

STATE OF NORTH DAKOTA

**MARKET CONDUCT
EXAMINATION
REPORT -
CHIROPRACTIC BENEFITS**

NORIDIAN MUTUAL INSURANCE COMPANY
DBA BLUE CROSS BLUE SHIELD OF NORTH DAKOTA
4510 13TH AVENUE SW
FARGO, ND 58121

As of December 31, 2000

By Representatives of the
North Dakota Insurance Department

12/19/01

STATE OF NORTH DAKOTA
DEPARTMENT OF INSURANCE

I, the undersigned, Commissioner of Insurance of the State of North Dakota do hereby certify that I have compared the annexed copy of the Market Conduct Examination Report -
Chiropractic Benefits of the

**Noridian Mutual Insurance Company
dba Blue Cross Blue Shield of North Dakota
4510 13th Avenue SW
Fargo, ND 58121**

as of December 31, 2000, with the original on file in this Department and that the same is a correct transcript therefrom and of the whole of said original.

IN WITNESS WHEREOF, I have hereunto
set my hand and affixed my official seal at
my office in the City of Bismarck, this _____
day of _____, 2002.

Jim Poolman
Commissioner of Insurance

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INTRODUCTION

Legislative History

Chiropractic benefits were first mandated for insurance coverage in two separate pieces of legislation beginning in 1979. The first bill was designed to present options to group health carriers for prescription drug and chiropractic coverage, for which an additional premium could be charged. This “mandated availability” bill eventually became N.D. Cent. Code § 26.1-36-06.

Subsequent legislation, introduced in 1989, became N.D. Cent. Code § 26.1-36-12.1, which mandated chiropractic coverage in group insurance policies.

Mandates and Utilization

Mandated coverage, as expected, opened the treatment to thousands of chiropractic patients. While many patients sought relief of chronic back pain, others began to use the benefits as a day spa, getting adjustments and related therapies two to three times a week. Blue Cross initiated an aggressive review process that began denying claims on grounds that the treatments were not medically justified or were excessive for the patient’s condition. Providers began to complain that the review process was oppressive and that implementation of “medical necessity” determinations by Company reviewers was often inconsistent with good patient care.

Scope of Examination

This target examination of Noridian Mutual Insurance Company (doing business as Blue Cross Blue Shield of North Dakota) was initiated in May 1999 in response to complaints and inquiries to the North Dakota Insurance Department about chiropractic benefits. Both consumers and providers lodged these complaints, primarily because of denied claims.

This examination encompasses the Company’s policies, procedures, and handling of chiropractic benefits from 1990 through September 2000, with emphasis on chiropractic claims dating from January 1, 1995, to September 1, 2000.

Outline of Major Issues

Certain philosophical differences exist between (and among) providers and the Company. Some chiropractors espouse approaches to chiropractic that are holistic or wellness based. They educate their patients to the value and necessity of continuous treatment of the “whole spine.” Others subscribe to national studies and college teachings suggesting that frequent and immediate adjustments are the only way to heal an acutely injured spine. Many indicated that they felt disenfranchised by the Company’s actions and appeals processes.

The Company controls utilization by reimbursing only treatments it finds to be “medically necessary.” While providers generally agree that the Company should only reimburse for medically necessary care, there is little consensus as to what constitutes medical necessity.

EXAM METHODOLOGY

Examination Authority - Company Profile

This target examination was conducted pursuant to N.D. Cent. Code § 26.1-03-19.2, et seq., following relevant standards and procedures set forth by the National Association of Insurance Commissioner's Market Conduct Examiner's Handbook, to the extent that they are consistent with North Dakota law. The exam began May 1, 2000, and was completed May 31, 2001.

Noridian Mutual Insurance Company (hereafter "the Company" or "Blue Cross") is a North Dakota licensed domestic company that holds an approximate 80% share of the health insurance market in the state. As of December 31, 2000, the Company had 204,846 contracts, including self-funded plans. It is located in Fargo, North Dakota.

Items Reviewed

The examiner reviewed chiropractic procedures, documents, statistics, and practice profiles compiled by the Company. Approximately 250 individual inquiries and complaints were evaluated, which were filed, phoned in, or otherwise presented to the Insurance Department during the course of the exam. Because of the informal nature of many of these inquiries, and because some providers encouraged their patients to complain to the Department during the exam, none of these complaints or inquiries are figured into the Department's reporting system totals for the year 2000. They are noted for exam purposes only. On an average annual basis, the Department receives between 10 to 15 complaints or inquiries about chiropractic benefits, mostly concerning Blue Cross benefits because Noridian is the state's largest health insurer. About 30 chiropractors were interviewed and additional interviews were conducted of medical or chiropractic professionals and support staff.

In looking at the individual cases, the examiner manually reviewed approximately 10,000 claims from 1998 until 2000. The Company electronically stores about 18 months of data in its claims database, which the examiner was allowed to access. The examiner also observed the practice patterns of about 70 chiropractors to better understand the difference in treatment philosophies. Using ACL audit software, the examiner reviewed 2,291,082 claims records for the years 1995-2000, an intense process that took five months to complete.

CHIROPRACTIC GUIDELINES AND UTILIZATION

Blue Cross Insurance Contracts - Coverage of Chiropractic Services

Most of the Company's insurance contracts are marketed as providing chiropractic benefits. But these benefits are restricted, based upon the Company's post-claim determination that the services were medically necessary and appropriate for the diagnosed condition. No pre-authorization is required although prior approval of treatment plans was part of the original 1989 guidelines that were in effect until 1998, when revised guidelines were implemented. Treatment plans were discontinued sometime in the early 1990s, according to Company recollection, because of the administrative time involved in reviewing each patient's treatment regimen. In abandoning prior approval, the Company apparently discarded its 1989 utilization guidelines, which outlined specific numbers of patient visits for various grades of diagnoses. The Company had no record of when these procedures were discontinued or what type of notice was issued to its providers. Company officials told the examiner that word was passed through the NDCA

at one of its meetings. A Healthcare Bulletin should have been sent out communicating this very important change in policy, since many chiropractors do not belong to the state Association. Healthcare Bulletins are the Company's way of communicating new program guidelines, billing instructions, changes in policies or procedures, or sharing information to providers.

Some specialized contracts, for certain groups, have a finite number of benefits based on an additional premium the employer is willing to pay. For instance, one large group plan provides for up to 26 chiropractic treatments annually. Another full service plan pays 100% of manipulations. Another provides 50 visits, including reimbursement for what is known as maintenance treatment.

Claims under these plans revealed a tendency for patients to use their chiropractic benefits early on in the year until reaching maximum limits. When they had exhausted the benefits and had to pay for subsequent services out of pocket, they often stopped going to their chiropractors for the remaining part of the year.

Finite benefit contracts are the exception. For most plans, co-payments ranging from \$10 to \$50 are standard for chiropractic visits, with \$10 to \$20 co-payments the norm. Then coinsurance of 70%, 80%, or 90% of the allowed charge is reimbursed for the chiropractic services. Again, the applied percentage depends on the type of service provided. In many plans, deductible limits apply as well. In those cases, generally services are reimbursed at 80-100% when the deductible is fulfilled. Other plans waive the deductible for some services. Most plans apply pre-existing condition limitations to chiropractic benefits, with waiting periods generally from 180 to 365 days and 270 days being standard.

Chiropractic Benefits

Benefits in most plans are limited to the following services: manipulations or adjustments, x-rays and office visits, mechanical traction, electrical stimulation therapies, and ultrasound therapy. Most plans do not reimburse patients for services such as hot/cold packs, acupuncture, or massage therapy. Other chiropractic supplies such as neck pillows, orthotics such as braces or shoe inserts, and nutritional supplements are usually non-covered services. In some plans the therapies (physical therapy, ultrasound, or forms of electrical stimulation) count toward physical therapy maximums.

No contracts limit the type of ailment a patient must suffer from in order to seek chiropractic treatment. Thus, although many patients seek relief for back and neck problems, others schedule chiropractic treatments for migraine or tension headaches; stress; allergies; hypertension; carpal tunnel syndrome; jaw problems; obesity; digestive or menstrual problems; earaches; asthma; foot, knee, and elbow pain; or chemical dependency addictions. Parents even have infants treated by chiropractors for colic or sleeping disorders. Athletes seek treatment for sports injuries or re-injuries or to maintain team eligibility.

Chiropractic Services

Although most chiropractors perform spinal adjustments, others are branching out into services such as lifestyle counseling, nutritional management, rehabilitation, exercise physiology, and sports injuries. They espouse beliefs that vertebral subluxation - misalignment of the spine – is the cause of most disease. Some chiropractors have established multi-disciplinary clinics with gymnasiums, massage therapy, and other wellness services, combining overhead expenses

with physical therapists, massage therapists, and physicians. Many have enlisted the services of practice building consultants who stress the importance of promoting lifetime (maintenance) care to ensure spinal health. Some set up booths at health fairs, especially targeting families with children. Increasing numbers of youngsters are obtaining spinal adjustments and therapies on a regular basis for wellness purposes. Others promote high tech scanners that purport to detect even the slightest spinal abnormality – and they stress that they can always find one, especially after the patient suffers a minor accident. This global clinical approach has resulted in steadily increasing demand for chiropractic services, with spiraling costs. Chiropractors are even selling their services to pet owners to ensure the spinal health of animals.

As the chart below illustrates, total charges for chiropractic services have doubled from 1994 to 1999, the latest year for which statistics were available. Payments by the company for chiropractic services have more than doubled in that same time period, even though the patient count rose by only 1½ times. The average number of visits per patient reimbursed by the Company hovers at about 5½ visits per patient per year.

Activity	1994	1995	1996	1997	1998	1999
Total Charges	\$6,347,196.00	\$7,372,255.00	\$8,733,697.00	\$11,053,132.12	\$12,266,586.03	\$13,504,744.73
Total Payments	\$2,640,960.10	\$3,086,989.00	\$3,632,501.00	\$ 5,170,705.18	\$ 5,919,771.67	\$ 6,423,259.49
Patient Count	50,788	55,201	60,641	69,177	74,740	82,310
Visit Count	268,200	300,630	348,032	393,353	419,894	448,837
Average Charge Per Patient	\$ 124.97	\$ 133.55	\$ 144.02	\$ 159.78	\$ 164.12	\$ 164.07
Average Payment Per Patient	\$ 52.00	\$ 55.92	\$ 59.90	\$ 74.75	\$ 79.20	\$ 78.04
Average Visits Per Patient	5.281	5.446	5.739	5.686	5.618	5.453
Out of State Total Charges	\$ 384,972.75	\$ 454,671.92	\$ 709,794.69	\$ 1,139,319.40	\$ 1,347,051.99	\$ 1,222,582.50
Out of State Total Payments	\$ 151,433.59	\$ 186,180.58	\$ 256,293.50	\$ 432,446.26	\$ 488,541.98	\$ 488,002.01
Out of State Average Visits	7.201	7.037	8.606	8.859	9.019	7.549
Therapy Charges	\$ 917,928.74	\$ 1,016,268.67	\$1,291,931.58	\$ 1,467,322.48	\$ 1,625,537.15	\$ 1,803,392.16
Therapy Charges As % of Total Charges	14.46	13.79	14.79	13.28	13.25	13.35
Accident Count	40,774	Not Tabulated	93,722	68,115	70,861	69,950
Accident % of Total Visits	15.20	Not Tabulated	26.93	17.32	16.88	15.58
X-ray Charges	\$ 502,172.16	\$ 560,000.13	\$ 657,679.53	\$ 666,157.82	\$ 682,087.61	\$ 694,909.66
Number of X-rays	10,654	11,323	12,869	12,429	12,367	12,347

Statistics of Average Patient Use

This average visit count is one of the issues the Department looked into in 1995. It remains a point of controversy for two reasons. The Company has not released usage statistics to its chiropractors, so they are not aware of how to practice according to their peers, and how to bring their practices in line with Company utilization expectations. The other reason is that nationally recognized studies that the Company incorporates into its guidelines (and incorporated into the NDCA, which helped formulate the Company's guidelines in 1989), recommend more than 5.5 visits annually to treat acute conditions. One 1991 study sponsored by the RAND Corporation concluded that patients with acute low back pain found more significant relief in concentrated spinal manipulations than they did treating with medical doctors. A 1990 RAND panel recommended a trial course of two weeks of alternate manipulative procedures before considering treatment to have failed. Theoretically, the patient would be adjusted daily or every other day under this treatment regimen. At a minimum this would involve 5 treatments, and could entail 10 or more.

National Utilization Standards

A 1992 study from the Mercy Consensus Conference (a committee convened to study chiropractic quality assurance) examined frequency of care and sanctioned treatments of 1 to 19 visits over a period from a day to two months for certain spinal conditions. The Mercy guidelines have been generally interpreted to allow a minimum of 12 chiropractic treatments for an acute spinal condition.

A Lewin Group study of Medicare chiropractic services involving 1.3 million beneficiaries found that in 1997, the average patient used 10.6 services per year. North Dakota's Medicare chiropractic average was slightly lower than that, at 8.9 visits per year, but still above the Blue Cross average. Chiropractic textbooks advocate anywhere from 10 to 76 weeks of treatment for various grades of whiplash, with daily treatments tapering off gradually to once a week. (Whiplash: The Master's Program 1996, p. 83). The examiner received both of these documents in conjunction with interviews conducted for this examination.

The American Chiropractic Association (ACA) endorses initial treatment plans that should not project beyond 30-45 days except in chronic cases. But the ACA, whose guidelines are also incorporated into the Company's guidelines, does not indicate how many treatments in this interval are considered appropriate.

Managed Care Principles

The Company has denied an increasing number of claims each year while 5.5 remains the average number of visits. It appears this is the result of managed care principles. Basically, chiropractors are held accountable for their services. The Company evaluates accountability by requiring that all treatments must be validated through proper documentation. Chiropractors must demonstrate clinical necessity and adequate outcomes (patient improvement). The chiropractic guidelines mandate that they also show cost effectiveness.

Medical Necessity Guidelines and Treatment Goals

The Company reimburses chiropractic services that it determines to be "medically appropriate and necessary." Guidelines for determining medical necessity are as follows:

- A. The services, supplies or treatments are medically required and appropriate for the diagnosis and treatment of the [patient's] illness or injury.
- B. The services, supplies or treatments are consistent with professionally recognized standards of health care.
- C. The services, supplies or treatment do not involve costs that are excessive in comparison with an alternative service that would be effective for the diagnosis and treatment of the [patient's] illness or injury.

Treatment goals include the following:

1. Therapeutic Care: Treatment considered necessary to establish a stationary status at maximum improvement.

2. Supportive Care: That phase of therapeutic care necessary for re-education or functional restoration of an injured body system or part. It includes treatment that relieves exacerbations, but there must be continuing documented subjective and objective signs of improvement.
3. Maintenance/Preventive Care: A regime designed to provide for the patient's continued well being or for maintaining the optimum state of health while minimizing recurrence of the clinical status. These treatment procedures are considered necessary to prevent the development of clinical status. This type of care relieves the symptoms of exacerbations but results in no net improvement of the patient's stationary condition. Maintenance care is a non-covered service.

Application of the Guidelines

Although the medical necessity guidelines are elastic enough to be workable, this allows individual case-by-case interpretation and possible inconsistent application of the standards. Providers have questioned whether reserving the right to make this determination has allowed the Company to usurp their autonomy, toward a goal of rationing care. Allegedly, it is confusing for consumers to discern the fine line between medical necessity as defined contractually for coverage purposes versus what the provider and patient believes is medically necessary. This ambiguity is the focal point of almost all consumer complaints the Department has received over chiropractic services.

If the chiropractic "professionally recognized standards of health care" as set forth in subsection B above depart radically from what the Company actually will reimburse for some patients, there is a risk of misleading marketing of the plans if the Company denies a claim because a patient's numbers of claims exceed the generally accepted numbers of treatments. This is what one complainant asserted (YQA 501806982). This patient pointed out to the Company that national standards, which the Company had invoked in its guidelines, would have theoretically allowed him 18 visits annually. The patient was placed on a schedule allowing one visit every five weeks.

Utilization is based upon "regional standards of care" and treatment protocols for similar conditions, according to chiropractic guidelines. Providers argue that the Company has a commanding share of the regional healthcare market and maintains utilization averages within the region that are abnormally low year after year compared to national standards. To the extent the Company controls utilization within the region, the providers argue it is circular reasoning to say a regional standard shall establish utilization.

Supportive vs. Maintenance Care

The distinction between supportive and maintenance care causes much of the disagreement between the Company, its providers, and subscribers. A Healthcare Bulletin issued in April 1997 defined maintenance care as "therapy that is performed to stabilize a chronic condition or to prevent deterioration... Once the maximum therapeutic benefit has been achieved for a given condition, ongoing maintenance therapy is not considered to be medically appropriate and necessary." The Company issued a Healthcare Bulletin in June 2000 stating, "[We] do not take the position that maintenance care does not benefit the patient. It is simply not a covered service." The Company appeared in some respects to be using pain-based strategies in their determination of what constituted maintenance care that were difficult to interpret or

understand.

Consumers oftentimes ask the Department how much pain they needed to experience for reimbursement under these plans. Some providers say they tell patients that if they are not in acute pain, they risk having their treatments denied. This may cause patients to exaggerate their symptoms. Chiropractors could not assure patients whether the claim would be allowed or denied because of uncertainty as to how the Company would interpret its medical necessity criteria. The consultant maintains that patients should only go to chiropractors as needed, on a “PRN” basis. Chiropractors say this is poor patient management, and they should be able to schedule patients for repeat visits as needed for a particular condition without fear of having services denied. Some providers who had follow-up care denied stopped scheduling patients entirely. Their observation was that scheduled patient visits were more likely to be denied. Chiropractors who schedule follow-up visits must write off the costs of any denied services under the participating agreements with the Company.

Controlling Utilization

The Company uses provider agreements for controlling utilization and reinforcing the medical necessity guidelines. The contractual agreements for participating providers indicate that the Company will reimburse for chiropractic services “which are deemed medically necessary and appropriate, rendered at an appropriate level of care, and of an acceptable quality.” Providers will not be reimbursed for services deemed medically unnecessary by the Plan or for services requested by the patient that are non-covered.

The Company compiles statistics on utilization and places providers under focused review if their average patient visits become aberrant from the 5.5 visit average. This means that the provider has departed upward one or more standard deviations from his or her peers, compared to the Company determined average number of patient visits. The provider’s claims are then reviewed by the Company and often denied due to the frequency of the treatment. The providers have complained persistently to the Department that this 5.5 visit average is unrealistic when compared to the national statistics and is impossible to adhere to. Even providers who agree that averaging is the fairest way to set treatment parameters believe that 5.5 visits per year is not a realistic number when national averages are somewhere near 18 visits. According to the American Chiropractic Association, such conservative treatment practices appear to be too narrow in many cases to allow for a patient response.

Example

- One case involved two sisters treated at a rural chiropractic clinic that is open one day a week. Their primary care doctor had referred them for chiropractic treatment for different ailments and had recommended four treatments apiece. Claim 9933306274/02 – the third treatment for one sister – was denied because “the level and frequency” of care was determined to be excessive for the medical documentation the chiropractor sent the Company. The denial was appealed to the Peer Review Committee, which sided with the consultant who denied treatment. The second sister had two of her four treatments denied for the same reason. (Claim # 9933306272/02 and # 9933306273/01). The Peer Review Committee again sided with the consultant and upheld these denials. In part, the consultant indicated that claims of this nature were denied based on the premise that it is unlikely that two family members will meet the medical necessity criteria on the same day. When rural clinics are open only limited times, rural patients

may be disadvantaged in scheduling their visits.

Evaluation of Intangibles

The Company also evaluates results through reliance on tangibles - scientific methodology. Arguably, many chiropractic benefits cannot be measured, tested, or operationally defined, except in terms of patient satisfaction, which is generally high. Providers argue that because chiropractic is an imprecise science, they cannot predict patient response to various treatments, so they cannot assess during an initial visit whether a patient will require very few treatments to heal, or many. Some patients need perpetual treatment to prevent deterioration of a chronic condition that will never completely heal.

High Utilization

The Company, in addition to the above-mentioned profiling of chiropractors to determine utilization patterns, also compiles lists of “high utilizers” of chiropractic services – patients who seek frequent chiropractic treatment over long periods of time. Once designated as a high user, these subscribers’ claims are flagged for manual review, and many of their visits are denied due to the frequency of the treatment. All of the denials are issued after treatment has been rendered, making the patient liable for unanticipated costs, or making the provider write off the costs of the services.

This compilation yielded some alarming trends of doctors overtreating their patients and consumers abusing the system. The patient who topped this list submitted 418 chiropractic services in a 19-month period from January 1, 1999, through July 21, 2000. He accumulated charges of \$8,498. The Company paid \$3,302 and denied the remaining services. This patient would have had to visit his chiropractor nearly every day over the 19 months to amass 418 services. The next four patients on the list averaged more than 200 visits each during the same 19-month period, with chiropractic bills ranging from \$5,300 to \$9,100. All were treated by the same provider, who has left the state.

The list was evidence that some chiropractors are not exercising self-restraint. They continue treating patients who may be well, may have plateaued, or may not be responding to treatment at all. It is not reasonable for them to expect that any insurer will absorb such exorbitant costs without having to raise premiums drastically. Patient education is needed regarding the correlation between higher premiums, high use of services, or likelihood of denials. Both patients and providers need to understand that it is simply not feasible to provide every conceivable treatment for every patient without driving up costs substantially for all consumers.

Questionable Practices and Minor Ailments

Some questionable practices were noted in the manual claim review. One provider x-rayed a patient four times in a four-month period. When the examiner questioned this protocol, the provider indicated he used frequent x-rays as treatment tools, not as diagnostic guideposts. This same provider devised a continuing treatment plan to see a patient three times a week despite chart notes indicating that the patient’s pain had abated and he was “doing fairly well.”

Chart notes of many patients whose claims had been denied showed chiropractic treatment for stress, minor ailments, and low grades of aches, pains, and stiffness that might have resolved spontaneously. The ACA recommends that “subsequent patient visits should include significant patient improvement or regression if demonstrated by the patient on each visit.” The implication

is that treatment should stop once maximum therapeutic benefit has been reached.

Other Utilization Issues

Some overutilization may be driven by economics. At a winter 2001 meeting of the State Chiropractic Association (NDCA), members were circulating statistics indicating that 65% of the chiropractors in the state have been here less than five years. Many were deeply in debt after attending chiropractic college, and went deeper into debt financing new businesses. A middle-aged provider assessed the situation as a “subconscious” one. Younger doctors cannot afford to crack a patient’s back once and tell the patient to return when the pain is unbearable. They are more likely to develop a continuous treatment plan than a more established doctor with a flourishing practice who cannot see patients more than once a week or once every two weeks. The provider said the younger doctors were not necessarily practicing unethically, but economic reality was driving their decision to place most patients into regular treatment plans.

