Approved March 18, 1991
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Representative Turnquist at
Chairperson

3:30 ~~xxx~~ a.m./p.m. on Wednesday, March 6, 1991 in room 531 N of the Capitol.

All members were present except:

Elaine Wells, Excused

Committee staff present:
Emalene Correll, Research
Bill Edds, Revisor
Gena Lott, Intern
Chris Courtwright, Research
Nikki Feuerborn, Secretary

Conferees appearing before the committee:

Steve Dickson, Kansas Chiropractic Association
David Hanzlick, Kansas Dental Association
Dr. Ralph ~~Wells~~ Weber, Blue Cross/Blue Shield
Meyer Goldman, Human Prime Health
Bill Sneed, HIAA
John Grace, Kansas Homes for the Aging
Dr. Paul Bell, UNUM Life Insurance
David Brenna, UNUM Life Insurance
Dick Brock, Insurance Commissioner's Office

Others Attending:: See Attached List

Representative Welshimer moved for the approval of the minutes for March 4 and 5, 1991. Representative Helgerson seconded the motion. Motion carried.

Emalene Correll of the Research Department introduced the hearing on HB 2499 by giving a brief history and overview of the bill.

Steve Dickson, representing the Kansas Chiropractic Association, presented testimony as a proponent on HB 2499. He stated that this bill would act as an enforcement mechanism in that it would authorize the Insurance Commissioner to effect penalties if third party payers deny payment to providers which are covered under the insurees' policies. Numerous correspondence from claimants was attached to his testimony. (See Attachment 1). A copy of Kansas Statute 40-2,101 was attached (See Attachment 2) which stated that no policies, contracts or agreements for medical service shall deny reimbursement or indemnification for any service within scope of practice licensed under Kansas healing arts act.

David Hanzlick, Kansas Dental Association, appeared as a proponent of HB 2499. He stated that the purpose of the legislation was to strengthen the effectiveness of the "Insurance Equality" statutes. Without that protection, the patient might lose the right to seek care from his or her selected provider. See Attachment 3.

Dr. Ralph ~~Wells~~ Weber, Blue Cross/Blue Shield, testified an opponent to HB 2499. He stated that the intent of the proposed legislation is to circumvent managed care programs where benefits are available only upon referral by a primary care physician. The purpose of the bill is to prohibit the imposition of conditions which describe or arrange for referral policies which limit subscriber's access to covered services lawfully performed within the scope of any license, registration, or certificate of identified health care personnel. HMO's licensed in Kansas are required by state law to have externally certified quality assurance programs that guarantee that their members receive necessary care. Managed care programs must retain the primary care physician controlled referral process. (See Attachment 4.)

The committee questioned Dr. Wells extensively regarding the referral process and payment procedure for providers who are not listed on the referral list. Criteria for primary care physicians was discussed.

Meyer Goldman, representing Humana Prime Health, testified as an opponent to HB 2499. (See Attachment 5). His opposition included Section 2 and 3 as they could be construed as mandates to require use of members of the professions cited in the bill whether or not they are under contract with the HMO. This could also be construed to prohibit HMO's from selecting providers with whom they contract on the basis of appropriateness to render the needed services. Failure to pay contracted costs is an unfair practice already prescribed by legislation and should not be tied to a mandate to use specified providers.

Bill Sneed, representing HIAA, appeared as an opponent of HB 2499. It is their contention that the intent of the legislature in 1990 was to require fiscal impact reports so they could fairly evaluate social benefit versus social cost for such mandates. Therefore, HIAA is requesting that such a fiscal impact report be prepared. HIAA believes Section 3 of the bill is inappropriate inasmuch as payment for services should be equivalent to what is performed by whom, experience of the provider, etc. (See Attachment 6).

James Schwartz of KECH and Cheryl Dillard of Kiaser Permanente were unable to attend the hearing and sent testimony in opposition to HB 2499. (See Attachments 7 and 8).

