUST 1308996 GROUP 3308996 DIVISION            COV M  BENEFIT SET HM9L9

START 07 01 2003 STOP            LEGAL-ENT1        LEGAL-ENT2        OI 0
OPTUM          NON-MEDICAL   RETRO: RESTRICT N TIME 000 OON Y    PI
BEN-START 07 01 2005 BEN-STOP                FBI P PT D  PC HM9L96N9999
COPAYS:  PCP 010.00 SPC 010.00 HOSP 000.00 ER 050.00 DRUG          OFF
         URG        PED        PRT: 000 IPLAN 1 P-LVL    SOI KS CML
RIDERS: CHEM        VIS V1B    MH   DS1    CHIRO 000    DEN 000
```

A.

```
            CONSOLIDATED ELIGIBILITY SYSTEM SUMMARY MAINTENANCE          AUTO=N
        5 DEPENDENTS                                    NO MORE COVERAGES
CUSTOMER 1273976 EE 00031508758 ALT-ID 00830767757 CORP              POL 0273976
UPD   DCN              IDC                PREFIX S
LAST NAME [redacted]              FIRST ANTHONY      MI L SEX M M/S U
SSN 00031508758 REL 0 SEQ 001 TIC: REL EE SEQ 00 RETIRE              LATE ENRL A
BIRTH 06 18 1958 VIP    XREF EE                    EMPLOYMENT DATE 11 01 1998
```

B.

```
CUST 1273976 GROUP 3273976 DIVISION            COV M  BENEFIT SET HM9L9

START 11 01 2002 STOP            LEGAL-ENT1        LEGAL-ENT2        OI 0
OPTUM          NON-MEDICAL   RETRO: RESTRICT N TIME 000 OON Y    PI
BEN-START 11 01 2005 BEN-STOP                FBI P PT D  PC HM9L96N9999
COPAYS:  PCP 010.00 SPC 010.00 HOSP 000.00 ER 075.00 DRUG          OFF
         URG        PED        PRT: 000 IPLAN 1 P-LVL   SOI KS CML
RIDERS: CHEM        VIS V1B    MH   KC5    CHIRO 000   DEN 000
        DRUG        SPH        RXMX          HMO                TRVL
```

Relative to the following, the Company respectfully disagrees:
SECTION ONE – 2005-2006 Policy Year Claims
491744543 (EE) 000366791 111294531801(S) 02/28/05 - #21
Although the Company acknowledges that this claim was denied to reflect a limited benefit had been exhausted, the Company respectfully disagrees that the denial was erroneous. This claim was handled after later dates of service were processed. At the time of processing, there were no remaining benefits available.

Relative to the following, the Company respectfully disagrees:
SECTION ONE – 2005-2006 Policy Year Claims
492529600 (RR) 000705697 123727594101(Z) 11/29/05 - #18
Although the Company acknowledges that this claim was denied to reflect a limited benefit had been exhausted, the Company respectfully disagrees with providing payment on this claim at this time. It appears that this denial reflecting benefits were exhausted was issued based on a calendar year calculation. Upon further review, it does appear benefits would have been available using a policy year benefit calculation. However, since the time of this denial, payment has been issued on other dates of service and the 26 visit limit based on a policy year was subsequently exhausted. In effect, the member did receive the full 26 visit benefit for the policy year.

Relative to the following, the Company respectfully disagrees:
SECTION TWO – 2004-2005 Policy Year Claims
488968046 (EE) 000705697 105433177204(Z) 01/28/05 - #2 (E-filed)
Although the Company acknowledges that this claim was denied to reflect a limited benefit had been exhausted, the Company respectfully disagrees with providing payment on this claim. It appears that this claim was processed to incorrectly reflect a denial code of 9L on one of the charges submitted for that date of service. The CPT code billed (97032) does not count towards the member's visit limitation. This code is typically included as incidental to the main service and additional payment is not available. However, this claim will be reprocessed to reflect the correct denial reason code.

TARGET REVIEW-JO Denied Claims

Field Size:	16
Sample Size:	16
Type of Sample:	Census
Number of Errors:	8
Error Ratio:	50%
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 34 claim records, 11 enrollees and 16 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), and (4), and 376.1230, RSMo

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

Member ID #	Group Pol. #	DOS	Claim Number
342362749 (EE)	000705812	04/25/05	110714180501
342362749 (EE)	000705812	05/04/05	110714180501
424500249 (EE)	000705697	01/11/05	102903650001

490861957 (CH)	000705697	01/05/05	103097635101
493908303 (EE)	000705812	06/13/05	118191384402
493908303 (EE)	000705812	06/29/05	118191384402
493908303 (EE)	000705812	06/30/05	118191384402
497921475 (EE)	000705697	01/13/05	102903650201

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 UHCMW and the Company response to "Target Review – J0 Denied Claims". Both are incorporated into the response to this allegation.

III. COMPLAINTS APPEALS 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 Company recorded 51 complaints during 2004 and 2005. These included 18 provider complaints, 23 MDI complaint inquiries and 9 additional consumer complaints. The examiners reviewed all Consumer (non DIFP) grievances/appeals and all DIFP Complaint inquiries.

The examiners noted the following errors in this review:

4. Under case number 323578 in reference to member #499685510, the Company denied a claim for chiropractic care on the basis that the DOS exceeded the policies limit of 20 visits in a calendar year, when in fact the policy allowed for 26 visits.

Reference: 375.1007(1), RSMo, and 20 CSR 100-1.020

Company Response:

We agree with the facts that the claim processor made an error and incorrectly processed these claims by limiting the number of visits. However we disagree that it was committed in conscious disregard of 375.1007 (1) and 20 CSR 100-1.020 or committed with such frequency to indicate a general business practice as outlined in 375.1005 regarding improper claim practices.