Outlining the Departmental Role

The Department’s role in this matter is limited by statute. Insurance regulators do not have the jurisdiction to determine what constitutes medical necessity, but can look to the *process* of determining it to see if overall it is fair to all consumers. This process appeared to the examiner to lack clarity and consistency, which in turn caused confusion and discontent with consumers. N.D. Cent. Code § 26.1-04-03(9) prohibits certain claims settlement practices when performed with a frequency indicating a general business practice. Fairness, in this context, may refer to clarity and consistency in Company standards. Inconsistent claims handling may be an unfair claims settlement practice. This is not to say that all claims must be honored. The examiner noted the above instances where it appeared that chiropractors were treating their patients much too frequently, and patients who were seeking unnecessary services were encouraged to keep coming in. These abuses have forced the Company to try to control utilization. There is no doubt that there are deep “scope of practice” differences between the Company’s reviewers and many of the state’s chiropractors that cannot be resolved easily. The Department cannot resolve these differences, but encourages the parties to work to resolve the issue.

Most of the providers contacted by the Department offered to participate in any panel convened to study alternatives to the system in place. Some state regulators who have grappled with similar problems have moderated forums to reach consensus decisions on alternative care (chiropractic) benefits. That is an option available in this instance.

Marketing of the Plans

Statutory authority does attach to the marketing of these plans, under the Prohibited Practices Act. When it markets plans that offer chiropractic benefits, the Company can potentially violate the Prohibited Practices Act prohibiting misleading advertising if the Company places artificial impediment to the reimbursement of those services which its marketing materials lead people to believe are covered. The Company should ensure that it is not interfering with chiropractors’ practices or placing artificial constraints on care through undefined caps or denials of services.

Alternate Ways of Controlling Utilization

The Department is aware there might be no perfect system. The Department further may lack jurisdiction to specifically require a particular process. However, the Department would encourage the Company to come to the table with interested parties to examine alternative

methods of controlling utilization and managing care.

Because the denials based on a lack of medical necessity are the focal point of consumer and provider dissatisfaction, the examiner will suggest alternate ways for the Company to control utilization that do not involve medical decision-making. Even providers who do not have problems with the system in place disagree with the Company as to what constitutes medical necessity. The examiner is not suggesting a system that grants the treating provider a presumption of correctness, because of concern that those who overtreat would expose the plan to unanticipated costs and increased liability. It would undermine a system of checks and balances that works to provide good medicine at an affordable price. Alternatives are, however, being suggested because facts observed by the examiner indicated that the present system of chiropractic claims handling lacks uniformity and predictability.

Other states' insurance statutes establish reasonable standards to cap utilization of chiropractic benefits. For instance, Virginia limits coverage of chiropractic services to musculoskeletal ailments only, and plans do not have to provide coverage for visceral conditions arising from problems or dysfunctions of the abdominal or thoracic organs. (8 VSA 4088a). This law also limits coverage of therapies or physiotherapy modalities and rehabilitative exercises.

Actuarial caps can also effectively control utilization. Minnesota Blue Cross plans offer a finite number of benefits, averaging around 20 per year although this could be a disadvantage to persons who legitimately require additional treatment. Also, the company might correctly anticipate a tendency for utilization to reach the numeric limitation. However, a year-end incentive for those providers who would not automatically use treatment maximums could deter potential increases in visit numbers, while providers who conserved treatment could be reimbursed higher amounts. The Company could offer an endorsement for additional visits as an optional benefit for purchase.

Insurers in other states have put dollar limitations or lifetime maximums in benefits plans for specialized services or chronic illness that are historically difficult to control. The Company could insert an "alternative care" maximum on benefits, or structure plans with a medical spending account that would apply to alternative care. Patients could elect to use it as they wished – with the understanding that their premiums would rise, perhaps significantly, for these services.

Benefit design is fundamental to utilization management. Co-pay requirements are an effective brake on use of services. Higher co-pays have been shown to decrease utilization substantially. An analysis of data from the 1974-82 RAND Health Insurance Experiment assessed the effect of cost sharing on the use of chiropractic services. (*Medical Care* 34(9), pp. 863-872, Shekelle, 1996). The study, supported in part by the government Agency for Healthcare Policy and Research (AHCPR, now known as the Agency for Healthcare Research and Quality or AHRQ), reported that any level of cost sharing equal to or greater than 25% decreased chiropractic use by half compared to free care. The study was obtained through an interview for this examination.

Medicare, and some states, limit coverage of chiropractic services to spinal ailments only, and do not reimburse for treatment of extremities. The Company could model its guidelines after these types of guidelines to control costs.

Finally, a pre-certification process should again be reconsidered. Treatment plans can be reviewed prospectively and potentially high claims can be identified early and appropriate case

management interventions achieved. Providers can be made aware of potential problem cases early on. It lets consumers know what they can expect for treatment costs, rather than getting bills for denied services they did not anticipate, and it allows patients to benefit from having the most effective and appropriate treatment plan in place. It also can minimize the frustrations and ill will that retrospective review and retroactive denial of services is creating. The payor benefits from cost effective use of services.

Evaluating the Cost Factors

It appears the Company has occasionally denied the most cost-effective and efficient services, while paying the more expensive claims of non-chiropractors.

Examples

- One complainant had numerous chiropractic treatments for headaches. It appeared from studying her claims that when she believed her \$30 chiropractic visits were not being paid, her next visit was to Mayo Clinic for a brain MRI. (Claim # 9923085552). The cost was \$1,960. The Company's share was \$1,822.80. The patient also had an extensive course of physical therapy, which she indicated that she underwent because her chiropractic visits were not being paid. The physical therapy (Claim # 9930211350/00 and others) was all reimbursed.
- Another complainant indicated that she turned to an orthopedic specialist when her chiropractic care was denied. (Claim # 0021313191/00.)
- A similar situation was noted with patient XXX XXXXXXXXXX, who was seeing two different chiropractors for migraine headaches from 1999-2000. She stated she had numerous claims denied. During this course of treatment, she underwent two brain MRIs in 1999 and skull x-rays at a hospital. All of these services were reimbursed. The chiropractic care had relieved her headache symptoms, she indicated in her complaint.

Contract language states the Company will reimburse services that are “medically appropriate and necessary as determined by [it] and within the scope of the licensure and practice of a chiropractor, to the extent services would be covered *if provided by a physician.*”

Recommendation No. 1: For services conducted within the scope of practice of chiropractors, the Company must not discriminate against chiropractic treatment by reimbursing services of certain professionals while denying similar services provided by chiropractors, or by reimbursing similar services at different levels.

Documentation Guidelines and Issues

More elaborate documentation was required for reimbursement by the late 1990s. Many chiropractors in the past had maintained minimal patient records. Documentation has been difficult for some to adopt because of the way their practices are structured. Physicians practice in multi-doctor clinics or hospitals that impose documentation standards, or have professional record-keepers on staff. Many have medical directors or coding specialists who oversee the documentation and provide guidance as needed. Chiropractors are often in single practitioner

settings, or have small clinics they manage themselves. If they have not learned proper documentation in chiropractic college, there is usually no professional assistance within their own practice, especially in rural settings. Many of the chiropractors over age 50 who spoke to the Department indicated that note-keeping was not taught or emphasized in college, so they placed low priority on refining their documentation.

Chiropractors indicated that they particularly began having problems in 1997 when new CPT codes went into effect on May 1 of that year. CPT codes are Current Procedural Terminology codes, published by the American Medical Association. The coding system – a five-digit numerical code - provides uniform language that accurately describes medical, surgical, and diagnostic services. Two digit modifiers can also be appended when appropriate to clarify or modify the description of the procedure. (For instance, indicating whether the right or left side of the body was treated.) Rules for assigning appropriate codes are complex, but the codes are used universally in processing healthcare claims. The complexity of the documentation for chiropractic procedures under the 1997 CPT codes required specialized training or knowledge for compliance. In late 1998 the Company sent out form letters instructing chiropractors how to document charts for medical necessity. It appears as if only those who had demonstrated difficulty received the letters.

The Company also sent out a Healthcare Bulletin in April 1997 spelling out the requirements for documenting chiropractic procedures. Some providers received letters in 1998 informing them how to document charts for medical necessity. One of the most important documentation changes implemented ongoing pre-manipulation patient evaluations for every visit. Chiropractors had to list subjective and objective findings, the treatment plan and his or her opinion as to the effectiveness of future and past treatments. (Chiropractors are taught that these are SOAP notes, for Subjective, Objective, Assessment and [Treatment] Plan.) Chiropractors performing certain therapies, such as ultrasound or electrical stimulation, also had to document the type of therapy performed, the anatomical location where it was applied, and the duration of the therapy. Minimum durational times were established for certain therapies. Essentially, documentation was required so chiropractors would assess the patient's condition at each stage and evaluate the necessity of all treatment rendered.

Providers who continued to experience problems documenting services were placed on review by the Company; their claims were scrutinized and denied if mistakes persisted. The documentation requirements were the source of many provider complaints to the Department.

Many providers said they did not know or understand the utilization and documentation guidelines. The examiner found that they were neglecting their responsibility to read the publications the Company had issued, because adequate notification was sent. Whenever a provider requested a copy of the guidelines, the Company promptly sent them. Additionally, the ACA documentation recommendations indicate that the patient's name and the initials of the person making the chart notation should appear on each page of the medical record. State and national associations conduct training seminars and issue examples of how to document treatments that are readily available to providers. An abundance of information can be obtained on the Internet. Providers who are not properly keeping records simply are not exercising due diligence in their practices.

That said, there may be opportunities to improve the process. For instance, it appears unreasonable that "all chart notes must either be signed or initialed by the individual who performed the services." Many providers have streamlined their records and store all patient

charts on computer. This requirement forces them to download and print out patient files and sign or initial the notes, which imposes additional administrative costs on the clinics.

Recommendation No. 2: The Company should consider removing the chart signature requirement from its guidelines for providers with electronically stored medical records and explore the possibility of electronic signatures for those providers.

There did appear to be some inconsistencies in how the consultant reviewed the chart notes and whether he was requiring all chiropractors to adhere to the same high standards. The thoroughness of this review is detailed later in the report.

Reimbursement Policies - Systemic Abuses

The examiner noted consequences of the tightening reimbursement requirements. Given reimbursement policies, coding restrictions, and utilization reviews, some chiropractors felt an incentive to only report those symptoms and diagnoses that facilitated reimbursement. They said that reimbursement policies occasionally influenced the records kept and the diagnoses reported. Some said this “gaming the system” approach was necessary to ensure quality care. Others rationalized it by citing patient advocacy. All denied that financial self-interest was the motive.

Many chiropractors complained to the Department that they were criticized for their documentation of subjective patient complaints, especially in cases where patients were unable to articulate their discomfort. These providers said if their chart notes were reviewed by the chiropractic consultant and if the consultant determined that the provider was asking leading questions, the provider was made to write off the costs of any denied services.

Entrepreneurial efforts were also not supported by the Company. Certain clinics were immediately placed “on watch” if they developed creative ways of evaluating and treating patients, or entered into office sharing arrangements with other providers to provide multiple services and split overhead costs.

A finite number of visits or a dollar maximum on benefits are ways to curb abuses of the system. Admittedly there is no foolproof method that will curb abuse. There will always be providers who try to circumvent the rules to make money. But the examiner noticed some correlations: The more restrictive Company reviewers got, the more creative some providers became, manipulating the reimbursement rules to benefit their patients.

PEER REVIEW PROCESS

The Chiropractic Consultant and Committee

Utilization guidelines from 1989 indicate that the Company would engage the services of a North Dakota licensed chiropractor to serve as consultant “for its quality assurance and claims adjudication procedures.” The guidelines also indicate that the Company would establish a Chiropractic Claims Review and Policy Advisory Committee consisting of three “cooperating chiropractors.” This has come to be known as the Peer Review Committee. Each member was to serve for 36 months, with rotating terms. The 1989 guidelines indicated that “the Review Committee shall meet as needed, *but not less than monthly*, to review all files and claims which

have been designated for review.” Those guidelines were in effect from 1989 until September 1998.

The Company did not followed its guidelines. The Peer Review Committee met only three or four times a year, according to meeting minutes produced. This delayed the review process and decisions as to contested claims. For instance, one complainant appealed her denied services (Claim # 9931504108/00) on November 30, 1999. Her provider received a decision upholding the denials 10 months later, on September 29, 2000. This was not a singular incident.

Review Protocol

The Company guidelines also indicated that the Committee was to review each case individually and “forward its determination for payment or denial to [the Company] *along with a written explanation of the basis for the position of the Review Committee.*” No such explanations are contained in the Company records produced. Committee meeting minutes only indicate continued denials, with rare approvals of services. Chiropractors who pressed the Company occasionally received an explanation for the continued denial, but those generally came verbally. Even patients who appealed denied services were not provided a definitive basis for the denial. In the above-mentioned appeal, the provider requested an explanation for the decision. The Company failed to respond.

N.D. Cent. Code § 26.1-04-03(10) prohibits unfair communications by an insurance company. Companies, under this portion of the Prohibited Practices Act, must adopt and implement reasonable standards for prompt handling of communications about grievances. The Company should respond substantively to a provider who requests explanation of denied services, especially when the Company’s own guidelines specify that such written explanations are required. The statute addresses communications to “insureds or claimants.” In most cases, providers received an explanation of appealed services that simply repeated the Explanation of Benefits sent to the patient, without giving a basis for the decision.

Recommendation No. 3: The Company should promptly respond in writing to all providers and patients who request explanations of denied services under N.D. Cent. Code § 26.1-04-03(10). Letters of explanation and final decisions should be sent to all appealing parties.

Committee Membership

Another section of the guidelines suggests that the Peer Review Committee members will be rotated after each reviewer’s three-year term is up. “The North Dakota Chiropractic Association is encouraged to recommend individuals to [the Company] for appointment to this committee,” the guidelines state. In reality, two members of the Committee have served since inception, and only one new member has been appointed in the 11½ years that the guidelines have been in effect. The Company has ignored recommendations from the NDCA as to prospective Committee members, and continues to re-appoint the same reviewers.

How Peer Review Works

The theory behind peer review is sound. Theoretically, it is aimed at early intervention, review of care by peers, the curbing of “coding creep”, and prospective guidance rather than retrospective disputes. Early intervention by a peer can avert an ineffective course of treatment

without unnecessarily burdening busy claims adjusters. Chiropractic treatment often builds in small increments until the provider attains a large bill. This pattern sometimes occurs without close review by claims adjusters trained to focus attention on more dramatic and costly cases. It may be particularly relevant in this case because the Company indicated that it does not have cumulators built into its automated claims system to track ongoing utilization.

Chiropractors are more likely to respond positively to review by other chiropractors rather than physicians, nurses, or claims reviewers. Once a diagnosis is known, the reviewer can indicate to the treating chiropractor the appropriate length of care based on established protocols and eliminate unnecessary services such as x-rays.

The Company's own Quality Management Plan, which includes peer review guidelines, outlines various interventions to assist aberrant providers in bringing their practices into line. The Plan includes initiatives such as "Opportunities for Improvement" and a "Corrective Action Plan" in which the Company works with the provider to achieve the corrective action once practice issues have been identified and documented. The provider is permitted to see any records accumulated that pertain to the provider's practice, and has 30 days to review any findings and respond to them.

ChiroChoice and JRY, Ltd.

In practice, peer review has not worked well for several reasons. In 1995, the consultant and the two Peer Review Committee members who have served since inception founded a for-profit partnership called Jacklitch, Remmick & Yohe, Ltd., otherwise known as JRY. JRY does business as ChiroChoice, a chiropractic preferred provider organization, or PPO.

The name of this PPO may infer an association with Blue Cross, since many of the insurance products marketed by the Company have a "choice" in the name such as "BlueChoice," "SelectChoice," "FirstChoice," or "BasicChoice." Although the Company cannot control an independent entity, it might have warned the group that this name could be problematic, especially because of its consulting relationship with all three partners. It should have distanced itself from the potentially misleading identity after incorporation of the PPO. Some consumers told the Department they thought this group was the Company's own network and that they were receiving cheaper care by selecting a chiropractor who belonged to ChiroChoice. That is because some chiropractors advertised their membership in the PPO.

ChiroChoice in 1996 recruited about one-third of the providers throughout the state to join this PPO, charged membership dues, set credentialing procedures, and formed utilization guidelines modeled closely after Blue Cross' policies. The PPO was marketed as an elite group of chiropractors that could provide the highest standard of care and would police its own members for over-utilization. It successfully bid its utilization management services to Medicare and North Dakota Workers Compensation. The JRY partners have the exclusive contracts to review chiropractic services of those two agencies, so three chiropractors review most chiropractic services in the state. They have also negotiated with some major medical centers in the state to enable their members to be the exclusive providers of chiropractic services for those entities.

Conflicts of Interest

The Company should be aware that this presents the committee members – its reviewers - with a potential conflict of interest. For Blue Cross, the partners review the services both of

chiropractors they are in direct competition with, who are not members of the PPO, and chiropractors they have a direct business relationship with.

JRY even bid its services to Blue Cross as a specialty provider network in July 1997. The BlueChoice product has a series of medical networks established in which subscribers can qualify for discounted care if they use network providers, much like an HMO.

The networks, not the Company, select specialty providers to participate. Thus, the Company suggested that ChiroChoice approach each network if it wanted to be the exclusive providers of chiropractic services. With regard to the SelectChoice products, the Company told the JRY partners that subscribers had bought the product with the understanding that they could get chiropractic services from any participating provider, and not a select organization.

Many chiropractors voiced their concern about this relationship to the Department, and the “omnipotent power structure” that has been created, in their words. Providers said the partners’ all-encompassing utilization control of chiropractic services in the state was too concentrated in the hands of too few. Many said that if they experienced problems with the JRY partners over Medicare reimbursement, that spilled over into their relationship with the three in their Blue Cross reimbursement – or vice versa. Providers placed on watch for Workers Compensation claims often found themselves under focused review at Blue Cross.

One provider who said he experiences no difficulties with the partners, nevertheless expressed some concern that the reviewers were using Workers Compensation standards when scrutinizing Blue Cross claims, and he did not feel these were appropriate parameters when most health insurance patients were not seeking intense treatment to return to the workplace. Another said he had concerns that they were using Medicare review standards which deny treatment of all extremities.

Chiropractors in the state agree that they should have a group to promote chiropractic care within a managed care framework, to credential members, and improve overall services and image. Many agreed that the relationship with the NDCA was necessary to give chiropractors a voice and presence with the Company. But there appears to be little satisfaction with the status quo. Some chiropractors argued that a liaison committee, made up of the various geographic districts, is necessary between the Company and the NDCA, and not just a single provider as is the current situation.

Inconsistencies Among Patients

Finally, the reviewers appeared to be treating existing patients differently from new patients, even though they presented with similar diagnoses. For example, Claim Nos. 0007604281 and 0007604283 involved a rural couple involved in a farm accident. The husband was an existing patient. The wife was not. All of her claims relating to the incident were paid. His, including x-rays, the office visit, and manipulation, were denied as medically unnecessary. The guidelines indicate that an office exam is allowed once every 18 months except “when circumstances require an extended evaluation of an established patient.”

X-rays are allowed when medically necessary. There was no rationale as to why the consultant or reviewers determined that the wife’s visits were medically necessary, while the husband’s were not. The provider indicated that he would not think of treating the husband without an examination or x-rays after the accident for fear of incurring malpractice – or ruling out a fracture. The Company’s own documentation (V-Note to husband’s Claim No. 0009604541)

indicated that “this is not an accident. This is a exacerbation [sic] of an accident or is not an accident.” This is an example of inconsistent application of the guidelines. The wife’s case was considered to be an accident. The husband’s was not.

Because of the dissatisfaction of some with the status quo and the perception of conflicts of interest and possible favoritism in the review and appeals process, change is recommended to return the process back to a true peer review.

N.D. Cent. Code § 26.1-04-03(17), effective August 1, 1999, prohibits insurers from giving incentives to withhold medically necessary care. Blue Cross needs to be careful that its retainer of the JRY partners, because they effectively control costs and utilization in the Company’s opinion, does not violate this section of the Prohibited Practices Act.

Recommendation No. 4: The Company should change chiropractic consultants and Peer Review Committee members immediately due to the perception of conflicts of interest and possible favoritism. The Company should regularly rotate members of the Committee as intended by its guidelines and accept names for appointment from the NDCA. At least two alternate members should be appointed to deal with situations in which a conflict of interest is present for the regular voting members.

Integrating Diverse Treatment Philosophies

Another reason for changing members is to accommodate the different philosophies espoused by all providers in the state. Many of the newer chiropractors use activators or integrators, a high velocity rubber mallet that delivers gentler treatment than the physical “back crackers” who use their own strength to manipulate patients. The providers who use these torque methods generally require more treatments than those who use manual treatments. Activator supporters indicate that these methods work better on patients, and especially geriatric ones. The consultant and Peer Review members use manual methods. All of them have been in established practices for more than 20 years. A diversity of philosophy may be required to smooth the relations the Company has with the providers who are schooled differently.

Although the Company does not need to raise treatment parameters specifically to accommodate other philosophies, it should not ignore their treatment methods. One provider indicated that the concept of “outliers” is a matter of perception. The gentler treatment methods require longer treatment parameters, so chiropractors who use activators will always be skewed toward the fringe area when visits numbers are averaged. He defined it as comparing apples to oranges and indicated that national studies don’t validate a “right” way or a “wrong” way to treat people.

Appeals Delays and URAC

Committee members do not prepare in advance for meetings. Company officials say the members meet as needed, discuss the cases brought before it, and review the patient charts during the meeting. Many providers complained that appeals took too long, especially when the Committee only met three or four times a year. The incident mentioned above, a 10-month delay in the appeal, was not an isolated one. Most contracts promise that the Company “shall make a final determination on each appeal within [45/60] days of receipt of all information

requested...to complete the review.” In the instance in which the Company took 10 months to decide the appeal, no records indicate that it requested additional information to review in the interim.

Additionally, the Company applied for utilization review certification through the American Accreditation HealthCare Commission and is nationally accredited. This is referred to as “URAC,” for its former name, Utilization Review Accreditation Commission. In the 1999 application for re-certification, the Company attested that it was meeting certain standards in its retrospective review and appeals process. UM (Utilization Management) 4 and 35, for standard appeals regarding medical necessity, mandate a 30-day window for decisions once the reviewers have received necessary documentation from an appealing provider or patient. It does not appear the Peer Review Committee is in compliance with these standards.