The Hearing on HB 2420, eligibility for long term care insurance benefits, began with testimony by proponent John Grace, representing the Kansas Association of Homes for the Aging. (See Attachment 9). Mr. Grace testified that two changes need to be made to the bill: 1) recognize cognitive disability as a trigger for benefit; and 2) recognize residents of continuing care retirement communities as eligible groups for long term care insurance.

Dr. Paul Bell, Assistant Medical Director of UNUM Life Insurance Company of Portland Maine, testified as a proponent of HB 2420. They are a disability insurance carrier and use ADL's (activities for daily living) as an assessment tool. Current law in Kansas states that insurers cannot use medical necessity as a condition for long term care insurance benefits; insurers may use a physician's recommendation that services are necessary. With the passage of this bill, the market will expand and consumers will have greater choice of long term care insurance products. (See Attachment 10).

David Brennan assisted Dr. Bell in answering questions from the committee regarding financial arrangements between their company and HIAA, the possibility of policy change within UNUM in order to do business in Kansas, exact assessment instruments, and the appropriate trigger for benefits to begin.

Bill Sneed, representing Health Insurance Association of America, appeared as a proponent of HB 2420. See Attachment 11. HIAA supports provisions on long-term care which would expand the long-term care insurance market and utlimately provide a more wide-range selection to the Kansas consumers for available options of long-term care insurance.

Dick Brock, Insurance Commissioner's Office, spoke as an opponent of HB 2420. (See Attachment 12). Over 20 insurers have long term care products available which have been approved for Kansas. Consumer complaints regarding the sale and value of long-term care products have decreased dramatically since the enactment of legislation controlling them was implemented in 1988. Mr. Brock stated that HB 2420 proposes

to again open the door to pre-conditions for benefit eligibility which necessitated the legislation of 1987. With the "notwithstanding" introduction in the proposed amendment, an insurer would be free to condition benefit eligibility on such functional and cognitive assessments as it deems appropriate regardless of the safeguards regarding such things as coverage for Alzheimer's disease, senile dementia or other real problems experienced by policyholders and others prior to 1988.

There were no other conferees appearing at the hearing of HB 2420.

Representative Sprague moved for the favorable passage to the consent calendar for HB 2441 - secondary mortgage enhancement act. Representative Neufeld seconded the motion. Motion carried.

The meeting adjourned at 5:50 p.m.

GUEST LIST

COMMITTEE: Insurance DATE: 3-6-91 W

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Nancy Zogleman	Topeka	BC/BS of Ks.
Ralph Weber MD	Topeka	BC/BS of Ks
Mayer L. Goldman	Kansas City	KHMO Assn.
David Hanzlick	Topeka	KS Dental Assn
Eric Loewe	Chicago	NAII
Michael W. Foley	Northbrook, IL	Allstate
Dick Black	Topeka	Ins. Dept
Harold Riehm	Topeka	KAOA
Gary Robbins	"	KOA
Joe Furjanic	Topeka	KCA
Steve Dickson	Topeka	KCA
Bill Sneed	Topeka	NIAA
Mary Spinks	Topeka	Health Benefits Admin
David Brenerman	Portland, Maine	UNUM Life Ins. Co.
Paul Bell, M.D	Portland, Maine	UNUM Life Ins. Co.
John Grace	Topeka	KAHA
Dave Hanson	Topeka	NAII
LJ Schneider	Topeka	HIAA

TESTIMONY OF STEVEN M. DICKSON
BEFORE THE HOUSE INSURANCE COMMITTEE
March 6, 1991

GOOD AFTERNOON LADIES AND GENTLEMEN. I AM APPEARING TODAY AS LEGAL COUNSEL ON BEHALF OF THE KANSAS CHIROPRACTIC ASSOCIATION IN SUPPORT OF HOUSE BILL 2499. I APPRECIATE YOUR ALLOWING US THE OPPORTUNITY TO SPEAK TO YOU TODAY.