Recommendation No. 5: The Company should adhere to its contractual appeals provisions and the URAC standards. Peer Review Committee members should meet no less than monthly to decide appeals from denied claims or services. The Company should also reconcile its contract language and chiropractic guidelines to reflect the procedures certified to URAC specifying a 30-day turnaround time on appeals.

Independent Judgment in Reviews

The Review Committee’s lack of preparation in advance of its meetings also may result in the Committee members unduly deferring to the recommendation of the consultant. The Committee, according to minutes produced by the Company, functions as an adjunct of the consultant and not as an independent review board. Very few decisions by the Committee in 10 years overturned an adverse ruling by the consultant. This reinforces the perception of unfairness of the review and appeals system.

Recommendation No. 6: The individual members of the Peer Review Committee should exercise judgment independent of the consultant.

The Company was asked to provide all correspondence sent to providers and patients. It produced hundreds of form letters to providers indicating that the Committee had made a “careful review” of the services appealed. The form letter reads, “Medical necessity has not been demonstrated in these cases and denial of benefits is continued.” It continues, “No further appeals will be considered on any of the denied services and all of your future claims will be reviewed for medical necessity and appropriateness.” According to documentation provided by the Company, not a single letter was sent out from 1990 through August 2000 indicating the Committee had overturned a prior decision and awarded benefits. If a prior decision were to be overturned, the company indicates the claim would be reprocessed with a new Explanation of Benefits.

Schedules of Care

Beginning with the March 24, 1995, meeting, the Review Committee began placing numerous appealing patients “on maintenance” schedules of care. This trend continued through the April 4, 1997, meeting. Committee meeting minutes suggest that for nearly two years the Peer Review Committee was allowing maintenance care benefits for certain patients that were not

contractually provided and in violation of Company guidelines. Maintenance care is a non-covered service that the Company has denied in thousands of other cases.

Recommendation No. 7: To the extent meeting minutes purport to place patients on maintenance, Peer Review Committee members should not allow maintenance care for some patients that is not contractually obligated.

After 1997, the Committee continued to place patients on schedules of care. It is unclear if these schedules were considered maintenance care or supportive care because the meeting minutes often did not specify which. The Committee continues to do this at the present time, and this is problematic. If chiropractic services are reimbursed based on medical necessity, it is unclear how allowing a patient one visit every 3-5 weeks meets this criteria if the Company automatically pays such benefits.

Notification of these schedules of care is also an area that needs to be addressed. The Company did not produce any correspondence in which the patient or provider is notified of this schedule of care determined by the Company. Patients only learned of this if they had subsequent claims denied because they had “exceeded the schedule of care”, or if they pressed the Company claims staff as to why their care was being denied. Providers were not advised of these schedules either, and sometimes learned of subsequent denials when they were forced to write off the costs of any care the Company determined had exceeded the schedule. The company indicates since January 2001 it notifies patients of scheduling care.

The examiner specifically requested correspondence in the files of 10 subscribers who had been placed on schedules of care by the Peer Review Committee. None received letters putting them on notice that their benefits were being reduced. This would appear to violate the Company’s appeals process guidelines. It also may not be in compliance with the procedures the Company certified to URAC. One patient, after continually pressing the Company, received a letter on April 5, 2000, confirming that she had been placed on a schedule of care but not informing her what it was. (Plan XXX XXXXXXXXXX).

Utilization Review Applicability

Providers and patients have reasonable expectations of reasonable care under their contracts with Blue Cross. When they have not been informed that the Company has determined that a restricted level of care will be allowed in the future, that interpretation of the contract should be communicated to the patient and the provider.

But when the Company reviews chiropractic services, either through the watch process or those appealed by a consumer, and its reviewers recommend prospective courses of treatment, N.D. Cent. Code Chapter 26.1-26.4 becomes relevant. It specifies that utilization review is a system for prospective and concurrent review of the necessity and appropriateness in the allocation of health care resources and services. Specifically, N.D. Cent. Code § 26.1-26.4-04 mandates a two-day notification period for determinations of all prospective services. This would apply when the Peer Review Committee or the chiropractic consultant places any Blue Cross patient on a prospective schedule of care.

Recommendation No. 8: Written notification to every patient placed on a schedule of care by the Company's consultant or Peer Review Committee should be sent within two days. Letters should also be copied to the patient's last treating provider. The schedule of care should be fully disclosed.

The South Dakota System of Review

South Dakota has a peer review system for chiropractic services in which regional clusters of chiropractors serve on review panels. The executive chairman, in an interview, said the system has worked well because potentially all chiropractors in the state can serve on panels, which ensures fairness in the decision-making process. It is a "do unto others" psychology, but the chairman said professional courtesy has not hindered decision-making. The nominal costs of a review are incurred by the insurer or attorney requesting it. Patients who request a review pay no costs because it is a consumer protection board.

Alaska's Peer Review Standards

Alaska sets out standards for peer review committee members that merit mention. These laws prohibit peer review committee members from reviewing cases in which they have a direct business relationship with the chiropractor being reviewed. A direct business relationship can include a contractual one, which would include ChiroChoice members. The statute also places one citizen member on a four-member panel of reviewers. The remaining members are chiropractors. 12 AAC 016.400.

Recommendation No. 9: The Company should study other states' statutes for peer review standards, consider adopting similar guidelines for its own peer reviews.

Interested parties, such as the chiropractors individually or the NDCA, could assist the Company in lobbying for a change in the North Dakota statutes to allow for similar provisions.

Reviewing Maintenance and Supportive Care

Company reviewers also appeared not to be consistently applying standards for maintenance or supportive care. The maintenance care definitions prevented patients from receiving supportive care for chronic conditions and acute care for exacerbations of existing conditions. For example, Claim No. 9936404122 appears to fit the definition of supportive care, but was denied. So do several other claims submitted by this patient but denied by the Company.

The ACA has definitions of supportive and maintenance care that may provide brighter distinctions. Supportive care, in relevant part, is defined as: "Long-term treatment/care that is therapeutically necessary. This is treatment for patients who have reached maximum therapeutic benefit, but who fail to sustain benefit and progressively deteriorate when there are periodic trials of treatment withdrawn..."

Maintenance care is defined, in pertinent part, as: "Elective health care that is typically long-term, by definition not therapeutically necessary but is provided at preferably regular intervals to prevent disease, prolong life, promote health and enhance the quality of life. This care may be provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration or it may be initiated with patients without symptoms in order

to promote health and to prevent future problems...”

Recommendation No. 10: The Company should consider revising its descriptions of supportive and maintenance care to more closely resemble the ACA definitions.

Such definitions might promote better understanding by providers and patients as to what constitutes maintenance care and minimize complaints for denials of this type of treatment.

Finally, the Company needs to bring its chiropractic peer review process into compliance with its own Quality Management Plan. This would include working with aberrant providers and would require better oversight of the Committee.

THE 1009 LIST AND TREATMENT PROTOCOLS

High Utilizers of Chiropractic Services

Most providers had patients on the list of “high utilizers” that the Company compiles to track patients who have high use of chiropractic services. These patients are identified internally by having a “1009” limit placed on their claims. This numeric code automatically holds all of their chiropractic claims for manual review by the chiropractic consultant. Their medical chart notes are ordered and the consultant reviews them for medical necessity.

Use of Therapies

Examining this list of patients and the treatments many chiropractors were giving yielded some inconsistent findings. One of the differences in treatment philosophy involves the use of therapies given in addition to a traditional manipulation. Therapies are services such as ultrasound or electrical stimulation. Many chiropractors use these because they say therapies relax the muscles and enhance the manipulation. The Company’s guidelines specify that use of therapies must adhere to the same standards of medical necessity as manipulations. The consultant indicated that chiropractors must exercise an independent medical decision to use each therapy – at each visit. He said if he sees patterns of chiropractors “rotely applying” therapies, he will deny these as medically unnecessary unless the chart notes indicate the need for such treatment. Most of the patients with high utilization patterns receive therapies in addition to their manipulations. The therapies are separately billed services that increase the cost of each visit. The guidelines specify that only two therapies per visit will be allowed.

Possible inconsistencies occurred in determining whether therapies were medically necessary.

Examples

- One of the consultant’s patients, XXX XXXXXXXXX, received 37 treatments in 1999 and 24 treatments in the first half of 2000. Each treatment involved the use of ultrasound, a therapy, as well as a manipulation. None of the patient’s claims were denied.
- Patient XXX XXXXXXXXX was treated by the consultant 49 times in 11 months from October 1999 to August 2000. Each treatment again involved the use of ultrasound with manipulations. None were denied.

- Patient XXX XXXXXXXXXXXX was treated by the consultant 41 times in 1999 and 23 times in the first half of 2000. Only six of these 64 treatments did not combine ultrasound with manipulation. Additionally, two manipulations were submitted on December 30, 1999 (Claim Nos. 0001014611 and 0000378700) and three manipulations plus an ultrasound treatment were submitted on March 9, 1999 (Claim Nos. 9907810341 and 9906912231). None of these frequent visits and therapies were denied.
- In contrast, patient XXXXXXXXXXXX, who was not seeing the consultant, had a similar number of treatments for a similar diagnosis, most with electrical stimulation, another form of therapy. This patient's claims were reviewed by the consultant, who denied much of the therapy as medically unnecessary.
- Patient XXX XXXXXXXXXXXX sought similar treatment as the consultant's patients above. About once every 10 days the patient was treated with manipulation and ultrasound. At least one-third of these visits were denied by the consultant or reviewers due to the frequency being excessive or the provider failing to demonstrate the medical necessity of the treatment. The therapy portion of Claim No. 0007704289 was denied as medically unnecessary.
- Patient XXX XXXXXXXXXXXX submitted 18 treatments in 1999 that entailed manipulations plus ultrasound. On the 19th visit, the consultant denied the patient's therapy as medically unnecessary. The following month he placed this patient on a schedule of care to allow one visit every four weeks. The patient remained on this same schedule in the year 2000. (Neither the patient or provider was informed of this limitation of her prospective services, as suggested above to comply with N.D. Cent. Code Chapter 26.1-26.4.)
- Patient XXXXXXXX, from late January 1999 until the end of the year, saw Provider No. 4311, one of the Company's Peer Reviewers, 45 times. The patient saw the same provider 30 times in 2000 through July. All 75 visits entailed use of electrical stimulation with manipulation. Only his last visit, on July 27, 2000, was denied for reasons of medical necessity.
- Complainant XXX XXXXXXXXXXXX saw his chiropractor considerably fewer times than the case referred to above during the same 18-month period. He had ultrasound treatments and manipulations, much of which were denied because the Company's reviewers determined they were medically unnecessary. His provider was on watch.
- Complainant XXX XXXXXXXXXXXX had all but three visits denied in 1999 as medically unnecessary. By mid 2000, when the examiner reviewed this patient's claims, not a single visit had been allowed the entire year. The patient was also receiving therapies and manipulation simultaneously. The provider was on watch.

The reasons for these inconsistencies are unclear, but the consultant and Peer Reviewers appear to be allowing more treatments for their own patients than they are for other chiropractors. The patients appeared to be suffering from similar musculoskeletal ailments. If reviewers are deviating significantly upward from the average annual number of visits (5.5),

they should be doing so for all similarly situated patients and not just their own. The treatment frequency seems high for the reviewers' patients compared to the other chiropractors.

Thoroughness of the Review

Between the number of providers who must send in chart notes with each claim, and the number of patients, mostly the high utilizers, being scrutinized for their treatment, thousands of pages of chart notes are being submitted to the Company each month.

The consultant is a part-time contractor who is only at the Company one-half day a week. He submits hours that he spends reviewing claims outside of his on-site time. Comparing the number of hours he submitted (30-35 per month until 1998, then 40-50 per month to the present) and the amount of paperwork to be reviewed, it appears difficult if not impossible for one person to thoroughly review these records. This may be the cause of the inconsistencies and delays detailed herein.

THE WATCH PROCESS AND PROFILING

The Science of Profiling

As previously stated, the Company compiles statistics on each chiropractor. This process is called profiling. Insurers often compile such statistics to study utilization patterns and establish providers' resource consumptions. However, without defined goals, this information can be misused. In some respects the Company appeared to be using the profiling information to establish ongoing cost containment and accountability mechanisms. In other cases it appeared as if profiling was used to force behavioral changes to cut costs when it might have been directed to quality improvement. Theoretically, profiling is used to standardize practices, enhance uniformity, and reduce variation in practice patterns. This in turn reduces disparity in treatment. It is a controversial practice.

Profiling can be put to good use. It can be used to initiate creative discussions among practitioners and insurers about clinical variation and positive changes that may be used to improve the provider's clinical decision-making. It can be an opportunity to benchmark practices and physician performance, conduct peer comparisons, and improve the quality of care through education and feedback. If endorsed by participating practitioners, it can promote development of internal protocols that strengthen efficiency and ultimately help an organization's utilization management activities evolve into a more sophisticated medical management program.

Another weakness in profiling is that diagnosis codes often do not indicate how sick the patient is. A diagnosis code usually does not indicate the degree of muscle spasm, for example, or the severity of a muscle sprain or strain. This may compound inaccuracies in profiling. Patient transience also undermines profiling information. Again, this is more prevalent in chiropractic patients who tend to drift from provider to provider looking for relief, and sometimes are seeing two chiropractors simultaneously or a chiropractor and a medical provider at the same time.

Examples

- For instance, Patient No. XXXXXXXXX alternately saw Provider Nos. 4236 and 4311, one of the reviewers, numerous times in 1999.

- Patient No. XXXXXXXXXX saw three providers, including the same reviewer, between 1999 and 2000.
- Patient No. XXXXXXXXXX saw eight different providers those two years.

Blue Cross Profiling: The Watch Process

Blue Cross began profiling chiropractors sometime in the 1990s. Letters went out in 1996 to specific providers concerning their use of certain procedure codes and placing them on notice that continued use of the codes would result in future denials of their claims. At the end of 1997, claims personnel compiled statistics on the main chiropractic procedure codes that went into effect earlier that year. Personnel also averaged costs per visit of each provider as compared to the profile average. This was initially put to good use. In 1998 the Company sent letters to “outliers” – providers whose performance was identified as being outside acceptable norms. The letters indicated what percentage each code should be used to be within average ranges and told the providers which codes they were aberrant in. But this appears to have been the only remedial use to which the Company put this profiling information.

Outliers are subject to an internal process of focused review called a “watch.” Providers on watch must submit chart notes with all claims and frequently services were denied if they did not. Submitting chart notes can be an administrative hardship: Chiropractors reported spending significant amounts of administrative time communicating with the Company on medical review and medical necessity issues, and over denied claims. The cost to produce a great volume of medical charts and send them all to the Company can be quite high for the providers on watch. Some providers have been on watch for many years, according to Company records.

Once a provider is placed on watch, the Company programs an automatic “hold” onto all claims submitted. These claims are set aside for review by the consultant and the provider must submit chart notes to document each service billed. Some providers on watch for many years have their own “hold codes” assigned solely to their provider number or clinic.

If chiropractors on watch do not submit chart notes with their claims, the claims are automatically denied until the notes are received. This potentially violates the Prohibited Practices Act, N.D. Cent. Code § 26.1-04-03-(9)(c), which mandates that insurers conduct a reasonable investigation into a claim. Denying claims without conducting any investigation does not appear to comply with the statute, particularly when there can be lengthy delays in getting the medical records sent to the Company.

Recommendation No. 11: The Company should bring its watch procedures into compliance with N.D. Cent. Code § 26.1-04-03(9)(c) by sending claimants notice that their claim is being held pending receipt of more information, and not summarily denying claims without conducting a reasonable investigation.

Denied Claims for Watch Doctors - Lack of Controls or Coordination

In most cases, as both the manual and automated claims reviews indicated, claims initially denied for these providers usually remained denied even after the chiropractic consultant reviewed the records and even after the denials were appealed. The claims review indicated that appeals had anywhere from less than 1% chance of being overturned, to a 20% chance at

best, depending on the year. On any given year, about 20% of all chiropractors are on “full” or “partial” watch. They receive half of all claims denied for treatment reasons.

The Company has no auditable procedures for subjecting a provider to being on watch. One letter to a provider dated February 4, 2000, indicated that “we are in the process of establishing specific criteria for a chiropractic focused medical review process to replace the current process.” As of late 2000, it appears none had been formulated.

Recommendation No. 12: The Company should establish written guidelines for placing chiropractors under focused review and communicate those guidelines, once formulated, to each chiropractor. If the Company distinguishes between full and partial watch, it should define each category and criteria for placing a provider within each. Target goals for utilization should be communicated to all providers if they are incorporated into watch status. These guidelines should be published in the Company’s Quality Management Plan.

The Company indicates it has drafting guidelines accordingly.

Profiling Statute

In 1999, the North Dakota Legislature passed N.D. Cent. Code § 26.1-36-41. In relevant part the law states that insurers may not use profiling information to unfairly disadvantage a provider. Subsection 2 mandates that if an insurer uses profiling information to evaluate a provider’s practice, “the entity shall provide upon request of the practitioner at any time, a description of the criteria, data sources, and methodologies used to compile the practice profile concerning the practitioner and the manner in which the practice profile is used to evaluate the practitioner...” (Similar due process provisions under N.D. Cent. Code § 26.1-17-12(2) were in effect while the Company was a nonprofit health service corporation, until January 1998.)

The examiner believes that Blue Cross has committed numerous violations of this statute by refusing to disclose profiling data to chiropractors that have requested it.

Examples

- On Aug. 21, 2000, Provider No. 4384 requested his profiling information and the Company refused to provide it.
- Provider No. 4253 made three requests for this information in June, July, and August 2000 and was refused.
- Provider Nos. 4245 and 4249 requested the profiling data in October 2000. Again, the providers were refused the information. The Company drafted a form letter in response to these requests, stating that the statistics “are not appropriate for distribution in their current format” because they contained statewide comparative data that was unable to be refined for dissemination. Provider Nos. 4245 and 4249 received a letter from the Company on July 17, 2000, that stated in part, “Your request for practice pattern reports is an area that we are looking into as this may well improve communications between our offices and help alleviate future misunderstandings.” The letter acknowledges

that the Company needs to improve its communications since the Company controls the substance of the information to be communicated to the providers.

- Provider No. 14095 was especially diligent in his contacts with the Company concerning his watch status. He made numerous calls over a two-year period, and then engaged in ongoing correspondence with the Company (and the NDCA) attempting to improve the aspects of his practice that he believed were the reason he was on watch. He sought feedback. In one call documented, he indicated that the experience of being on watch for several years was so stressful to his partner that she was thinking of retiring, even though her career had barely begun. (DCN ND 9917300407). Although he did not specifically request his profiling data by using the precise term of art, in December 2000, he finally wrote to ask why he had been on watch for several years. In part, the Company's response was, "The content of the submitted documentation is not the primary reason for your clinic being placed on a prepayment review. Another factor includes utilization and comparison of statistics to your peers..." The Company should have disclosed the profiling statistics and advised the provider where his utilization was in relation to his peers, or indicated what the benchmark was so that he could bring his practice into line with Company expectations.

Recommendation No. 13: The Company, within 30 days of this report, should bring its profiling data into compliance with N.D. Cent. Code § 26.1-36-41 and disclose statistical profiles to all providers who have requested them. All future requests for profiling data should be complied with in a timely manner.

The Company indicates it expects to be in full compliance in 2002.

The Company explained it did not consider watch status to be a "sanction" under the statutory language. This is debatable. Watch status appears to subject providers to a disproportionate amount of delayed and denied claims and to impose administrative and financial hardships on them.

The statute imposes a six-month remedial period in which a provider can bring an "excessive or inappropriate practice pattern" in line before sanctions are imposed. Without having to resolve whether watch status is a sanction within the meaning of the statute, it would demonstrate good faith on behalf of the Company to provide such a six-month remedial period. The Company should work with identified aberrant providers for the six-month period specified in N.D. Cent. Code § 26.1-36-41(1) before imposing sanctions such as watch status and should give written notice to all providers it places under focused or heightened review.

Educational vs. Punitive Process

Although the Company indicated that it endeavored to educate the outliers to help them bring their practices into line, providers on watch reported losing business because of the denied claims. Many argued that it constituted restraint of trade or damage to their practice.

The Peer Review Committee has periodically invited various providers to meetings to discuss their treatment protocols as part of an "educational process," as the consultant said. Several providers who attended the meetings told the examiner that they were subjected to humiliating scoldings and there were never offers of help to bring their practices within Company

expectations – especially when they were not told what those were. Meeting minutes do not give indications of what transpired between the Committee and the sanctioned providers, except to note their appearances at various meetings.

Watch Notice

Compounding the watch process was the lack of notice. The Company did not start informing providers that they were on watch until mid 1998. Until then, providers learned of it through the denied claims or through patients who investigated the denials themselves. In 1997, a few providers received letters indicating they were being scrutinized for their practice patterns. When the Company did begin to formally notify providers they were being placed on watch, the letters began, “We are requesting chart notes on virtually all services you provide to our members. Because of your high utilization of services, we need these records to determine appropriate reimbursement to our members.” It goes on to instruct the provider how to submit chart notes with all claims, then indicates, “If your utilization pattern improves significantly, these procedures are subject to modification.”

Many providers found this letter to be too vague to inform them as to which aspect of their practice needed reforming. And although the Company compiles statistics on utilization and charges, no specific standards for placing a provider on watch were identified. The Company monitors treatment frequency for high utilization, but that appears to be only one factor contributing to the decision to put the provider or clinic on watch. Other factors include the use or misuse of certain codes, frequent use of x-rays or therapies, or other unknown factors. Some providers were confused when they received letters indicating they were being placed on watch because of utilization problems. They assumed they were being punished for treating their patients too often.

Coding of Patient Visits

Another reason providers were put on watch was their use, or misuse, of certain treatment and procedure codes according to a Company statistical study.

Examples

- Provider Nos. 4253, 4332, and 4293 were notified that they were put on watch because of their high use of extremity codes, used to indicate treatment of arms, legs, or feet. However, the statistics showed that their use of this code was equal to Provider No. 4282 who has never been on watch.
- Meanwhile, Provider No. 4393 used the same code at a rate three times higher than Nos. 4253 and 4293, yet is not on watch.
- Provider No. 15022 is not on watch, yet their use of this code was twice that of Nos. 4253 and 4293.

Imprecise standards such as these, and word of mouth as to which providers have been put on watch, have caused others to avoid proper coding to avoid being placed on watch. This has caused overall downcoding and lower reimbursements throughout the state. Providers who do use this code had some concerns that the reviewers were applying Medicare standards to their use. As previously mentioned, Medicare does not reimburse for treatment of extremities.

Use of X-Rays

The use of x-rays has also been cited as placing providers on watch. One provider interviewed said he was scrutinized for his use of x-rays. He indicated that he felt he was being singled out because he hired an x-ray technologist. He pointed out that many rural chiropractors do not have x-ray machines, so their non-use of these diagnostic tools artificially skews average use down. X-rays are also based on medical necessity determinations, and are generally allowed at an initial visit, when circumstances indicate that the patient's condition has changed or the patient has suffered a new injury. In the case mentioned earlier in which the provider x-rayed his patient numerous times within a short span, the Company was contractually obligated to deny the claims, and correctly did. The provider is on watch, but it is unclear if his frequent use of x-rays is the reason. Another provider suggested that chiropractors who do not have x-ray technology should not be averaged in with those who do because it will lower the median.

Patients on Watch

As previously stated, the Company also put high utilizers on watch. Those are the patients identified above, with the numerical code that isolates their claims for manual review. Other than a series of letters that went to certain patients in 1991, most patients on watch did not appear to be getting reasonable notification from the Company.

The Company should notify such patients that their utilization is aberrant, and in extreme cases, invoke the case management benefit section of the contract to better control the patient's care. Based on the Company contracts, the patients have reasonable expectations of continuing care, and if the Company is going to prospectively alter the terms by lowering future benefit amounts, the subscribers should receive written notice.

ChiroChoice Members and Watch Status

Few ChiroChoice PPO members are placed on watch. This has been a source of criticism from providers outside of the network. The examiner ran some tests for one year during the automated claims review that indicated that ChiroChoice members had considerably fewer denied claims than providers on watch and fewer denials than the main population of chiropractors. But because only one year of claims was analyzed, the examiner is not able to draw any conclusions from the results. Although the results might suggest that ChiroChoice members were receiving more favorable treatment, the analysis had the potential to be flawed because if a chiropractor was on watch, and a member of the PPO, he or she would appear in both sets of analysis.

EXPLANATIONS OF BENEFITS

Explaining Medical Necessity

The Company determines medical necessity. But because the Company has reserved the right to determine medical necessity, it must explain the evidence upon which its reviewers determine when a treatment is not medically necessary. Consumers have complained that the Company has failed to deliver consistent, reasonable explanations as to why it has not found medical necessity.

Explanations of Documentation Deficiencies

Some complaints the Department received were about the chiropractic denials and involve the Explanation of Benefits (EOBs). These generally come on blue paper. Some of the denials simply indicate that the Company or its reviewers have determined that chiropractic care is not medically appropriate or necessary. Others indicate that the information received did not medically justify or support the service billed or that medical necessity was not demonstrated. Perhaps the explanation that has generated the most complaints from patients and providers is as follows: "Based upon the information received, chiropractic care may be appropriate in your case; however upon receipt of the records, the documentation does not appear to justify the level and frequency of care."

Some providers considered this EOB derogatory, even defamatory. They argued that it implied that their documentation was deficient or that they were negligent in recording their patient care.

Example

- One disgruntled patient sent his provider (No. 4343) the following letter: "It appears from my BC/BS statements that the reason for this balance owing is that the frequency & level of care could not be justified based on your clinic's poor medical documentation... We're very dissatisfied that our ins. co. couldn't find you compatible with their standards... We feel that your [sic] half to blame for this... You need to take a serious look at how you document your progress & request for the patient's return visits."
- Another provider (No. 4207) interviewed for this exam expressed frustration about not being able to identify what specific documentation he had overlooked when his patients received similar EOBs. Other providers felt that the Company, in issuing this EOB, was misleading patients into believing the provider had not sent medical records at all.

Such adverse determinations may fail to communicate meaningful explanation for the reviewer's conclusion that the service was not medically necessary. Going forward, HIPAA (which will require standard reject reasons) and other legislative changes may require some modifications to the explanations.

Refining Explanations

If overutilization is the problem, the Company should explain what the benchmark is for the given diagnosis. If there are frequency parameters, the Company should disclose them, if not to the patient, then to the provider so the provider can explain them to his or her patient. If the procedure's usefulness is questionable, this should be explained.

Determining Liability for Denied Claims

Another issue involving the EOBs deals with liability for denied claims. In some cases the Company makes participating providers write off the costs of treatments the reviewers found medically unnecessary. In other cases patients were made liable for those services. The Company appears to have no formal procedures as to whether the patient or provider has to bear these costs, other than the participating agreements, which do not necessarily dictate the

actions taken.

The Company indicates it has some “rule of thumb” procedures in place. Those were as follows: If the provider is a participating provider, the chiropractic consultant reviewed the chart notes. If, in his opinion, the chiropractor encouraged the patient to come in unnecessarily, the provider was then liable for the costs of any services found to be inappropriate. If, in the consultant’s opinion, the patient was initiating the frequent or unnecessary visits spontaneously or against the provider’s advice, the patient was then liable for the denied visits. But patients often said they relied upon their chiropractor’s advice because they were not qualified to determine for themselves whether or when they should seek treatment. The ambiguities between what was discussed between patient and provider, or the understanding each had after a treatment, underscored the difficult task of determining who was at fault for the unnecessary treatment.

In many cases, patients who received EOBs stating that they had exceeded a schedule of care had their claims denied “subscriber liable.” (For example, Patient XXX XXXXXXXXXX had numerous claims denied for this reason.) They likely had reasonable expectations that their care was reimbursable, based on past treatments allowed. The patient above also switched providers, and this schedule of care followed the patient to the new provider, who was unaware of it. The patient’s fourth visit to the new provider was denied because it exceeded the schedule of care, leaving the provider to question the decision of *his* treatment protocol.

The handling of these liability issues led some providers to quit scheduling patients altogether - because they were penalized for it. The Company was essentially making participating providers liable for placing patients on treatment plans.

Examples

- Patient XXXXXXXXXX is an example of how inconsistently the liability determinations were applied. The patient’s treatment of July 9, 1999, was reimbursed. The next treatment, on July 14, was also paid. The July 16 treatment was denied provider liable. The next treatment, on August 5, was denied subscriber liable. The next treatment, on August 17, was reimbursed. The August 20 treatment was denied subscriber liable. The next treatment, on October 12, was reimbursed. The October 15 visit was denied subscriber liable. The next week’s treatment, on October 19, was denied provider liable. Three days later the treatment was reimbursed. The next six treatments were denied subscriber liable.
- Patient XXXXXXXXXX had similar inconsistencies in claims filed in 1999. One visit, on January 18, was denied as maintenance care. So was the patient’s February visit. The patients next two visits, on March 1 and April 1, were both reimbursed. The therapy was denied for the April 29 visit but the manipulation was reimbursed. The next three visits, in June, July, and October, were reimbursed. The traction during the October 8 visit was denied but the manipulation was reimbursed. The denials were provider liable. Yet the patient was only seen 12 times all year. The cluster of service dates indicated the patient was seeking supportive care, and probably acute care due to some exacerbation in October. The denials suggested that Company reviewers were arbitrarily selecting various treatments for denials arbitrarily.

The Company indicates its procedures for assessing liability will be in written form.

AUDITS

Insurer Right to Audit

The Company reserves the right to audit chiropractors' records to ensure proper billing and proper maintenance of patient records. Notice of the Company's right to audit is provided in the participating contracts and in the guidelines. There are no guidelines as to when an audit will be performed and what circumstances invoke one. The Company has increased the number of audits it has performed since 1995

Primarily, Company auditors look for medically appropriate services and correct billing. Their focus in the past two years has been looking for maintenance visits improperly coded for reimbursement. In 1995 and 1997, only one audit was performed in each of those years. None were performed in 1996 and 1998, according to records provided by the Company. In 1999, seven audits were conducted. In 2000, 11 audits had been performed at the time the on-site portion of this exam was completed.

Audited Providers

Providers selected for audits were not picked randomly. In some cases, they were on watch. In many other cases, they were related to each other. The examiner noted during the manual review of claims that if one provider began to experience problems with the Company, his or her relative often experienced similar problems. At times, relatives of providers on watch were placed under scrutiny regardless of whether they practiced together or separately.

For instance, Provider Nos. 4233 and 13708 are related and practice together. They were audited in 2000. So was their relative, Provider No. 4288, who practices in a different city. Provider No. 13050 was audited in 2000. So was his relative, No. 4375, who practices in a neighboring state. Some questioned the unique circumstances that led to their being singled out.

The Company was asked to explain the criteria it was using to conduct audits. At first officials said they were random. When the examiner pointed out the family connections, the officials said past problems or watch status often led to an audit. Without procedures in place, the audits appear arbitrary and used to sanction providers.

Recommendation No. 14: The Company should adopt procedures for conducting audits of providers and for outlining the circumstances that will lead to an audit.

Post-Audit Issues

Exit interviews appeared to be conducted in most cases, and re-audits were performed for at least two clinics that had documented bookkeeping problems. Audits should be performed with a goal of educating providers and providers should welcome the assistance. Some chiropractors told the examiner they felt the audits were performed because they were suspected of wrongdoing from the outset. They resented this suspicion and were uncooperative with the auditor, according to the audit reports the Company furnished.

If the auditor determines that services were medically unnecessary, either the subscriber or the provider is then responsible for the benefits that the Company previously paid. Claims processors then “back out” the claims from the system, as if the services never occurred. This entails reversing charges, coinsurance amounts and deductibles. This adds to Company administrative costs, but also causes problems with patients who thought they had fulfilled the latter two responsibilities. Although Explanations of Benefits list running totals of deductible and coinsurance amounts for the year, when adjustments are made after an audit, the patient must file a subsequent claim to learn of the revised accumulations. If the adjustment has not been made in the interim, the EOB might contain mistaken totals.

This practice can also cause problems when the provider has collected the co-payment amount. Some providers audited were asked to refund large amounts to the Company when it determined it had paid for unnecessary or incorrectly coded or billed services. Then providers had to refund co-pays already collected. Consumers were confused when they received letters from their chiropractors indicating they had refunds coming. Some patients did not want their money back. Others wanted it credited to future visits. Others wanted cash in hand when they presented themselves to the chiropractor’s office.

Of the 11 providers audited in 2000, most were cited for failing to sign or initial their chart notes (see Recommendation No. 2). The Company then requested refunds for claims it felt should not have been paid under the guidelines. Refund amounts ranged from a few thousand dollars to \$10,000. Most protested the punitive measures the Company took for first violations. One clinic hired an attorney. Some refused to refund the money.

In late 2000, the Company “resolved the issue in favor of the providers” according to a memo sent to the examiner. But in the meantime, some providers had refunded the amounts, and were then owed back the money by the Company. It set off a complicated process of reversal and re-reversal of the claims and caused much confusion to the clinics and customers. The clinics that reimbursed the Company refunded co-payment amounts to their patients, then learned the Company had reversed its position with regard to the penalties. Many wrote off the co-payments rather than try to collect them from patients a second time, fearing bad public relations and loss of business. These problems can be avoided if the Company adopts precise claims handling guidelines and follows those guidelines. The Company should treat audits as an educational process, rather than a punitive one, especially in cases of first violations of policies.

THE CLAIMS FLOW PROCESS AND MANUAL REVIEW

Electronic Submission

Blue Cross has an automated claims system. Many providers submit claims electronically, and they pass through the claims system automatically unless certain codes are programmed in to hold them for a particular reason.

There are two stages in the process. The first is data verification, in which information such as the subscriber’s name, address and plan type are verified. The second stage is the adjudication phase, during which the actual processing of claims takes place. In this phase, the computer checks for the type of coverage the claimant has, determines if deductibles apply, determines reimbursement amounts, and alerts the system when claims are to be held for manual review.

The Company has encouraged providers to submit claims electronically. Clinic administrators appeared satisfied with the system. They indicated that the submission of claims electronically take some diligence on their part to monitor for accuracy, but satisfaction overall is high. Administrators say the Company is quite responsive to their concerns and helps them track any missing claims. Paper claims are scanned into the system.

Manual Review and Holding Claims

Claims that do not pass edit rules or confidence levels in the system are held for manual review. Company officials indicated that the system has around a 90% pass through rate, meaning that only 10% of all claims are held for manual review. The Company has 750 reasons for holding claims. These apply at the verification stage. These may include the following: invalid procedure codes, invalid provider names or numbers (each provider is assigned a number for each location he or she practices in, so chiropractors with more than one office likely have a provider number assigned for each clinic), patient identification not found, name mismatches, etc.

There are 3,500 reasons for holding a claim during the adjudication stage. These include: coordination of other insurance coverage such as no-fault, Medicare, workers compensation, or a second policy; medical review or pre-existing conditions. An adjudication clerk determines if benefits should be paid, rejected, or transferred to a claims manager or specialist for review. The system has on-line "how to process" guidelines that assist claims handlers in the resolution phase. It appeared from the manual review that the chiropractic guidelines had correctly been programmed into the system. Some glitches were found in the automated review that will be detailed later in the report.

Tracking Outstanding Claims

The Company generates daily system reports to track outstanding claims. The examiner ran the 2.2 million chiropractic claims through an audit software program and found a turnaround rate of 10-13 days generally. This is a stellar rate of claims processing and the Company is to be commended for this. It is well within statutory parameters. The examiner ran all claims, medical and chiropractic, through the audit software for the years 1996 and 1997 and found similar excellent records. Again, the Company is to be commended for this performance. For claims submitted by physicians, the Company runs daily payments for subscribers, and weekly payments for the providers. It is at this time that the Explanation of Benefits (EOBs) are generated.

Downcoding Chiropractic Claims

Chiropractic claims are held during the adjudication stage when the provider or patient is on watch, so that their claims can be manually reviewed by the consultant or his assistant, a registered nurse.

As previously stated, the manual review detailed hundreds of incidents of downcoding, a process in which the Company's reviewers applied a lower reimbursement and procedure code than the one submitted. The consultant indicated that he does this when chart notes do not reflect that the specific procedure submitted has been performed. However, the sheer magnitude of claims reinforces concerns that a part-time consultant cannot thoroughly review

this many medical records in the hours he works and this may undermine the quality of the review process.

Deductible Issues

Another trend emerged in the manual claims review. As an example, Patient XXXXXXXXXX, in 1999, had 27 visits approved early in the year. All went to satisfy the deductible. Once this occurred, by May 1999, the next four visits were denied as medically unnecessary. Then the June 25, 1999, service was allowed. The next several visits were denied. This trend continued throughout the year, so that from May through December 1999, only five visits had been reimbursed. When asked why the 27 treatments were considered medically necessary when they satisfied the deductible, yet the remainder were medically unnecessary when the deductible had been filled, the Company indicated that it did not track deductible limits and did not make decisions on this basis.

Examples of Inconsistencies in Therapies

Another case illustrates the inconsistencies of allowing therapies. Claim No. 9823215287 denied the electrical stimulation therapy as medically unnecessary, denied one manipulation, and allowed another one that was applied to the deductible. The next month Claim No. 9828916220 allowed all but one manipulation and electrical stimulation treatment that applied to the patient's deductible. In Claim No. 9836319344, one month later, the patient's electrical stimulations were denied as medically unnecessary, when they appeared to be medically necessary the month before. The manipulations, except for one, went to satisfy the patient's deductible. The following year, Claim No. 9908210041 allowed all the patient's ultrasound therapy and manipulations, applying them to the deductible. The remainder of the year, every second or third treatment was denied for reasons of medical necessity while those allowed went to fulfill the deductible. In 2000, the Company had a pattern of allowing visits every two or three months, applying them to the patient's deductible. The remainder was denied as medically unnecessary.

Complainant XXX XXXXXXXXXX appealed denied services but the denials were generally upheld by the Company for dates of service in June and July 2000. More significantly, the Company put this complainant on a schedule of care but did not inform either patient or provider. The complainant also requested the chiropractic guidelines twice but did not receive them. (See Recommendation No. 8)

The Company states that it currently sends letters to patients in compliance with N.D. Cent. Code § 26.1-04-03(10).

The Appeals Process

The above-listed patient, along with several others including XXX XXXXXXXXXX, also complained about the futility of appealing claims. Of the 10,000 claims reviewed, few if any initial denials were overturned by Company reviewers, and this is supported by minutes of the Peer Review Committee. It appears XXX XXXXXXXXXX had numerous services that fit the definition of supportive care, but were denied as maintenance care. These services were continuously denied although the patient strenuously appealed the reasons given. It did not appear as if this patient's concerns were given any weight when the Company continued to deny the visits. Neither were the provider's letters, sent on behalf of the patient. The chiropractor diligently pursued responses from the Company as to why the services were not covered and did not

appear to receive a substantive answer. The patient, after persistent efforts, was finally advised that reviewers had instituted a schedule of care, but the schedule was never specified to the patient. (See Recommendation No. 8)

Examples

- Complainant XXX XXXXXXXXXX also appeared to have supportive care denied by the Company as medically unnecessary. Additionally, this complainant's denials did not seem to be consistent. The treatment consisted of manipulations, electrical stimulations, and hot/cold packs for back problems. On October 23, 1998, the hot/cold packs were denied as a "non-chiropractic service." The Company had paid for them the previous month. The Company continued to pay for all these services in 1998 and until 1999 when the hot/cold packs were again denied. It appears the Company inconsistently enforced its own guidelines. The Company also downcoded several claims sent in for this patient.
- Patient XXXXXXXXXX's provider sent chart notes with many 1999 dates of service. These chart notes showed inconsistencies in how the Company appeared to be making decisions. It was unclear as to what levels of pain and improvement warranted reimbursement because there seemed to be intermittent payment and denials of claims in which the patient experienced similar levels of pain. The fourth visit was denied due to the "level and frequency" of the treatments. They were found excessive for the diagnosed conditions. However, according to national standards, three treatments does not afford the patient an adequate treatment window in which to respond.
- Patient XXX XXXXXXXXXX was x-rayed by the chiropractor on September 3, 1999. The chiropractic x-ray was denied as medically unnecessary. Yet the Company then paid for a medical x-ray performed at a hospital on September 7, 1999 – at nearly three times the cost. Although the reimbursement was only about half the actual cost since some was applied to the deductible and coinsurance, the amount paid was still more than the denied chiropractic x-ray. It is unclear as to why an x-ray by a chiropractor should be medically unnecessary, but the same spinal x-ray at a clinic is not. (See Recommendation No. 1)
- In Claim No. XXXXXXXXXX, the Company also denied an earlier x-ray taken by the chiropractor. The denial reason was that the "level and frequency of care" was excessive. X-rays are diagnostic tools, not "levels of care." The reason for denial does not appear to be appropriate.
- Patient XXXXXX had numerous denied services between 1998 and June 2000 for reasons that the treatments constituted maintenance care. Yet the Company paid for orthopedic x-rays and tests for the patient's arthritis. The patient was seeing a chiropractor for joint pain – arthritis. (See Recommendation No. 1)
- Patient XXXXXXXXXX saw providers at a clinic on watch in 1997 and 1998 (No. 4343). Numerous visits were denied. The patient moved to a provider (No. 4274) who was a member of ChiroChoice and was not on watch. Between March 1999 and July 2000, the patient's 25 visits were all reimbursed with the new provider. This was considerably more than the patient had paid under the old provider.

Recommendation No. 15: The Company must ensure that it is not treating patients of providers who belong to ChiroChoice differently than patients of chiropractors who do not belong to the PPO. The Unfair Claims Settlement Practices Act prohibits reviewers from injecting personal or professional biases or preferences into any claims reviews.

Even though these are isolated instances and the Company may argue are not business practices, they suggest unfair claims handling practices and a system of favoritism.

THE AUTOMATED CLAIMS REVIEW

ACL Audit Software

The Department used an audit software program called ACL to examine the entire body of claims. ACL is a program that can read any electronically stored data and is used to perform statistical analysis. The Company “burned off” all of its professional claims from its computer main frame for the years January 1, 1995, to September 1, 2000, onto CD roms. These were then imported into the ACL program. The Company was also asked to furnish all codes and descriptions for holding, denying, or paying claims. The “denials” or reasons why all or part of a claim may not be paid are referred to by the Company as Reasons Not Allowed or RNAs.

RNAs can be items such as a “pure denial” for a medical reason (such as the service being medically unnecessary or inappropriate) or a coverage reason (such as the plan not providing certain benefits). RNAs can also include partial reasons such as applying all or part of the claim to deductibles or coinsurance. The Company furnished these hold and RNA codes in two separate Excel databases and they were also imported into the ACL program. RNAs and holds are seven-digit numerical codes that have corresponding written explanations that describe reasons why the claim was held, denied or partially denied.

Finally, the Company furnished provider names and numbers for all chiropractors that submitted claims during the six-year period. These were also in an Excel database and were imported into ACL. The examiner used this last database to extract all the chiropractic claims from the main body of professional claims by filtering out all claims filed by chiropractors. That resulted in the 2.2 million records analyzed, sifted down from nearly 30 million records for all professional claims in that time period. What follows is a year-by-year, or code-by-code analysis of how the claims were analyzed, and what was found. Although the Company refers to this data as “records,” they will be called “claims” for simplicity’s sake. A “record” can contain multiple “claims” because of the way providers submit them. In most cases, each chiropractic record contained one to four dates of service.

Records and Claims

Chiropractors usually practice alone or within their own specialty. There are only a handful of multi-disciplinary clinics (facilities with several specialties) in the state in which chiropractors practice with other professionals. With professional claims (those submitted by physicians), a patient could have multiple doctor visits and claims within one record. For instance, if a boy breaks his arm, he might go to the emergency room, be seen by the doctor there, then be x-rayed by a technician, then see an orthopedist who would set the arm. Three different professionals would all submit claims for that day’s visits that would be contained in one

“professional” record if the clinic filed all of these services on one claim. That would be the typical way professional claims are filed.

Chiropractors usually submit a limited number of services. They perform their own x-rays, manipulations, and therapies. Some submit claims daily, some weekly, and some much less often. But with respect to chiropractors, a record might be a single claim, or two or three dates of service for that patient. Thus, it is simpler to refer to each “record” as a “claim” in this report.

Comparisons Performed in the Analysis

The examiner compared providers on watch each year to those not on watch, and to the JRY partners (the reviewers who own the ChiroChoice PPO). The profiling data indicated that the JRY partners' profiles appeared to be different compared to the rest of the chiropractors, and in many cases resembled the watch doctors' profiles more closely than they did the whole chiropractic population. Additionally, the JRY partners had minimal claims denied or held for each year analyzed, considerably fewer than the chiropractic population at large. This finding suggests that the JRY partners may be receiving more favorable treatment than most chiropractors and much more favorable treatment than chiropractors on watch.

The examiner also selected three or four providers on watch each year and ran various comparisons of their claims submissions and denials against the JRY partners. This was an attempt to determine why they were on watch, how their profiles differed from the rest of the chiropractic population, and how each group (the JRY reviewers versus the selected watch providers) was treated with respect to claims processing. The watch doctors had their claims processed more slowly than the JRY Group. This was likely due to the review process. But profiles of the two groups were strikingly similar, based on diagnoses or procedures submitted. The conclusion is that some providers appeared to be placed on watch for reasons that are not clear.

Data Integrity Issues

Some data integrity problems were encountered during the electronic analysis. The RNA and hold code databases furnished by the Company sometimes did not match the information downloaded from the computer main frame, so many claims were denied with codes that did not have corresponding written explanations. Some of these denials were hidden within the system. The Company explained that these hidden codes were “stored” in the system under one number but appeared in the claims database under a different number.

1995 ANALYSIS

1995 Records Analyzed

337,074 records were analyzed for 1995. Of these, 335,113 or 99.42% of the records were classified by claim type as new claims; 969 were adjusted claims; 908 were reversed records in which claims were reversed; 12 records were deleted adjustments in which an adjustment to a claim was begun but stopped before completion either because of error or some other reason. These figures involved 172,317 actual claims, but because many of the records involved multiple claims or dates of service. It is unclear how these numbers are reconciled with the figures provided by the company--as shown in the chart on page 4 of this report. 277,957 chiropractic services were submitted during 1995.

All charges provided in the electronic data reveal charges submitted by chiropractors in 1995 was \$7,307,901.65, in comparison to the figure of \$7,372,255.00 provided by the Company.

1995 Provider Numbers

In 1995, 260 provider numbers submitted claims. Of those numbers, 50 (19.2%) provider numbers were on watch all or part of the year. A provider number is assigned for each location where a chiropractor practices.

1995 Days to Pay Claims

The average number of days it took to pay all claims was 11 days, which is a very good practice, and again, the Company is to be commended for this. The average time to pay adjusted or reversed claims was 44 days.

The consultant's claims were paid, on average, within nine days. The average was 12 days to pay Provider No. 4278's claims (one of the ChiroChoice partners and reviewers), and 8 days to pay Provider No. 4311's claims (the other ChiroChoice partner and reviewer). Watch providers' claims took longer to process. It took an average of 13 days to pay Provider No. 4253's claims, 14 days to pay Provider Nos. 4249 and 4245's claims, 19 days to pay Provider No. 15406's claims, and 20 days to pay Provider No. 4353's claims.

As a group, the JRY partners' claims were paid in an average of 9 days while a group of providers on watch were paid at an average rate of 15 days.

1995 Unusual Denials

In analyzing the new chiropractic claims as a whole by RNA descriptions provided by the Company, some unusual denials resulted. The Company should be aware of these apparent data entry errors in processing claims. For instance, this year 4 claims denied for services submitted by chiropractors were "amounts paid by the Black Lung Program," 1,035 claims were denied because "cement bases (for teeth restoration) not covered," 2 claims were denied because "correction of inverted nipple(s) is not covered," 2 claims were disallowed due to "lodging not covered," 2 disallowed due to "maternity services not covered," 1 disallowed due to "maximum of two retention pins allowed per tooth," 1 disallowed for "no coverage for lenses or frames," 73 denied due to the provider being a "non-participating dentist," 98 not allowed because "oral surgery recovery room not covered," 170 disallowed because "replacement of temporary services not covered," and 4 denied because "newborn not eligible for coverage." These numbers (1,302) represent nearly one percent of chiropractic claims improperly processed, whether from keying errors or other factors. The analysis showed that these denials were more identified with providers on watch. Of the adjusted or reversed claims, seven were denied due to the reason that "cement bases are not covered." While these individual claims may have been properly denied, there appears to have been coding or data storage irregularities.

Recommendation No. 16: The Company should review these claims and assign the appropriate denial codes and make refunds if the services should have been allowed. The Company should maintain records that accurately reflect the reason for denial.

1995 Missing Descriptions

Of the new claims, depending upon the analysis, 16-17% of all new claims passed through the electronic processing system with no RNA descriptions. This was an indicator of the magnitude of the data integrity problems previously discussed. Claims were apparently denied with no written reason showing up in the system to explain why.

Creating Filters for 1995 Data

The examiner filtered out the JRY partners' claims and the watch providers' claims and compared them by isolating 32 primary denial codes that are used to deny claims for reasons such as medical necessity or plan coverage (providing services or treatments the plan does not cover such as maintenance treatment).

In comparing the provider numbers with the number of claims filed, the examiner isolated 21 providers who each submitted more than 1% of all claims filed for the year. Of the 21, 7 were on watch. This represented 33% of the chiropractors that filed the most claims. The company indicated in early interviews that many providers are on watch because they treat patients excessively. This might account for the high number of claims submitted. The watch providers argue that the higher number of claims filed represent successful practices that the company was attempting to "pare down" by placing them on watch and denying claims.

1995 Diagnostic Codes

In analyzing diagnosis codes, the codes submitted by all providers for primary ailments resembled the Watch Group more closely than it did the JRY Group.

Time to File and Pay Claims in 1995

Numerous delays were found on the part of chiropractors in filing claims. Most were by providers on watch. In many cases the delays exceeded 365 days. Some delays approached two years. The provider guidelines indicate that they must file claims no later than the end of the next calendar year after providing the services, or the company will not reimburse the provider.

In further analysis, the examiner analyzed the number of days to pay claims (subtracting the receipt date of the claim from the paid date) by cross-referencing provider last names. The analysis contained intervals of payments made more than 20 days after receipt of the claim, over 30 days, more than 45 days, more than 90 days, and more than 180 days. Almost all of the providers experiencing claims payment delays were on watch. Some were the same providers described in the paragraph above. The significance of this particular analysis is that many chiropractors on watch experienced significant delays in getting their claims paid, apparently beyond the statutory limit of 15 business days provided by N.D. Cent. Code § 26.1-36-37.1.

Analysis of Charges for 1995

The examiner also analyzed charges not allowed, cross-referencing charges in excess of \$50, \$100, \$150, and \$200 not allowed, with the providers' last names. Many of the doctors on the lists of denied charges were providers on watch.

In analyzing charges submitted by individual providers, there was some correlation between higher charges and watch status. It cannot be said with any certainty that this was a trend, however. Charges were analyzed in excess of \$100, \$150, \$200, and \$250. The JRY Group had an average of \$19.70 in charges while the Watch Group had an average of \$20.53 in charges. This may be a result of therapy use, because the Company's own profiles show that many providers on watch use therapies. Or it could be a reflection of higher charges.

No firm conclusions could be drawn from analysis performed on benefit amounts allowed and paid amounts allowed on claims. The benefit amounts, although slightly higher for the JRY Group than the Watch Group, could be a result of the services offered, and not necessarily on whether the doctor was on watch or not. The paid amounts analysis was similarly inconclusive. The JRY Group had an average of \$14.00 paid per claim while the Watch Group had an average of \$13.83 paid. But in combining the results of all of this analysis (charges submitted versus benefits allowed or paid amounts), the conclusion to be drawn is that overall, the JRY group appeared to be receiving slightly more benefit amounts and slightly higher paid amounts for lower charges submitted.

1995 Individual Profiling Comparisons

The last analysis performed was the individual profiling analysis, in which the JRY partners were compared to three providers on watch (Nos. 4253, 4249, and 4245). This analysis indicated more evidence that the doctors on watch are subjected to less favorable treatment in the claims process. The JRY Group had only a small number of claims denied for treatment or coverage reasons while the three watch providers had two to three times higher rates of denials for these same reasons.

Analyzing the primary diagnosis codes indicated that the consultant had a similar diagnostic profile for claims submitted as the providers on watch, while the remaining two JRY partners appeared to have very different diagnoses compared to the other watch chiropractors.

1996 ANALYSIS

1996 Records Analyzed

In 1996, 370,649 records were analyzed, including 353,703 new claims, 8,320 adjusted claims, 8,471 reversed claims, and 155 deleted adjustments. About 5.5% of all claims were adjusted or reversed. The actual number of claims filed, obtained by analyzing the claim line number, was 186,057. This figure differs from Company numbers on page 4.

1996 Provider Numbers

Two hundred fifty-two (252) providers filed claims for the year. Of those, 52 were on full or partial watch or 20.6% of all chiropractors that submitted claims.

1996 Analysis of Reasons Not Allowed (RNAs)

In analyzing the Reasons Not Allowed (RNAs) for correct processing, the Company had a much better record than in 1995. In 1996, only about .25% of the chiropractic claims were incorrectly processed, but nevertheless involved more than 500 claims. As in 1995, many were denied for dental or vision reasons and the Company should consider reprocessing them. These unusual

reasons for denials again appeared to fall more harshly on the group of providers on watch. Those providers received .52% of the dental/vision/incorrect denials, while the JRY Group only received .03% of such denials. The Watch Group's incorrect denials were twice the rate of the entire population of providers. The conclusion is that somewhere in the holding or scrutinizing of these claims, errors are occurring.

Of the 32 RNAs isolated for specific review, such as supportive care schedule exceeded, information not supporting the claim, and services not allowed, these medically related treatment denials were disproportionately allocated to the Watch Group than the JRY Group. The JRY Group's denials for treatment reasons comprised .41% of records submitted for payment, while the Watch Group had a denial rate of 6.99% for similar claims submitted. The general population of providers had 1.51% of claims denied for treatment reasons. This is an indicator that the Watch Group was subjected to much higher denial rates than the average chiropractor, and the JRY Group experienced much more favorable claims processing than both the chiropractic population at large and the Watch Group.

1996 Days to Pay Claims

The average time to pay all chiropractic claims was 11 days, which is commendable. The average number of days to pay all adjusted claims was 23; the average time to pay reversed claims was 91 days. The average time to pay the JRY Group's claims was 9 days; the average time it took to pay the Watch Group's claims was 19 days. The average time to pay the consultant's claims was 13 days; Provider No. 4278, one of the ChiroChoice partners and a reviewer, was 11 days; Provider No. 4311, the other partner and reviewer, was 8 days.

By contrast, it took an average of 15 days to pay Provider No. 4253, who was on watch; 20 days to pay Provider Nos. 4245 and 4249, who were on watch; 34 days to pay Provider No. 15406, who was on watch; 9 days to pay Provider Nos. 4339 and 4295, who were not on watch; 12 days to pay Provider No. 4277, another reviewer, who is not a partner in the ChiroChoice PPO; and 24 days to pay Provider No. 11779, who was on watch.

1996 Analysis of Charges and Amounts Paid

For charges in excess of \$50, it took the Company an average of 13 days to pay all claims; for charges in excess of \$100, it took 17 days; for charges greater than \$150, it took 18 days to pay; for charges greater than \$200, it took 10 days to pay.

The total amount paid for all chiropractic services in 1996 was \$3,194,923.35. Total charges submitted to the Company were \$7,918,846.51. Total benefit amounts were \$6,828,648.32. These figures could not be reconciled with the Company numbers in the chart on page 4. The average paid amount was \$15.25. The average paid amount for the JRY Group was \$14.42; for the Watch Group \$14.78. The average charges for the JRY Group were \$21.10; for the Watch Group \$21.19. The average benefit amounts for the JRY Group was \$24.20; for the Watch Group \$23.35. Because of the differing figures, no conclusions can be drawn from this analysis that one group is favored above another, with respect to payments made.

The examiner again analyzed filed claims to isolate the providers who submitted the most claims. In 1996, 22 chiropractors each filed more than 1% of all claims filed. Of the 22, 8 were on watch, continuing the trend that one-third of the chiropractors filing the most claims were on watch.

In analyzing charges, there appeared to be a trend that correlated watch status with higher charges for services rendered. Many of the providers whose names were associated with the highest charges were on watch.

1996 Diagnostic and CPT Codes

Comparing the diagnostic profiles of the Watch Group and the JRY Group to the entire population of chiropractors, the JRY Group's diagnostic code submissions appear unique, while the Watch Group's diagnoses mirror the field as a whole.

Analysis of one primary diagnosis code, by cross-referencing these submissions with the individual provider names, indicated similar patterns of treatment as the previous year. The consultant appeared to be submitting similar diagnoses as the Watch Group, while the two remaining JRY partners had much different diagnostic submissions.

Analyzing the paid amounts for CPT (procedure) codes submitted, the consultant's treatment profile closely resembled one of the watch providers indicating that the majority of their reimbursed expenses came from manipulations and ultrasound therapy. The remaining JRY partners' profiles resembled the other two watch providers, who appeared to derive the majority of their reimbursed expenses from manipulations.

This trend was somewhat more difficult to see in analyzing the primary diagnosis codes that were reimbursed for the six providers. Two of the watch providers appeared to have similar profiles, and those bore some similarity to the consultant's profile. Profiles for the other two JRY partners were different in that they were reimbursed for a greater variety of diagnoses.

1996 Analysis of Claims Filing and Payments

The examiner encountered similar bookkeeping delays by chiropractors in filing claims for this year as the previous year. Many providers on watch were found to have had significant delays between the date of service and the receipt date of the claim, and many delays were in excess of a year's time.

1996 Analysis of Denied Claims

For 1996, comparing the JRY Group's claims to Provider Nos. 10080, 11779, and 4357, who were all on watch, the JRY Group individually had 1% or fewer claims denied for treatment or coverage reasons. The Watch Group experienced denials of similar claims at 4-5 times that rate.

1997 ANALYSIS

1997 Records Analyzed

In 1997, 382,983 records were analyzed. Of those, 345,420 were new records, 18,742 adjusted records, 18,681 reversed records, and 140 deleted adjustments. Of this number of records, 187,605 actual claims were filed. Again, these figures do not coincide with the Company's figures in the chart on page 4 of this report.

In analyzing the Reasons Not Allowed (RNAs), there still were incorrect denials, mainly for

dental reasons, but at a decreasing rate from the previous years. This mainly occurred when claims were adjusted or reversed and is something that the company should look at. Only about .07% of the claims were denied for inappropriate reasons, which represents a significant decrease from the past two years. The conclusion is that human errors are the reason for the incorrect denials.

1997 Provider Numbers

In 1997, 259 provider numbers submitted claims for the year. Of those, 61 actual providers, with 70 provider numbers (27%) were on full or partial watch for the year. A provider has a different number assigned for each location of practice, so providers with more than one clinic can have more than one provider number.

1997 Days to Pay Claims

For all providers, it took the Company an average of 11 days to pay new claims, 16 days to pay adjusted claims, and 92 days to pay reversed claims. For the JRY Group it took an average of 10 days to pay their claims; the Watch Group was paid on average after 22 days. The disparity between the reviewers and watch providers, with respect to claims processing, has widened from past years.

It took an average of 12 days to pay the consultant's claims, 11 days to pay Provider No. 4278 (a ChiroChoice partner and reviewer), 10 days to pay Provider No. 4311's claims (another ChiroChoice partner and reviewer), 17 days to pay Provider No. 4253's claims, 18 days to pay Provider No. 10080's claims, 20 days to pay Provider No. 4357's claims, 35 days to pay Provider No. 11779's claims, 33 days to pay Provider No. 15406's claims, and 23 days to pay Provider Nos. 4245 and 4249's claims. The latter seven providers were all on watch.

1997 Amounts Paid

When charges were over \$50, it took an average of 13 days to pay all claims. When charges were in excess of \$100, it took 9 days to pay claims; for charges over \$150, it took 5 days to pay. For both the JRY Group and the Watch Group, if charges were over \$75, it took an average of 11 days to pay. For the JRY Group if charges were over \$100, it took an average of 12 days to pay. For the Watch Group if charges were in excess of \$100, it took an average of 7 days to pay claims. No firm conclusions can be drawn from this analysis because of the minimal number of claims (12 of 382,000+ records) the JRY Group had for charges in excess of \$75. But the conclusion, based on three years of analysis, is that the amount of the charges submitted do not affect the speed of processing claims in a significant way, even though there is a correlation between higher charges and watch status.

The total amount the Company paid for all chiropractic claims in 1997 was \$3,740,436.85. Total charges for all chiropractic services were \$8,589,476.68. The total amount of all benefits allowed was \$7,802,013.28. These figures do not match Company figures on page 4. The average amount paid on all claims was \$17.13. For the JRY Group the average was \$16.03; the Watch Group was \$17.26. The average charge for all claims was \$24.80. The JRY Group's average charges were \$24.89; the Watch Group's average charge was \$24.86. The average benefit amount for all providers was \$28.15; the JRY Group's was \$28.78; the Watch Group's \$27.24. No significant trends or disparities were found here.

Twenty-one (21) providers each filed more than 1% of total claims in 1997. Again, 7 of the 21

were on watch, continuing the trend that one third of the doctors that submitted the most claims were on watch.

1997 Diagnostic and CPT Codes

When diagnostic codes were analyzed, the JRY Group again appeared to have a somewhat aberrant diagnostic profile than the average group of chiropractors according to the graphed results, while the Watch Group's diagnostic profile mirrored the average profile.

In 1997, the national system for coding chiropractic procedures and treatments (CPT codes) changed. Because many chiropractors said they experienced problems using the new codes, no conclusions will be drawn from the CPT analysis. However, the results did again reflect a trend of profiles in which the Watch Group more closely resembles the average profile than the JRY Group.

1997 Claims Filing Delays

In analyzing the days it took various providers to file claims, the statistics from this analysis continued trends from past years, showing many chiropractors are tardy in their filing of claims. Almost 30,000 claims – nearly 10% of all filed – were submitted by chiropractors 90 days or more after the services were provided. More alarming is that 11,500 claims were filed 180 days after treatment and 3,300 claims were filed more than a year after treatment. Again, many of the providers who figured prominently in this analysis were on watch and perhaps this is one reason why these providers are on watch.

In many cases the providers who delayed filing claims were also those whose claims took the Company the longest to pay. But in some cases it did not. Whether these were cases that were appealed to the Peer Review Committee is unknown, but delays of more than 180 days after receipt of the claim should be studied by the company as questionable under any circumstances.

1997 Individual Profiling Comparisons

The individual analysis, comparing the JRY partners to profiles of three watch doctors (Nos. 12264, 12083, and 10810) does not reveal differences in diagnostic codes or CPT codes. The consultant has a similar profile to Provider No. 10810 while the two remaining JRY partners' profiles resemble the two remaining watch doctors' profiles. It is apparent that the watch doctors are using more therapies (electrical stimulation or ultrasound) than the JRY partners, but that appears to be the major area of differentiation in their practices.

1998 ANALYSIS

1998 Records Analyzed

In 1998, 417,988 records were analyzed, including 380,586 new claims (91%), 18,601 adjusted claims (4.45%), 18,547 reversed claims (4.44%), and 254 (.06%) deleted adjustments. Of the records, 214,552 actual claims were submitted. Again, all records were analyzed.

1998 Provider Numbers

The number of chiropractors that submitted claims was 260. Of that number, 52 provider numbers and 42 actual providers were on full or partial watch. That was 20% of the providers.

1998 Analysis of Reasons Not Allowed

In analyzing all Reasons Not Allowed (RNAs), although there were less than half a percent of incorrect denials recorded, most again occurred when claims were adjusted or reversed, indicating human error. In those cases, usually dental or vision denials resulted that were not appropriate for chiropractic services. This is something the Company needs to review and correct because it signals that manual keying errors are the cause.

More chiropractic claims appeared to be denied in 1998 for medically related reasons or because subscribers did not return forms asking about other insurance coverage (for workers compensation, liability coverage, or subrogation or coordination of benefits). About 5.25 percent of claims were denied because of medically unnecessary services, services provided but not covered, or failure of subscribers or providers to provide necessary information for coverage of benefits.

The analysis to date shows that nearly 1% of chiropractic claims are denied without being processed because subscribers did not fill out or return Company mailings inquiring about other insurance such as workers compensation or no-fault coverage.

In analyzing the JRY Group compared to providers on watch, the JRY Group had 2.83% of claims denied for treatment, coverage, or lack of information reasons, while the Watch Group had 13.5% of claims denied for similar reasons.

1998 Days to Pay Claims

It took the Company an average of 14 days to pay all claims. This included new, adjusted, or reversed claims. For new claims only, it took an average of 10 days to pay and 55 days to pay adjusted or reversed claims. It took an average of 11 days to pay the JRY Group's claims while it took an average of 18 days to pay the Watch Group's claims. This disparity has decreased from the previous year, when it took more than twice as long to pay the watch doctors' claims as it did the reviewers' claims.

In the individual analysis, it took 12 days to pay the consultant's claims, 13 days to pay Provider No. 4278's claims (one ChiroChoice/JRY partner and Company reviewer), 9 days to pay Provider No. 4311's claims (the other ChiroChoice/JRY partner and reviewer), 20 days to pay Provider No. 15559's claims, 16 days to pay Provider No. 15620's claims, 24 days to pay Provider No. 15633's claims, 22 days to pay Provider No. 14148's claims, and 30 days to pay Provider No. 15405's claims. The latter five providers were all on watch this year.

By cross-referencing charges with the time to pay claims, the following results were obtained: It took an average of 13 days to pay all chiropractic claims when charges were in excess of \$50, 10 days to pay charges over \$100, 7 days to pay charges over \$150, and 5 days to pay charges over \$200. For the JRY Group, when charges were in excess of \$75, it took an average of 16 days to pay claims. For the Watch Group it took an average of 14 days to pay charges over \$75. When charges were over \$100, it took an average of 17 days to pay the JRY Group and 15 days to pay the Watch Group. This would indicate that no discriminatory patterns

were found in relation to the amount of charges submitted in relation to the speed of processing claims.

1998 Amounts Paid

The total amounts paid in 1998 for all chiropractic services were \$4,653,628.85. Total charges of all services submitted for the year were \$9,901,080.80. Total benefit amounts were \$9,113,614.97. These figures again do not match Company figures provided in the chart on page 4 of this report. But they do illustrate the rapidly escalating cost of chiropractic use from past years.

The average amount paid per chiropractic claim was \$18.01; for the JRY Group it was \$16.59; for the Watch Group it was \$18.32. This may be more reflective of the services offered. The reviewers appear to submit a disproportionately low percent of therapies compared to the chiropractic population as a whole. That would indicate the lower payments to the reviewers. The average charge for chiropractic services was \$25.99; for the JRY Group \$25.52; for the Watch Group, \$27.31. Again, these discrepancies can likely be correlated to therapy treatments. The average benefit amount was \$29.43; for the JRY group \$29.08; for the watch group \$28.65. This discrepancy is slight but may indicate that more claims are disallowed for the Watch Group.

In analyzing claims submitted by individual providers for 1998, 22 providers each submitted more than 1% of total claims filed. Of the 22, 6 (27%) were on watch. This percent is slightly down from past years when one-third of the busiest providers was on watch. But it also coincides with Company profiling figures and those compiled in this analysis. Many of the providers filing the most claims who had been on watch for several years indicated that they scaled back their practices or submitted fewer claims, anticipating denials.

1998 Diagnostic and CPT Codes

Once again analysis of the primary diagnostic codes submitted indicates that the Watch Group's diagnostic profile closely mirrors that of the average provider. The JRY Group, because they use far fewer procedures and therapies, has a diagnostic profile that is unique compared to the average provider and Watch Group. The CPT (procedures) codes analysis bears out similar findings. In analyzing the CPT codes that showed up most frequently for denied claims, it appears that basic manipulations and electrical stimulations were the procedures that were most denied.

1998 Claims Filing Delays

Late filing trends continued from past years. In 1998, 11,805 claims were filed more than 180 days after services were first provided. The reasons for these delays is unclear, but they are unacceptable and providers should not be prolonging the claims adjudication process because of the hardship this creates for consumers. This year, 4,210 claims were filed more than 360 days after services were provided. This is less than 1% of all claims filed, but such late filings can cause financial strain for consumers when bills come due for services they thought had been covered. It can also cause bookkeeping problems for patients trying to track annual health expenditures or deductibles.

Analysis of the days it took the Company to pay claims, by cross-referencing provider names, indicated that when Blue Cross delayed payment of a claim more than 30 days, the provider

was either on watch or one of the late claims filers identified above. Only about 1% of claims were delayed more than 90 days for other reasons, but again, the Company should take note of these delays, and the speed of the appeals process, because 1% of all claims is still a significant volume of claims.

1998 Charges and Benefits

Analysis of charges submitted and charges not allowed (CNAs) showed a direct link between higher charges and rates of denied claims. These two variables were in direct proportion to each other and in some ways linked to the watch doctors. The higher the charges submitted by the chiropractor, the more likely the provider was to have charges denied. Analysis of the CNAs further indicated this correlation between watch providers and the amount of charges not allowed. The majority of CNAs were apportioned among the watch providers when they submitted charges that were in excess of \$50. When the amount of CNAs was in excess of \$100, one watch provider accounted for 38% of these denials. This provider also had many of the highest charges for services. When charges above \$150 were not allowed, the same provider accounted for 56% of these denials. Because CNAs can include deductible amounts and coinsurance, no conclusions will be drawn from the results.

The analysis indicated little correlation between the amount of charges submitted and the amounts of benefits allowed, however. One would have expected that the higher the charges, the more the benefit amount. But that theory did not necessarily come through in the analysis. None of the providers who had higher benefit amounts were those who submitted the highest charges. And unlike past years, only a few of the providers submitting the higher charges were on watch.

When benefits were filtered to capture amounts in excess of \$75, only two providers who had the most benefit amounts (of the top six providers) were on watch, but those two did account for 42% of the highest benefit amounts allowed. Only 14 provider names surfaced in the analysis of benefit amounts allowed, when amounts were in excess of \$100, including the consultant. Of those 14, 4 were on watch.

There was a direct correlation between paid amounts and benefit amounts: the higher the benefit amount allowed, the more the provider was paid.

1998 Individual Analysis and Profiles

In the individual analysis, comparing the three watch doctors to the JRY partners, slight variations in compensation and the amount of benefits awarded were noted. Using CPT codes submitted, the examiner compared the paid amounts to the benefit amounts. The JRY partners were paid 53%, 55.86%, and 60.7% of benefit amounts, respectively. The watch doctors were paid 50.26% (Provider No. 15633), 52.9% (No. 14612), and 61% (No. 11419) of the benefit amounts, or slightly less than the JRY partners.

Comparing the benefit amounts to the charges submitted, the JRY partners respectively received 94.6%, 73.98%, and 78.55% while the watch doctors received 72.1% (No. 15633), 85.5% (No. 14612), and 75.38% (No. 11419). Comparing paid amounts to charges submitted, the JRY partners received 50.2%, 41.3%, and 47.69%, respectively, while the watch doctors received 36.2% (No. 15633), 45.27% (No. 14612), and 46% (No. 11419). This reveals that the JRY partners had higher benefits and payments per charges submitted than the watch doctors.

Comparing the six diagnostic profiles, (three watch providers to the JRY partners) it was difficult to determine why the providers were on watch. Based on diagnostic and CPT codes submitted, the three reviewers' profiles were similar to the providers on watch.

1999 ANALYSIS

1999 Records Analyzed

In 1999, 460,051 records were analyzed. Of those, 418,887 were new claims, 20,418 were reversed records, 20,481 were adjusted records, and 265 were deleted adjustments. Two hundred seventy-nine (279) provider numbers submitted claims for the year. Of those, 33 providers (38 provider numbers) or 14% were on full or partial watch, which is a decline from past years.

The watch providers submitted 97,727 claims or 21% of all claims. The JRY Group submitted 9,046 claims or just under 2% of the claims. Eighteen (18) providers each submitted more than 1% of all claims. Of those 18, 5 or 28% were on watch. The trend from previous years is that one-third of the busiest providers were on watch. According to 1999 figures, that statistic has declined nearly 5%.

1999 Analysis of the Reasons Not Allowed

Classifying the RNA descriptions once again revealed some unusual denials. One claim was denied for correction of an inverted nipple, one was denied because coverage is not provided for lenses or frames, two were denied because there was no coverage for nicotine addiction, one was denied because services for obesity were not covered, two were denied as diagnostic colonoscopy discounts, four were denied as septoplasty discounts, two were denied because of newborn eligibility, two were denied for lack of post-operative surgical instructions, four were denied because services by a nurse practitioner were not covered, and one was denied because serum IgE concentrations were non-covered items. This was a minimal number of claims – well below 1%, but the company should be aware of them. Most of these denials went to providers on watch during the claims adjustment process.

About 5.2% of claims for the entire population of chiropractors were denied for treatment reasons, or treatment decisions that led to a chiropractor providing a non-covered service such as acupuncture, maintenance treatment, or a certain therapy. The JRY Group had only .95% denials for treatment reasons while the Watch Group had 16.47% of their claims denied for treatment reasons, or three times the average provider's denials.

As with all previous years, the major reasons (90+%) for reversing or adjusting a claim are to apply a deductible or coinsurance, Medicare benefits, or provider discounts and not to overturn a previous decision to deny benefits.

1999 Days to Pay Claims

The Company averaged 15 days to pay all claims, still a very good record. Analyzing the payment times by claim type, it took an average of 11 days to pay new claims, 16 days to pay adjusted claims, and 93 days to pay reversed claims. It took an average of 13 days to pay the JRY partners' claims and 19 days to pay the watch doctors' claims. It took 20 days to pay the consultant's claims, 14 days to pay Provider No. 4278's claims (one ChiroChoice partner and

Company reviewer), 10 days to pay Provider No. 4311's claims (the other ChiroChoice partner and reviewer), 18 days to pay Provider No. 4253's claims, 18 days to pay Provider No. 4332's claims, 12 days to pay Provider No. 4349's claims, 25 days to pay Provider No. 14095's claims, 11 days to pay Provider No. 17459's claims, and 28 days to pay Provider No. 15405's claims. Five of the latter six providers were on watch this year. Provider No. 4349 is the official liaison between the Company and the North Dakota Chiropractic Association (NDCA).

It took 15 days to pay claims when charges were in excess of \$50, 20 days when charges were in excess of \$100, 18 days when charges were in excess of \$150, and 13 days when charges were in excess of \$200. It took 19 days to pay the JRY partners when charges exceeded \$75; 22 days to pay the watch doctors when charges exceeded that same amount. The JRY group did not submit charges in excess of \$100. It took an average of 24 days to pay the watch doctors when charges exceeded \$100. It cannot be concluded that the amount of charges affected the speed of claims processing, or that there were major differences in the speed of processing the ChiroChoice partners' claims compared to the watch doctors' claims.

1999 Amounts Paid and Charges

The Company paid out \$5,072,846.01 in reimbursement; total charges were \$11,201,898.89; total benefits allowed were \$10,146,108. Again, these figures could not be reconciled with Company figures in the chart on page 4 of this report.

Average charges for all chiropractors were \$26.74. For the JRY Group, average charges were \$26.40 and \$27.36 for the Watch Group. Average benefits were \$29.31; for the JRY Group \$29.11 and for the Watch Group \$28.97. Average paid amounts were \$17.81; \$16.05 for the JRY Group and \$18.03 for the Watch Group. No firm conclusions can be drawn from this combined analysis. The watch providers' charges are higher; thus their reimbursements are higher. Their benefit levels are slightly lower than average, but not significantly so.

1999 Diagnostic and CPT Codes

Analyzing the primary diagnosis, the examiner concluded that once again the profiles of the watch doctors more closely resembled the average provider's profile, while the diagnostic profile of the JRY Group appeared unique compared to the average. Cross-referencing the primary diagnosis code with certain denial codes (RNA 1200601, RNA 1200607, and RNA 1200609, to be explained further below in the report) to see which procedures were most frequently denied, since some of the complaints and watch status involve the overuse of therapies and x-rays, the most frequently denied procedure was the 739.1 diagnostic code, which is a basic manipulation. The JRY Group had no claims denied under RNA reasons 1200607 or 1200609 (both are inappropriate treatment denials) while the Watch Group had 7,271 claims denied for inappropriate treatment. The JRY Group only had 4 claims denied under code 1200601 (inappropriate services). By comparison, the Watch Group had 280 claims denied because of providing services not appropriate for a chiropractor in 1999. Denying basic manipulations would be an indicator of over-utilization and this analysis might suggest the chiropractors were on watch because of frequent treatments.

Procedure and treatment code (CPT) analysis was similar to the diagnostic profiles, although here the JRY Group's profile was closer to the average profile, but not as close as the watch providers.

1999 Delays in Filing Claims

Once again, numerous delays were found in filing claims. More than 4,000 claims were filed longer than 360 days after the services were performed. Many of the tardiest filers were on watch. Almost 2,500 claims were delayed beyond 180 days for payment. This can in part be attributed to adjustments or reversals, appeals, or tardy filings, but it is something the Company should study.

Whether these delays are poor billing practices on the part of the providers, or chiropractors are intentionally delaying the filing of claims hoping for an expedited or rushed review by the Company, cannot be ascertained from this automated review. But such delays in filing claims do not seem to be as prevalent in other healthcare settings such as clinics or hospitals.

Specifying a shorter time limit such as 90 days could help bring the tardy practitioners into line and allow chiropractic patients to better track their healthcare expenditures. At the very least, the Company could notify the tardy providers and urge them to adopt speedier billing practices.

1999 Charges, Benefits, and Paid Amounts

In analyzing charges submitted and charges not allowed (CNAs), there was a correlation between higher charges and the amount of charges not allowed. Higher charges resulted in larger amounts denied.

2000 ANALYSIS

2000 Records Analyzed

Claims were analyzed from January 1, 2000, until September 1, 2000. In 2000, 322,337 records were analyzed, including 287,223 (89.11%) new claims, 16,917 or 5.25% adjusted records, 17,454 reversed claims (5.41%), and 743 deleted adjustments (.23%). Two hundred ninety two (292) chiropractors submitted claims for the year. Thirty-seven (37) chiropractors (with 40 active provider numbers) or 12.7% were on full or partial watch for all or part of the year. This continues a downward trend of fewer providers being placed on watch.

2000 Days to Pay Claims

The Company took an average of 18 days to pay all claims. Breaking this down by claim type yielded the following: It took 10 days to pay new claims, 16 days to pay adjusted claims, and 139 days to settle reversed claims. This upward trend, that the Company is taking longer to settle reversed claims, is something the Company should study to determine if it is unnecessarily delaying appeals.

It took an average of 13 days to pay the JRY Group's claims and twice that (26 days) to pay the Watch Group's claims. Individually it took an average of 24 days to pay the consultant's claims and 8 and 11 days to pay the remaining JRY partners' claims, respectively. It took an average of 21 days to pay Provider No. 12264's claims, 11 days to pay Provider Nos. 4214's and 1492's claims, 16 days to pay Provider No. 13042's claims, 34 days to pay Provider No. 4207's claims, and 20 days to pay Provider No. 18819's claims. The latter six providers were all on watch this year.

When charges were in excess of \$50, it took an average of 15 days to pay claims. When charges were in excess of \$100 it took an average of 17 days to pay, for charges over \$150 it took 17 days to pay, and 15 days to pay charges over \$200. Again, the amount of the claim did not seem to affect the speed of processing.

For the JRY Group, when charges were in excess of \$75 it took 17 days to pay claims. For the Watch Group with similar charges it took an average of 18 days to pay. When the JRY Group's charges were more than \$100 it took an average of 13 days to pay, while it took 20 days to pay the Watch Group with similar charges. This last discrepancy does not particularly indicate discriminatory treatment because of the small percent of overall charges in this price range.

2000 Amounts Paid

In 2000, the total paid for all chiropractic services was \$3,104,772.54. Total charges were \$7,913,446.52. Total benefit amounts were \$6,897,791.84.

When the company paid the claims of the doctors on watch, there appeared to be little difference separating the Watch Group from the JRY Group. The Watch Group's average charges (\$28.03) were slightly higher than average (\$27.57), while the JRY Group's charges (\$27.00) were slightly below. In comparing benefit amounts to charges submitted, the Watch Group had a lower compensation rate (\$28.86) versus the average (\$29.27) and the JRY Group (\$28.83). The examiner believes that although this may not be statistically significant, the figures indicate that the Watch Group was not realizing as much income per visit as the average chiropractor or reviewers.

Payment amounts varied, so no conclusion can be drawn from this analysis either. The average payment was \$16.00; the Watch Group's was \$16.54 and the JRY Group's was \$14.92. This may be more reflective of the type of services provided than actual payment discrepancies. For instance, the consultant uses acupuncture relatively frequently. That is a non-covered service. The watch doctors tend to use more therapies than the JRY Group, which would account for the higher payments.

In 2000, 18 chiropractors each submitted more than 1% of the total claims filed. Of that 18, 7 (39.8%) were on watch, a higher percentage than past years. The JRY Group filed 7,101 claims or 2.2% of the total. The Watch Group filed 74,414 claims or 23% of the total claims.

2000 Diagnostic and CPT Codes

In analyzing primary diagnoses, the Watch Group's diagnostic profile resembles the average profile more than the JRY Group's does. When looking at the diagnostic reasons most frequently rejected by the Company as unnecessary treatments, diagnosis 739.3 presents more problems for providers, making them liable more often for rendering the unnecessary services and writing off the costs, while diagnosis 739.1 more often costs the subscriber for seeking the unnecessary treatment. Both of these diagnostic codes are for manipulations.

The analysis of procedure and treatment codes (CPT) indicated the following: The JRY Group's profile of submitted CPT codes looks unique compared to the watch providers' profile, which closely resembles the average.

Providers had to write off the costs of medically unnecessary electrical stimulations (CPT code 97014) more often, while subscribers had more basic manipulations denied that they were

financially responsible for, according to analysis of denial codes for unjustified care.

2000 Individual Profiling Comparisons

In individually profiling the three JRY partners versus three watch doctors (Nos. 4332, 15406, and 4207), diagnostic profiles differed for all six providers. With one exception, the JRY partners were paid more per benefits, or per charges, than the three watch doctors by much higher percentages. The exception was No. 4332, whose payment to charge ratio was about 1.5% higher than No. 4311, one of the review doctors.

The trends from years past continued into this year, according to analysis of days to file and pay claims. Many chiropractors delay filing claims for many months, up to a year. This sometimes correlated with the Company's lengthy delay in paying the claim. The watch providers were among those who took the longest time to file claims and whose claims it took longest to pay.

SPECIFIC CODE ANALYSIS - HOLD CODES

The 21 codes used most commonly to hold chiropractic claims were analyzed. The following is a description of each code and the results of the analysis.

1200601: This code is used to hold claims for services in excess of \$300 for referral to a claims examiner. In 1995, most of the providers whose claims were held for high charges were not on watch.

- In 1996, the consultant's name was on this list of providers. He accounted for 6.7% of all claims held for this reason. This may put a low level claims examiner in an awkward position, reviewing the charges of a person who has ultimate authority to determine many claims issues. It is possible that his high charges are attributable to treating patients with acupuncture which is a non-covered service.
- In 1997, the consultant appeared in the analysis as the provider whose claims were most frequently held for having charges in excess of \$300. Because the consultant had no denied claims for this reason, the higher charges did not affect allowance of the claims. Less than one-fourth of the providers whose names appeared in the analysis results for this code were on watch.
- In 1998, most of the providers on this list of results were not on watch. The consultant had the second highest percentage of claims held for this reason. In 1999, about one-third of the providers whose names were on this analysis list were on watch but only one of the top four providers (whose claims were held most frequently for this reason) was on watch.
- In 2000, the consultant had 10.83% of all the claims held for this reason. Most of the doctors on this analysis list were not on watch.

Although other analysis correlated high charges to watch status, as outlined above in the annual statistics, the watch doctors' claims were not held for reasons of reviewing services for such high charges, as might be expected.

1200602: This code is used to manually review high utilizers of chiropractic services and is assigned to patients, when their claims come into the system. In 1995, in general, the doctors on watch did not have the most patients deemed high utilizers of chiropractic services. Instead, doctors *not* on watch comprised the majority of those with patients who had the most frequent visits.

- In 1996, the same trend held true. Many of the providers with the highest number of patients who sought excessive treatment were not on watch this year either. Four percent of all claims were held this year to manually review whether the patient has sought excessive treatments. This required the consultant's review of thousands of claims.
- In 1997, only a third of the chiropractors in these results were on watch. The providers with the highest percent of claims held to assess excessive treatment were not on watch.
- In 1998, 31 providers each had more than 1% of all claims held for this reason. Of that 31, only 8 were on watch. As with last year, less than one-third of the providers on this list were on watch. The same trend held true in 1999. Of the six providers whose claims were held most frequently for this reason, only two were on watch.
- In 2000, use of this code was applied to hold more than 20,000 claims. Only one-fourth of the chiropractors whose claims were held because their patients were seeking frequent treatments, were on watch. The amount of claims held for manual review stresses the enormity of the consultant's job in reviewing all of these patient records and brings into question the feasibility of a sufficiently thorough review process.

The Company indicated that treatment frequency is one factor in putting a provider on watch. The results of this analysis undermine such decisions.

1200603: This code is used to hold claims to manually review chiropractic services for "appropriate billing." The list of names that the analysis revealed was totally allocated to doctors on watch in 1995. Three providers on watch (Nos. 4245, 4249, and 4352) accounted for 35% of all claims held for this reason. The analysis indicated that none of the JRY partners had a claim held and manually reviewed in 1995 for appropriate billing.

- In 1996, this code, which the claims processing guidelines indicate is supposed to be used solely to hold the claims of providers on watch, also turned up the names of two providers not on watch, so this code use needs to be more selectively used. In 1996, 10% of all chiropractic claims were held for manual review because the chiropractor was on watch. Again, this entailed the manual review of thousands of claims.
- In 1997, this code appeared to be applied correctly with the exception of one provider whose claims were held. The doctor had been taken off watch in early 1996 according to Company records. In 1998, three doctors who were taken off watch in 1997 were still having their claims held for watch status during this year, so the Company was misapplying this code or had not removed it for these

specific doctors. Although only a small number of claims (42 in all) were improperly held for this reason, it is being brought to the Company's attention because these claims may have been delayed for manual review due to error.

- In 1999, five providers whose claims were held most frequently (their combined numbers of held claims were 80+% of all claims held for this reason) were on watch, but only half of the remaining providers on this list of results were on watch, so the company is holding the claims of 20% of the providers not on watch to review their billings.
- In 2000, this code was used to hold the claims of three providers not on watch, as well as several who were.

1200604: This code holds claims to review office exams. Per the guidelines, one office visit is allowed every 18 months unless the patient has a new injury or different diagnosis that might support the need for an additional office consultation.

- In 1995, providers not on watch were most prominent in this analysis. If the company is considering misuse or over-use of office visits as criteria for watch status, the criteria is not consistently applied because the watch providers do not have the highest statistics in this area. This trend held true for 1996.
- The company appeared to focus heightened surveillance on office billings in 1997, as most providers who submitted any type of chiropractic claim showed up on this list of results. In 1998, most of the providers whose claims were checked most frequently for proper office exam billing were not on watch.
- In 2000, most of the providers whose claims were held for this reason were not on watch.

1200606: is a code used to verify accident charges. In 1995, only five provider names surfaced in the analysis and of those only one was on watch. No conclusion will be drawn from this analysis because the provider's last name that showed up in the analysis also belongs to two relatives of the watched doctor, who were not on watch. Their claims may be included in the analysis. By cross-referencing last names with the codes, it was not possible sometimes to separate one relative from another if two or more chiropractors shared the same last name.

- In 1997, four of the five providers on this analysis list were on watch, but the number of claims reviewed for proper coding of accidents had decreased from previous years, indicating that most providers were correctly using this code according to utilization guidelines. In 1998, of the six providers on this list of results, five were on watch.
- In 1999, only five providers' claims were held in 1999 to check accident coding, but this entailed reviewing 664 claims. The Company should work with these providers to ensure that they understand proper use of the accident codes. In 2000, all of the providers whose claims were held for this reason were on watch, indicating problems following the guidelines.

1200607: This code is used to manually review multiple use of therapies or modalities when three or more therapies are billed in one visit. In 1995, about half of the names that the analysis

revealed were on watch. The Company indicated that use of therapies can put a chiropractor on the watch list. But again, not all of the providers who accumulated the most held claims were on watch, so if this is one component of watch status, it is not being applied across the board to all providers.

- In 1996, use of therapies and modalities did appear to be linked to watch status, according to the code analysis. This year, the majority of providers in the analysis results were on watch.
- In 1997, as with previous years, the connection between use of therapies and watch status is tentative. Although a third of the providers whose claims were held this year were on watch, the chiropractors whose names figured prominently on this list of results were not.
- In 1998, one provider who had been removed from watch status in 1997 had 43.6% of all claims held for this reason. One-third of the providers whose claims were held to manually review coding of therapies were on watch this year.
- In 1999, although three of the providers whose claims were held most frequently for this reason were on watch, most of the providers on this list of results were not. It does not appear, therefore, that use of multiple therapies is a valid reason for being put on watch, or more of the providers on this analysis would be on watch. In 2000, one-fourth of the providers on this list of results were on watch.

1200608: This code is used to review the use of multiple adjustments and manipulations. It holds claims so the consultant can check procedural codes against each other, to ensure that chiropractors are not 'piggy-backing' multiple types of adjustments within one visit, thereby increasing the costs to the insurer. In 1995, in some cases the analysis yielded the names of chiropractors on watch. In many cases, it did not. If this reason is among the criteria for placing providers on watch, it is not being uniformly applied to all providers whose statistics in this area are highest.

- In 1996, analysis of this code indicated that use of multiple adjustments during a patient's visit appeared to be peripherally connected to watch status. Of the seven providers whose percentages were highest in this analysis, three were on watch.
- In 1997, the Company appeared to heighten scrutiny of these procedures, as most providers who submitted claims for multiple adjustments turned up on this list of results. Of the 11 providers whose claims were held most frequently to review billings, only 3 were on watch. In 1998, of the 10 providers whose claims were held most frequently to review their billings for this reason, only 2 were on watch.
- In 1999, almost every provider in the state showed up on this list of results, including the JRY partners, who had 93 claims held for review of procedures. Although some of the chiropractors on this list of results were on watch, most were not. Of the 12 chiropractors whose claims were held most frequently for review of multiple procedures, however, only 7 were on watch.

- In 2000, one-fourth of the providers on this list of results were on watch. The conclusion from this code's analysis is that there may be a tentative connection between multiple use of manipulations and watch status, but the majority of chiropractors who may be abusing or over-using manipulations are not under focused review and perhaps should be.

1200609: This code is used to hold claims for "scope of practice review." Although some of the doctors on watch figured prominently in the analysis list in 1995, it cannot be said conclusively that that was the overall trend. Again, if the company was theoretically using this code to identify problematic providers, it was not applying the test uniformly.

- In 1996, use of this code was again not confined to watch doctors. Less than half of the providers whose claims were held for this reason were on watch. In 1997, one third to one-half of the doctors on this list of results were on watch; of the 14 doctors whose claims were held most frequently for this reason, 9 were on watch.
- In 1998, about two-thirds of the providers in this analysis were not on watch. The provider who had the most number of claims held for this type of review had been taken off watch the previous year. Of the 10 providers whose claims were held the most for this reason, only 4 were on watch.
- In 1999, all three JRY partners appeared in the results, along with about a third of the providers in the state. Most of the providers whose claims are being reviewed under this code reason were not on watch. So it appears that scope of practice issues are not related to watch status. But it is unclear who exactly is reviewing the consultant's claims or those of his ChiroChoice partners. Again this could subject a claims examiner to uncomfortable pressure when reviewing the claims of the reviewers. If the consultant is doing the claims review, there would certainly be a conflict in him reviewing his own claims and those of his business partners.
- In 2000, one-fourth of the providers whose claims were held for this reason were on watch.

1200610 is a code used to review x-ray charges against diagnosis codes submitted. For instance, if the patient complains of neck problems, a lower back x-ray should not be submitted with the claim. In 1995, the list of results revealed mainly non-watch doctors as those whose statistics are higher, including the JRY Group. If the Company is checking x-ray charges as a way to monitor practices, the watch doctors are disproportionately low in the amount of x-rays taken or mistakenly submitted.

- In 1996, improper use or coding of x-rays was again not a factor in watch status based on the analysis. Claims held for manual verification of x-rays included a list of providers that mainly were not on watch.
- In 1997, less than one-fourth of the providers in this analysis were on watch and only one of the doctors whose claims were held most frequently was on watch. This year's analysis would indicate that misuse or miscoding of x-rays has little impact on determining whether or not a provider is placed on watch status. In

1998, of the 14 providers whose claims were held the most frequently to check x-rays, only 3 were on watch.

- In 1999, no conclusion could be drawn from use of this code, because it appeared to correspond to the number of x-rays a provider takes. The more x-ray claims providers submit to the Company, the more heightened the scrutiny of them. Use of this code does not necessarily coincide with watch status because only a minority of providers whose x-rays are manually reviewed are on watch. It appears to be more of a “scope of practice” issue. Some chiropractors routinely x-ray their patients. Others do not take any x-rays.
- In 2000, one-fourth of the providers on this list of results were on watch. This again may be more reflective of those who do take x-rays and not necessarily a precursor to watch status.

1200611 is a hold code reserved for one clinic on watch, according to Company claims processing guidelines. The company appears to be incorrectly using this code because the names that the analysis revealed were not only the providers the code was apparently designed for (Nos. 4245 and 4249), but two others as well. It is possible the Company is using the code to review providers that may be atypical in some area, but the guidelines reflect a more narrow purpose. That is to review one specific clinic.

- In 1996, the clinic on watch had 11,526 claims held under this code. All of these claims necessitate a manual scrutiny of each corresponding medical record, making the review process time-consuming, expensive and questionably thorough. This is an extraordinary number of claims for a part-time consultant to review, especially since dozens of other providers are on watch and submitting medical records too. And as this section of the report illustrates, thousands of claims are being held for other reasons as well, that all require submission and review of a patient’s medical record.
- In 1997, this code’s use was apparently enlarged to scrutinize more providers on watch than the initial clinic that the code was designed for. A half dozen providers on watch had their claims held under this code.
- In 1998 several providers’ claims were also held under this code, including a new provider who recently had joined the primary clinic on watch. The next year the code appeared to only be assigned to the original clinic for which it was designed. No other providers’ claims were held under this code.
- In 2000, 100 claims of a doctor not associated with the clinic this code is assigned to, and not on watch, were also held. Because of the length of time it takes to manually review these claims, the Company should analyze use of this code to ensure that claims are not being delayed for review unnecessarily due to application errors.

1200612 is a code used to hold claims for manual review of therapies. In 1997, eight providers appeared on this list of results. All were on watch. Proper use or coding of therapies is a factor in watch status, according to Company officials. So this hold code is being properly used. In 1998, of the 11 providers whose names appeared on this analysis, 10 were on watch.

- In 1999, 1,467 claims were manually held for the consultant's review. Six of the seven providers on this list were on watch, indicating a direct correlation with therapy use and watch status. In 2000, all of the providers whose claims were held for this reason were on watch.

1200613 is used to review multiple manipulations and their coding, particularly CPT (procedure) code 98942. This code specifies that chiropractors must manipulate five spinal regions for proper submission of the procedure. If the provider has not documented each spinal region manipulated, the company "downcodes" the procedure to one that is used for a less extensive degree of manipulation. This results in lower reimbursement to the provider. In 1997, less than one-fourth of the providers on this list of results were on watch. Hundreds of claims were downcoded. But in doing so, the consultant had to have reviewed each medical record.

- In 1998, only 3 of the 20 providers on this list of analysis were on watch. Again most providers who submitted claims for multiple manipulations showed up on this list of results. Most of the providers whose claims were most frequently held for this type of review were not on watch, including one of the reviewers.
- In 1999, one provider accounted for nearly 75% of all claims held for this type of review. This provider was on watch. One of the consultant's ChiroChoice partners was also on this list. Although only one claim was reviewed, such reviews – one partner reviewing his business partner's claims – might suggest an appearance of impropriety or a conflict of interest.
- In 2000, one chiropractor that had been removed from watch last year accounted for the majority of claims held for this reason. This suggests that either he was prematurely removed from watch or that the consultant unnecessarily was reviewing his claims. Without watch procedures, it is difficult to follow the process that Company reviewers are applying.

1200614 is a code used to hold claims to review procedure code 98941, to verify if the provider is manipulating three spinal regions. Use of this code has been drastically reduced from previous years since only five claims were held for review in 1999. That indicates that chiropractors are either learning to use the CPT code correctly or deliberately down-coding their services to a 98940 code (manipulation of one to two spinal regions) to avoid scrutiny by the Company.

1200615 and **1200616** are codes used to set aside the claims of specific providers to review their claims and chart notes. These codes were added to the system in 1998. They were used correctly because use of the codes did not filter out other providers' claims for manual review. All three of the providers assigned these specific hold reasons were on watch for this year.

- In 1999, code 1200615 was almost correctly being used because the provider on watch assigned to this code comprised 99.89% of the claims that came up in the analysis. Another provider's claims – only two – came up as well. Because the watch provider is a single practitioner, the two other claims held must be errors unless the second doctor occasionally practices with the doctor on watch. Code 1200616 only pulled up claims filed by the clinic assigned the code so it was being used correctly in 1999.

1200619 holds claims for review of procedure code 97140, a new CPT (procedure) code for manual therapy techniques that necessitates 15 minute intervals of treatment for each region the care is administered to in order to be properly used. The first tracking of this code use was in 1999. No conclusions will be drawn from the analysis because of the small number of claims held.

1200620 is another code reserved for a specific clinic on watch. In 1999, the first year for which it apparently was used, it correctly held only the claims of the providers at the clinic that the code was assigned to.

- In 2000, a provider who was not associated with this clinic had claims held under this code. The provider went on watch in 1999.

1200621 is another code used to review multiple billings of adjustments and manipulations. In 1999, only three providers were on this list of results. One was on watch. Because of the small number of claims held under this code, no conclusions will be drawn from the analysis.

- In 2000, all four providers on this list of results were on watch.

1401006 is a another code used to police for over-utilization, to check the number of visits per the condition submitted. In 1995, the number of providers on the analysis list who figured prominently in the statistics were not doctors on watch.

- In 1996, the analysis added support for questioning the validity of treatment frequency as a factor in placing providers on watch. The chiropractors that had the most claims held to check treatment frequency under this code were not on watch.
- In 1997, about one-fourth of the providers on this list of results were on watch, but only three of the providers whose claims were scrutinized most frequently were on watch. In 1998, one provider who was on watch this year accounted for 11% of all claims held. But the majority of providers on this list of results were not on watch, nor were they among the providers whose claims were most frequently held for this reason.
- In 1999, 12 providers each accounted for more than 2% of the claims held for this reason. Of the 12, 5 were on watch. In 2000, one-fourth of the providers on this list of results were on watch.

This analysis corroborates the analysis of code 1200602 above, which is the code used to police patients for overutilization of chiropractic services. Less than half of the providers on each list of results were on watch. The Company, if it is using treatment frequency as a reason to place providers on watch, is not considering all factors that contribute to high utilization or placing the wrong providers on watch.

1401013 is a code used to hold claims to review them for medical appropriateness. In 1999, only 12 claims were held for this reason so no conclusions will be drawn.

702001 holds claims for treatment deemed to be maintenance care. It was not analyzed for 1995. In 1996, one clinic on watch accounted for almost 77% of the 1,058 denials. Most of the remaining providers on this list of analysis results were on watch.

SPECIFIC CODES ANALYSIS - REASONS NOT ALLOWED

1200200 is a code used to deny claims and designate the subscriber liable for seeking unnecessary or medically inappropriate services. Of the 12 providers who had the most frequent denials in this category, only 4 were on watch. The rest were not, including Provider No. 4311, who is on the Peer Review Committee. When the subscriber is made liable for the services, the provider does not have to write off the costs of the services.

- In 1996, these denials were mostly isolated to the providers on watch. In 1997, about one-third of the providers on this list of results were on watch, including five of the seven providers whose claims were denied most frequently for this reason. In 1998, the providers who had the most claims denied for this reason were not on watch, although two had recently been removed from watch status.
- In 1999, only 40 claims were denied for this reason, so no definitive conclusions can be drawn from the analysis. Providers whose claims were denied for this reason were both watch and those not on watch, although half of all claims denied under this code were submitted by watch doctors.

This denial punishes the patient for seeking excessive treatment, not the provider. When these claims come in, the consultant generally reviews each medical record and makes a determination as to whether the provider encouraged the patient to come in for services that were not necessary, or whether the patient sought this treatment against the chiropractor's advice. But because the Company does not have firmly established rules for designating either the subscriber or provider liable for medically unnecessary services, there is a question as to whether some providers are receiving favorable treatment – or some consumers are receiving adverse treatment.

And again, this process results in the delay of claims and requires the manual review of thousands of medical records by a single reviewer. The Company needs to watch these delays to ensure that it is complying with all statutes and accreditation procedures it certified as being in compliance with.

1200208 is a denial code used when chiropractors on watch did not submit patient chart notes with their claims. In 1998, use of this code was not confined strictly to providers on watch. The analysis indicated that numerous chiropractors had claims denied because they had not submitted supporting medical records. About half of the chiropractors whose claims were most frequently denied for lack of chart notes were on watch.

- In 1999, many chiropractors whose claims were denied for this reason were not on watch, including those who had the most denials. The Company appears to be requesting chart notes from providers not on watch and rejecting their claims when they do not send in the medical records. Because the company reversed only about 4% of claims this year, those initial denials have a 96% chance of remaining denied once the provider sends the chart notes in.
- In 2000, numerous chiropractors not on watch had claims denied for this reason because they failed to send chart notes in. This again calls into question the thoroughness of the review process. The consultant is not only reviewing the thousands of claims of watch doctors, but is also reviewing the chart notes of others as well.

1200288 is another code used to reject claims when chiropractors have not sent chart notes in. In 1999, this code was not just applied to watch doctors. Far fewer claims were rejected overall under this code than the above-listed 1200208 code, but the guidelines do not give clear information as to when one code would be used as opposed to the other, when both appear to deny claims for the same reason. In 2000, about one-third of the providers in this analysis were on watch. It is possible that the Company is using one code for participating providers and the other for non-participating chiropractors, but the analysis indicates that it is then incorrectly being used.

1200601: This code is used to deny claims when services are not appropriate for a chiropractor. In 1995, there were 3,123 denials for this reason or about 1% overall. Of those the JRY Group had 29 denials or .9%. The Watch Group had 670 denials or 21.5%.

- In 1996, of the 547 claims denied for this reason, 100 or 18% were watch doctors. Only two claims or 0% were JRY denials. In 1997, one-third to one-half of the providers on this list of results were on watch, but only 4 of the 14 providers whose claims were denied most frequently for this reason were on watch.
- In 1998 some of the providers on this list were on watch, but the chiropractors whose claims were most frequently denied for this reason were not. One clinic, comprised of two doctors not on watch, accounted for 25% of the claims denied for this reason.
- In 1999, most of the providers on this list of results, whose claims were denied under this code reason, were not on watch. In 2000, only one-fourth of the providers whose claims were denied for this reason were on watch this year.

It appears as if this code has only a tentative correlation to watch status, or the Company is not concerned about those providers whose treatments are most frequently deemed medically inappropriate, or that lead to non-covered services.

1200603 is a code used to deny non-participating providers' claims as medically unjustified. This makes the subscriber liable for payment of the claim. In 1998, the first year for which this code was analyzed, one clinic on watch accounted for 69% of all claims denied for this reason. Another clinic on watch had 12% of the denied claims. It did appear as if a small amount of claims were denied for participating providers because of this reason. This made the subscriber liable, when the provider should have written off the costs of the unnecessary visits under the participating contract with the Company.

1200604: This code is used to deny claims when the patient has exceeded a schedule set by the Peer Review Committee. In 1995, it was not confined to providers on watch. The majority of claims denied for this reason were not watch doctors.

- In 1996, although the majority of providers whose claims were denied for this reason were on watch, only two of the top six providers on the list were watch doctors. In 1997, about half of the doctors on this list were on watch, including the providers most frequently denied for this reason. In 1998, none of the chiropractors whose claims were most frequently denied for this reason were on watch.

- In 1999, more than half of the providers on this list of results (whose patients had sought excessive care) were not on watch. In 2000, about one-third of the providers on this list of results were on watch. Treatment frequency, this analysis shows, is not a valid indicator of watch status.

1200605 rejects physical therapy when performed by a chiropractor. In 1997, of the six chiropractors on this list, three were on watch. In 1998, only eight chiropractors had claims denied for this reason. One provider on watch had 55% of all denials. Another provider not on watch had nearly 31% of the remaining denials.

- In 1999, of the 529 claims rejected for this reason, 501 of those or 94.7% were submitted by two providers not on watch. In 2000, one provider not on watch accounted for 75% of the 377 claims denied for this reason.

Although the Company indicated that therapy use – or misuse – is a factor in placing a provider on watch, use of this code is not a consistent indicator of watch status.

1200607 is a denial code used for unjustified chiropractic care, making the provider liable for the services. All four providers whose claims were denied in 1996 for this reason were on watch. The code was not analyzed for 1995.

- In 1997 and 1998, the majority of providers on this list were on watch, including all of those that accounted for the most denied claims under this code. In 1999, only one-third of the providers on this list of results were on watch, so it cannot be said conclusively that providing medically inappropriate care is a criteria for being placed on watch.
- In 2000, about half of the providers whose claims were denied for this reason were on watch.

This code discourages the provider from encouraging the patient to come in unnecessarily or placing patients on schedules of care that the Company deems unwarranted. There are fundamental weaknesses with this approach. The Peer Review Committee places patients on schedules of care frequently. When committee members do this, the services are reimbursed as long as the patient does not exceed the schedule. When other chiropractors use schedules of care, the claims are denied and they are often forced to write off the costs. If each service is to be judged on grounds of medical necessity, as all contracts state, any predetermined schedule of care likely runs afowl of the contractual provisions, and also creates the risk of violating the discriminatory prohibitions outlined in N.D. Cent. Code § 26.1-04-03(7)(b). The Peer Group and consultant cannot place patients on schedules of care that they are denying when other providers implement similar treatment schedules.

1200608 denies claims for invalid procedures performed by chiropractors. In 1997, although about one-half of the providers on this list were on watch, only three of the top nine providers whose claims are most frequently denied for this reason were on watch.

- In 1998, because only 64 claims were denied for this reason, no conclusion will be drawn from any analysis. In 1999, only 24 claims were denied for this reason, and because this is an insignificant amount, no conclusions will be drawn from the analysis.

1200609 is a code used to deny chiropractic care that is unjustified, making the subscriber liable for payment of the claim. This code was first used in 1998 and was instituted to replace denial code 0096700 (below). This RNA is used when patients seek care on their own (not because of the doctor's recommendation, according to the consultant) that is excessive for their condition or exceed a schedule of care set by the consultant or Peer Review Committee. Potential problems with schedules of care have already been discussed above.

Many nonparticipating providers were on this list, because there is no contractual arrangement with these chiropractors that forces them to write off the costs of unnecessary services. One clinic on watch in 1998 accounted for 21% of all denials for this reason. Most of the chiropractors whose claims were most frequently denied by this code were on watch.

- In 1999, only one-fourth of the providers whose patients' claims were denied for this reason were on watch. The next year, one-half of the providers whose claims were denied under this code were on watch. This analysis reinforces the conclusion that providing excessive treatment is not conclusive criteria for being on watch.

1200611 denies claims as a result of various audits the company performs on several clinics throughout the state. Most of the providers targeted for audits were on watch in 2000, the first year for which this code was significantly used, or the audited providers had been on watch in the recent past. These claims (2,447) were denied because the auditor found that the providers had not signed or initialed their chart notes as required under the guidelines. But it appeared as if at least one provider whose claims were denied was not among those audited, according to Company records, unless at the time the chiropractor was practicing at one of the audited clinics.

701303: This code is used to deny medically unnecessary visits. Although a minimal number of claims were actually denied in 1995 under this code, 45% of the claims denied for this reason were filed by doctors on watch.

- In 1997 most of the providers on this list were on watch, including all of those whose claims were most frequently denied for this reason. In 1998, of the five providers who accounted for 75% of the claims denied for this reason, all were on watch. Another code, **701304**, is used similarly, but because only 16 claims were denied in 1998 for this reason, no conclusions will be drawn from this minimal sample. This code only denied nine claims the following year, so this is a statistically insignificant amount.
- In 1999, RNA 701303 appeared more closely correlated to watch status than RNA code 1200607 above. But less than half of the providers whose claims were denied under RNA 701303 were on watch this year.
- In 2000, most of the providers whose claims were denied by this code were on watch. One clinic on watch accounted for 47% of the 1,146 denials. Another clinic on watch accounted for 22% of the remaining denials.

701306 denies claims when the Company finds that manipulations were not medically necessary under its guidelines. This could be for a variety of reasons but primarily because the patient's condition is relatively minor and does not warrant the treatment on that particular

occasion. In 1997, half of the chiropractors whose claims were denied for this reason were on watch, indicating some correlation between treatment frequency and watch status. But in 1998, less than one-fourth of the doctors on this analysis list whose claims were denied for this reason were on watch.

- In 1999, only 25 claims were denied for this reason so no conclusion will be drawn from the analysis. Most of the doctors on this list of results were not on watch.

701307 is a new code used to deny services as not medically necessary, first used in 1999. Eleven providers each accounted for more than 2% of all claims denied for this reason. Of the 11, 5 were on watch. But those five accounted for 48% of the claims denied for this reason.

- In 2000, considerably fewer claims were denied under this code than the above-listed code (701306). One clinic on watch accounted for 18.65% of the 327 claims denied for this reason. About half of the providers whose claims were denied under this code were on watch. This is another code that necessitates manual review of medical records with each claim filed to determine the necessity of the treatment given.

702001 is a code used to deny services as non-payable because of maintenance care. In 1995, a greater percentage of watch doctors had claims denied for maintenance care than non-watch doctors. It is unclear if the claims were submitted as non-payable or were found to be so after being submitted as other types of care.

- In 1996, the majority of claims denied for this reason were filed by one clinic on watch (No. 4343). The CPT (procedure) code analysis did not indicate that the claims were submitted as maintenance care because the examiner was unable to pull up a significant number of claims by putting the code for such treatment into the system. Only a minimal number of claims, based on the analysis, are actually submitted as maintenance care because this is optional on the part of the provider. Thus, these claims were submitted as payable services, in which the chiropractors likely coded them as supportive care or another form of treatment. The claims were subsequently denied as maintenance care. Many of the providers on this analysis result were on watch.
- In 1997 almost all of the providers on this list of results were watch doctors, with one clinic on watch accounting for 50% of these denials. In 1998, most of the chiropractors in this analysis were on watch. In 1999, two clinics on watch accounted for the majority of denials (61.2%) for this reason.
- In 2000, one clinic on watch accounted for 50% of the 320 claims denied for this reason. Most of the providers whose claims were denied under this code were on watch.

Again, because the Company reviewers are placing patients on schedules of care that fit the definition of maintenance treatment, it is a discriminatory practice when the claims of other providers are denied because they have been deemed non-payable because the same reviewers determined that they are maintenance in nature.

702006 rejects claims when chiropractors perform examinations too frequently. One exam

every 18 months is allowed unless the patient's diagnosis changes or there is a new accident or exacerbation of the condition. In 1999, since only 86 claims were denied for this reason, no conclusion will be drawn from the analysis. Problems in this area likely center around providers failing to read or understand their guidelines specifying when examinations will be compensated.

702400 denies claims of durable medical equipment that is not a covered item in all Blue Cross contracts. In 1997, only a minority of providers whose claims were denied for this reason were on watch. Submission of these claims appears to be discretionary because of the non-payable status of the services. Providers can submit them, knowing they will not be reimbursed, simply to document the treatment rendered for their patients.

- In 1998, of the 197 claims denied for this reason, most of them belonged to doctors who were not on watch. Although only 256 claims were denied for this reason in 1999, most of the providers who submitted such claims were not on watch.

702500 is a rejection of foot orthotics such as heel lifts. In 1996, about a third of the providers in this analysis were on watch, including the chiropractors whose claims were most frequently rejected for this reason. In 1997, about half of the providers on this list were on watch for the year.

- In 1998, only 67 claims were denied for this reason. Most chiropractors, perhaps knowing these are generally non-covered services, appear not to be submitting claims for such services. In 1999, only a third of the providers who submitted these denied claims were on watch, but since only 157 claims were denied for this reason, it was a statistically insignificant amount.

702802 is a denial when information from the provider does not substantiate or document the service provided. In 1996, about half of the providers whose claims were denied for this reason were on watch. These are generally found to be provider liable, so the chiropractor would have to write off the costs of the services.

- In 1997, most of the providers in this analysis were on watch, with one clinic on watch responsible for 40% of the denials under this code. In 1998 half of the providers on this list of results were on watch. In 1999, most of the providers whose claims were denied most frequently, were not on watch. The following year, four providers, none of whom were on watch, accounted for the majority (72.8%) of the 375 claims denied for this reason.

Use of this code also necessitates a medical chart review by the consultant, adding to the number of records he is under contract to review.

702807 is a code used to reject payments for unnecessary x-rays. Only about a third of the providers in these results were on watch in 1996. The providers whose claims were most frequently denied for this reason were not on watch. The conclusion is that misuse or overuse of x-rays does not appear to be conclusive criteria for watch status. Typically these denials make the provider write off the costs of the unnecessary service.

- In 1997, more than half of the providers in this analysis were on watch, with one clinic on watch receiving nearly 24% of the denials for x-rays. In 1998, most of

the providers whose claims were denied for improper or excessive x-rays were on watch. This analysis indicates some connection between use of x-rays and watch status, but like the code used to hold claims to review x-rays, these results may be more linked to those chiropractors that have x-ray technology and not necessarily to the misuse of it.

702808 is a code used to deny benefits for certain non-reimbursable services provided at the same time as a manipulation. This could entail inclusive services such as a hot pack or non-payable services such as massages. Although a minority of providers on this list were on watch in 1996, the providers whose claims were most frequently rejected for this reason were predominantly watch doctors.

- In 1997, more than half of the providers on this list were on watch, including two clinics that accounted for 36% of the denials for this reason.

702818 is another code used to deny services when the documentation from the provider did not substantiate the service billed, making the provider liable to write off the costs. In 1997, a majority of the providers on this list were on watch and especially the chiropractors whose claims were denied the most frequently for this reason. This trend continued into 1998.

- In 1999, one clinic on watch accounted for 34% of the denials under this code, although less than one-fourth of the providers in this analysis overall were on watch. In 2000, half of the providers whose claims were denied for this reason were on watch, with one clinic on watch accounting for 30% of the 752 claims denied.

This is another code that necessitates a manual review of all claims and medical records by the consultant or a claims examiner.

703737 is another code used to make the provider liable for denied services deemed to be medically unnecessary. In 1997, the majority of providers on this list were on watch. This code is used for participating providers. **703837** is a similar code for non-participating providers, but because they are not contractually obligated to provide only appropriate services, they cannot be held liable for visits deemed to be unnecessary. In 1997, six providers, all on watch, were on this list.

- In 1998, under code 703737, one-third of the providers in this analysis were on watch, including those whose claims were most frequently denied under this code. For this year, RNA 703738 listed only 16 claims denied for this reason. All but one provider was on watch, but because of the small number of claims denied, no conclusions will be drawn from the analysis.
- In 1999, about a fourth of the providers whose claims were denied by this code were on watch.

755001 is a denial of therapies, mostly electrical stimulation, when performed as indicated. Denials for therapy use in 1995 were somewhat correlated with watch status. Of the 16 providers who had the most claims denied under this code, seven were on watch.

- In 1996, about half of the providers on this list of results were on watch and many of the providers whose claims were most frequently denied for this reason

were watch doctors. Use of this therapy – or misuse or miscoding of it – may peripherally be connected to watch status.

- In 1997, most of the chiropractors whose claims were rejected for this reason were on watch. In 1998 two clinics on watch accounted for more than 61% of the denials for this reason.

853501 rejects excess therapies. In 1998, the first year for which this RNA was analyzed, only 35 claims were denied for this reason. Two of the seven providers on this list of analysis results were on watch.

859000 rejects acupuncture, which is a non-covered service. Because it is, and likely is discretionary for providers to file the claims, no conclusions will be drawn from this 1997 analysis.

- In 1998, although 900 acupuncture claims were not paid, no conclusion will be drawn from the analysis because of the non-payable status of the service. No conclusions will be drawn from the 1999 analysis either.
- In 2000, the 694 denials are reflective of the providers who perform acupuncture and not necessarily indicative of watch status. But because the number of acupuncture claims appear to be diminishing over the years, either fewer chiropractors are performing these services or fewer are submitting the claims.

868512 rejects x-rays when they do not match the diagnosis code. For instance, if the chiropractor diagnoses a cervical sprain, but indicates that he has performed thoracic x-rays, this RNA would then reject the x-rays submitted on the claim. (In lay terms, if the patient came in complaining of neck pain and the chiropractor then x-rayed the patient's back, the back x-rays would be rejected because they would not match the diagnosis.) In 1997, about half of the providers on this list were on watch. This might indicate bookkeeping or coding problems or poor documentation practices.

- In 1998, the results obtained from analyzing this code were quite different from the results obtained when running the hold code 1200610, which holds claims for the identical reason. Different providers surfaced on each list of results, so the conclusion is that either the electronic system is catching the discrepancies between x-ray and diagnosis during the final claims adjudication process, or the providers whose claims are being held to review these discrepancies are not the ones whose claims should be manually reviewed. This is because they are not the providers whose claims are denied most frequently for this reason.
- In 1999, only 92 claims were denied for this reason, so mismatching x-rays do not appear to be a problem area for most providers or is a problem that is diminishing.

0096700, one of the “hidden” denial codes used for excessive treatment, yielded 5,811 denials in 1995. Its descriptive reason states that “based on ... medical information, chiropractic care is appropriate in your case; however, upon receipt of the records, documentation does not appear to justify the level and frequency of care.” One clinic on watch in 1995 accounted for 25% of these denials. Nine of the 10 doctors whose claims were denied the most frequently were on watch. The reason the examiner uses the terminology “hidden” is because this is the code that

handwritten guidelines indicated was reserved for the consultant's manual use and did not have a written explanation within the system.

- In 1996, all of the providers who had the most claims denied for this reason were on watch. These results would indicate that frequency of treatment is one factor in watch status. More than 8,000 claims were denied for this reason. One clinic on watch accounted for 30% of all denials for this reason.
- In 1997, more than 6,000 claims were denied for this reason, with watch doctors occupying the top spots on this list of analysis. This indicates a direct correlation between frequency of treatment rendered and watch status.
- In 1998, the year for which this RNA was supposed to have been phased out and replaced with RNA 1200609, analysis showed almost 700 denials. This indicated that claims adjudicators were not using the new code exclusively. The providers whose claims were most frequently denied for this reason in 1998 were on watch, with two clinics on watch accounting for 32% of the denials.

0055500 is another of the "hidden" codes. Although not detected in 1995, the following year it was used to deny manipulations deemed to be medically unnecessary. Of the 174 claims denied for this reason in 1996, about half of the providers were on watch.

- In 1997, 152 claims were denied under this code, again only found when the examiner experimented with permutations of the numbers and finally pulled claims up under 55500 because codes provided by the Company listed it under 80555. Only one-third of the providers whose claims were denied for this reason were on watch.

Six other codes with "80" prefixes were detected, but only a small number of claims were found, so although their use will be figured in overall totals, no individual conclusions will be used. It is apparent from the analysis that the old three-digit claims numbering system was being phased out.

COMBINED CODE ANALYSIS

1995: By combining all 32 of the denial codes analyzed above, the following resulted: In 1995, 11,128 claims, or 3.3% of all chiropractic claims filed, were denied for the treatment or coverage reasons listed above. Of the 11,128 denials, the JRY Group had only 49 denials (the consultant had 5 of those 49), while the Watch Group had 6,191 of the denials. That means that the Watch Group, which comprised 19.2% of all chiropractors, received 55.6% of all denials for treatment reasons. One clinic received 30% of the Watch Group's denials and about 10% of the denials overall.

During this year, 96,401 claims were held for some type of manual review or processing, determined by combining all 21 hold reasons above. This was 28.6% of all claims filed. Of those held claims, the JRY partners had 1,125 claims, or 1% of the total, held for various reasons. The watch group had 50,712, or 52.6% of the held claims. The enormity of this number indicates that it is simply not possible for the consultant to thoroughly review all of the medical records that are supposed to be submitted with these claims based on the time billed for his reviews.

Of the 11,128 denials, only 22, or .2%, were reversed; only 1.76% of the denied claims were adjusted. That means that if a patient or provider wanted to appeal the denial of benefits, they stood a 99.8% chance of being unsuccessful. Slightly more denials are adjusted – 1.76%, but in general, appeals are meaningless and denied claims remain denied throughout all stages of the appeals process.

1996: This year 17,280, or 4.7% of all chiropractic claims were denied for the treatment or coverage reasons above. One clinic on watch accounted for 33% of those denials, while watch doctors figured most prominently in the analysis of providers who had the most claims denied for treatment reasons. The JRY Group only had 9 denials (this did not include the consultant, who had no denials) while the Watch Group, which is 20.6% of all providers, accounted for 13,421 or 77.7% of the denials.

Of these denials for treatment or coverage reasons, only 2.56% of these claims were reversed and 7.49% of the denied claims were adjusted. That means if a person had a denied claim for any of these reasons and appealed it, there was a 97.54% chance of the claim remaining denied. For 1996, appeals again were futile.

Numerous other denials were issued by the company in 1996, separately not statistically significant but figured into the overall total below.

1997: This year, 19,512 records, or 5% of all chiropractic claims, were denied for the reasons above. Of the denials, the Watch Group had 11,956 while the JRY Group only had 51 records denied, all but 15 for acupuncture. The Watch Group, 20% of the providers, accounted for 61.2% of the denials for treatment reasons. The percentage of denials for the JRY Group was so minimal as not to register a percentage.

A larger percent of claims were reversed in 1997 - 12.25% of claims denied for the treatment reasons above - while 28.38% of the denied claims were adjusted. This means that 87.75% of all denials for treatment reasons remained denied, and that appeals had about a 1 in 9 chance of succeeding at best. Separate analysis of the reasons claims are adjusted or reversed indicated that it is to apply deductible amounts, coinsurance, or for other bookkeeping reasons, and not generally due to an appeal.

Meanwhile, 105,031 records were held to scrutinize treatments. Of those, the JRY Group had 940 records held while the Watch Group had 58,601 records held. The Watch Group accounted for 55.8% of the held records while the JRY Group had less than 1% of their claims held for manual review. Again, many of these held claims are supposed to be manually reviewed, along with the corresponding medical records, by the consultant.

Numerous other claims were denied in 1997 for miscellaneous reasons, separately not statistically significant, but figured into the overall total denials for treatment reasons.

1998: Combining all the denial codes above resulted in 27,158 denied claims, or 6.5% of the total claims, reflecting a steadily rising percent of denials. The JRY Group had only 115 denials. The watch providers had 12,923 denials, or 47.6%. That means that 20% of the providers received nearly half of all denials for treatment reasons, a statistic that has remained constant over the past four years.

Running this analysis for the JRY Group and Watch Group revealed a possible code misuse of RNA Code 1200208. This is the code used to deny claims of providers on watch if they have

not sent chart notes in with their claim. Forty of the JRY Group's claims apparently were denied for this reason, but none of these providers were on watch. That would indicate that the code is being used for providers that are not on watch as well as those on watch. Proper use of this code should have indicated that the Watch Group had all the denials for Code 1200208, or 9,746 claims. But the Watch Group only had 4,352 of the RNA 1200208 denials, so the code is being used for all providers, and not as the guidelines specify.

Analyzing the individual JRY partners along with three providers on watch (Nos. 15633, 14612, and 11419), the consultant had all 40 of the RNA 1200208 denials, while the remaining partners did not have any. It was unclear if the consultant was ordering his own chart notes for his review or if these were claims processing errors.

When all of these 32 denial reasons were categorized by claim type, higher rates of adjustments and reversals emerged as compared to the main body of claims. Of the denials for treatment reasons, 21% of were reversed, and 16.9% were adjusted. That means that if a patient appealed from a denial of those isolated by the examiner, the patient had a 1 in 5 chance at best of reversing the adverse decision, much better than previous years. But again, it appeared as if the typical reasons for adjusting or reversing claims were for bookkeeping reasons, and not to over turn an appeal.

Also, in 1998, 112,736 claims were held for manual review for the 21 reasons listed above in the specific code analysis. The JRY Group had 1,392 claims held or 1% of all held claims. The Watch Group had 53,283 claims held or 47% of all held claims. Again, 20% of the providers had 47% of all held claims.

1999: 30,086 claims were denied for the medical or coverage reasons listed above, plus the miscellaneous reasons that did not amount to statistically significant numbers individually, but were tallied in overall totals. This represented 6.5% of all claims, about the same as last year. The JRY Group only had 80 claims denied. The Watch Group had 15,754 claims denied. That was 52.3% of all denials.

Since only 14% of providers were on watch in 1999, that 14% had more than half of the claims denied for medical or treatment reasons. Two clinics on watch figured especially prominently in those denials. Fewer chiropractors were on watch but they still accounted for more than half of all the denials issued.

Of the claims held for the 21 reasons above, 87,234 claims or 19% of claims were held for manual review. Of those claims, 624 were submitted by the JRY Group. The Watch Group had 37,301 claims held or 42.8% of all held claims. These claims usually result in a manual review of medical records. If one does the math, the consultant spent an average of 30 hours per month or 21,600 minutes reviewing claims. If all 87,234 claims were reviewed, as the Company's procedures indicate, approximately .24 of a minute was spent on each claim or around 15 seconds!

Not all claims need to have chart records reviewed. For instance, a claims reviewer can check mismatching x-rays and deny a claim if the diagnosis is not compatible. But the majority of the claims, especially those of the watch doctors, are reviewed by the consultant.

When the 32 denial reasons were then categorized by claim type, a higher percentage of reversed or adjusted claims emerged, compared with the overall chiropractic claims filed: 14.85% of the denied claims were adjusted and 17.74% were reversed. If a claim was denied

for any of the reasons isolated by the examiner, there was a 1 in 6 chance that the adverse decision would be reversed in a best case scenario. But again, when each claim type was classified by reason, overturning appeals was not the reason most claims were adjusted or reversed. The reasons were bookkeeping for applying deductible amounts, coinsurance, or other factors.

Numerous other claims were denied for miscellaneous reasons that, standing alone, were not statistically significant but were factored into overall denial reasons listed below.

2000: This year, 22,094 claims were denied for the 32 treatment reasons, representing 6.85% of all chiropractic claims filed. Of those denied claims, the JRY Group had 231 or 1% of all denials, while the Watch Group had 11,723 or 53% of all denials. The Watch Group, nearly 40% of the providers, accounted for 53% of the denials.

When the 21 hold codes were tabulated together, 63,404 or 19.67% of all claims were held for manual review or input. Of these, the JRY Group had 653 or 1% of the held claims, while the Watch Group had 30,205 or 47.6% of the held claims.

Categorizing the denied claims by claims type once again yields a better ratio of adjusted or reversed claims compared to overall claims filings. Of the 32 RNA codes used to deny claims for medical or coverage reasons, 15.55% of the denials were reversed, so if a patient appealed one of the denial reasons isolated by the examiner, he or she had almost a 1 in 6 chance of getting the adverse determination reversed, while 22.76% of the denied claims were adjusted.

Hundreds more claims were denied for miscellaneous reasons, which separately are not statistically significant but were figured into overall totals. None of the "hidden" codes used in past years could be detected during the year 2000.

EXAMINER'S CONCLUSIONS

Analysis of the 32 main reasons for denying chiropractic claims, and the 21 primary reasons for holding claims for manual review, supports recommendations that the chiropractic review system in place is in need of a thorough review. Protections need to be developed, implemented, and followed for both consumers and providers. The analysis appears to support chiropractors and patients who question the impartiality, thoroughness, and consistency of the Company's chiropractic claims review process.

Chiropractors are placed on watch for reasons that were not always clear or uniformly applied. The reasons verbally provided by the Company did not always appear to be supported by the data. Chiropractors placed on watch have a disproportionate ratio of claims being held, delayed, and denied. Statistics indicate once a claim is denied, it most always remains denied. The electronic analysis of the Company's records shows that the Peer Review Committee affirms with apparently little question decisions made by the consultant, calling into question the meaningfulness of the appeals process. Because thousands of claims are held each year for manual review, it appears it would be impossible that these claims would receive adequate, thorough, and meaningful review.

Although the number of chiropractors on full or partial watch fluctuates from year to year, the percentage of claims being denied for treatment or coverage reasons has doubled from 3.3% in 1995 to 6.85% in 2000. The chiropractors on watch are seeing increasing numbers of denials,

many for questionable reasons, as the years progress.

Analysis of the specific codes shows that many chiropractors who are demonstrating coding, treatment, or documentation irregularities are escaping scrutiny, while others who appear to be reasonable practitioners are being placed on watch. The consultant and Peer Reviewers have an extraordinarily low number of denied claims compared to the chiropractic population as a whole. The Peer Reviewers should reasonably experience average rates of denials, which they do not. It appears they are receiving favorable treatment.

The codes analysis also shows that the claims of certain chiropractors are being needlessly delayed for scrutiny because some codes are not being correctly used according to their published guidelines. The Company should make a better effort to see that its codes are being properly used.

The Company has a difficult job ahead. It needs to educate consumers on the necessity of conserving medical care and how frequency of treatment impacts premium rates. It has a right and perhaps some obligation to control use of chiropractic services and to bring abusing providers and consumers into line. But it must do so in a manner that is consistent and fair. To do so it must develop clearer claims processing guidelines.

SUMMARY OF RECOMMENDATIONS

Recommendation No. 1: For services conducted within the scope of practice of chiropractors, the Company must not discriminate against chiropractic treatment by reimbursing services of certain professionals while denying similar services provided by chiropractors, or by reimbursing similar services at different levels.

Recommendation No. 2: The Company should consider removing the chart signature requirement from its guidelines for providers with electronically stored medical records and explore the possibility of electronic signatures for those providers.

Recommendation No. 3: The Company should promptly respond in writing to all providers and patients who request explanations of denied services under N.D. Cent. Code § 26.1-04-03(10). Letters of explanation and final decisions should be sent to all appealing parties.

Recommendation No. 4: The Company should change chiropractic consultants and Peer Review Committee members immediately due to the perception of conflicts of interest and possible favoritism. The Company should regularly rotate members of the Committee as intended by its guidelines and accept names for appointment from the NDCA. At least two alternate members should be appointed to deal with situations in which a conflict of interest is present for the regular voting members.

Recommendation No. 5: The Company should adhere to its contractual appeals provisions and the URAC standards. Peer Review Committee members should meet no less than monthly to decide appeals from denied claims or services. The Company should also reconcile its contract language and chiropractic guidelines to reflect the procedures certified to URAC specifying a 30-day turnaround time on appeals.

Recommendation No. 6: The individual members of the Peer Review Committee should exercise judgment independent of the consultant.

Recommendation No. 7: To the extent meeting minutes purport to place patients on maintenance, Peer Review Committee members should not allow maintenance care for some patients that is not contractually obligated.

Recommendation No. 8: Written notification to every patient placed on a schedule of care by the Company's consultant or Peer Review Committee should be sent within two days. Letters should also be copied to the patient's last treating provider. The schedule of care should be fully disclosed.

Recommendation No. 9: The Company should study other state's statutes for peer review standards, consider adopting similar guidelines for its own peer reviews.

Recommendation No. 10: The Company should consider revising its descriptions of supportive and maintenance care to more closely resemble the ACA definitions.

Recommendation No. 11: The Company should bring its watch procedures into compliance with N.D. Cent. Code § 26.1-04-03(9)(c) by sending claimants notice that their claim is being held pending receipt of more information and not summarily denying claims without conducting a reasonable investigation.

Recommendation No. 12: The Company should establish written guidelines for placing chiropractors under focused review and communicate those guidelines, once formulated, to each chiropractor. If the Company distinguishes between full and partial watch, it should define each category and criteria for placing a provider within each. Target goals for utilization should be communicated to all providers if they are incorporated into watch status. These guidelines should be published in the Company's Quality Management Plan.

Recommendation No. 13: The Company, within 30 days of this report, should bring its profiling data into compliance with N.D. Cent. Code Chapter 26.1-36-41 and disclose statistical profiles to all providers who have requested them. All future requests for profiling data should be complied with in a timely manner.

Recommendation No. 14: The Company should adopt procedures for conducting audits of providers and for outlining the circumstances that will lead to an audit.

Recommendation No. 15: The Company must ensure that it is not treating patients of providers who belong to ChiroChoice differently than patients of chiropractors who do not belong to the PPO. The Unfair Claims Settlement Practices Act prohibits reviewers from injecting personal or professional biases or preferences into any claims reviews.

Recommendation No. 16: The Company should review these claims and assign the appropriate denial codes, or make refunds if the services should have been allowed. The Company should maintain records that accurately reflect the reason for denial.

CONCLUSION

An examination has been conducted of the market conduct affairs relating to chiropractic benefits of Noridian Mutual Insurance Company dba Blue Cross Blue Shield of North Dakota as of December 31, 2000.

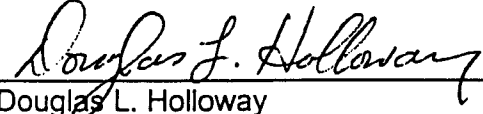
The exam was conducted in accordance with NAIC procedures. Sarah Smith, Market Conduct Examiner, performed this exam.

EXAMINATION REPORT SUBMISSION

The Company's cooperation in this exam is hereby noted. This examination report is respectfully submitted to the Honorable Jim Poolman, Commissioner of Insurance, North Dakota Insurance Department.

Respectfully submitted,

Date: 12-19-01



Douglas L. Holloway
Special Assistant Attorney General
Deputy Commissioner
N.D. Insurance Department