THIS INITIATIVE COMES AT SOME WHAT OF AN INTERESTING TIME. WE REALIZE THAT YOU ARE IN THE MIDDLE OF VERY POWERFUL PLAYERS CONCERNING SOME VERY POWERFUL ISSUES. THE REASON WE ARE HERE IS TO ATTEMPT TO ENFORCE THE WISHES OF THIS LEGISLATURE FROM YEARS AGO. WE DO NOT ASK YOU TO ADD ANYTHING TO THE REQUIREMENTS ALREADY IN PLACE. <u>THIS IS NOT A MANDATE</u>. THIS IS SIMPLY ENFORCEMENT OF EXISTING LAW. TO DEMONSTRATE, LET ME SHOW YOU THE LANGUAGE FROM K.S.A. 40-2,101.

IT LOOKS LIKE A PRETTY STRAIGHT FORWARD STATUTE. THERE IS NOTHING CONFUSING ABOUT IT. ONE WOULD THINK THAT ANY CLAIMS ADJUSTER WHO READS THE STATUTE WOULD UNDERSTAND THAT THEY CANNOT DENY PAYMENT TO A D.O., M.D. OR D.C. SIMPLY BECAUSE OF THE CLASSIFICATION OF THEIR LICENSE. YET, THAT IS WHAT THEY ARE DOING. AND BECAUSE OF THE WAY THE STATUTE IS WRITTEN, THEY CAN GET AWAY WITH IT. LOOK AT THE STATUTE AGAIN. IS THERE ANYTHING IN THE STATUTE WHICH PROVIDES FOR ANY ENFORCEMENT MECHANISM? THE ANSWER IS NO.

HOUSE BILL 2499 WILL SIMPLY PROVIDE FOR THE ENFORCEMENT OF K.S.A. 40-2,101 AND SIMILAR STATUTES. THE PROBLEM WITH THE CURRENT STATUTORY SCHEME IS THAT MOST CLAIMS ARE TOO SMALL TO WARRANT THE ATTENTION OF STATE GOVERNMENT, THE ATTORNEY GENERAL'S OFFICE OR

Insurance
March 6, 1991
Attachment 1

INDIVIDUAL ATTORNEYS. MANY OF THESE CLAIMS ARE IN THE NEIGHBORHOOD OF $100 TO $300. HOWEVER, THROUGH SHEER VOLUME, THESE CLAIMS CAN BE SIGNIFICANT.

LET ME EXPLAIN THE TYPICAL SCENARIO. JOHN DOE BUYS AN INSURANCE POLICY WHICH IS SUPPOSED TO COVER HIM IF HE GETS SICK OR IS INJURED IN AN ACCIDENT WHERE HE HAS NO THIRD PARTY CLAIM. HE IS NOT HURT VERY BADLY. HE GOES TO HIS CHIROPRACTOR AND IS TREATED APPROPRIATELY AND GETS OUTSTANDING RELIEF. THE TOTAL BILL COMES TO $300. THE BILL IS SUBMITTED TO THE INSURANCE CARRIER WHICH HAS COLLECTED PREMIUMS ON THIS POLICY FOR THE LAST FIVE YEARS. THE INSURANCE COMPANY SENDS THE BILL IN FOR REVIEW. THIS PROCESS CAN TAKE FROM ONE TO THREE MONTHS. AFTER THE REVIEW PROCESS, JOHN DOE GETS A FORM LETTER IN THE MAIL STATING THAT HIS POLICY PROVIDES FOR PAYMENT FOR REASONABLE AND NECESSARY SERVICES. THEY DO NOT BELIEVE THESE SERVICES WERE REASONABLE AND NECESSARY. THEREFORE, THEY DECLINE TO PAY THE BILL. THE REVIEW IS DONE BY SOME ANONYMOUS INDIVIDUAL WHO MAY OR MAY NOT BE A DOCTOR.

JOHN DOE GETS ON THE PHONE TO THE INSURANCE ADJUSTER TO FIND OUT WHY THEY DENIED THIS CLAIM. THE INSURANCE ADJUSTER TELLS HIM THAT HE SHOULD NOT HAVE GONE TO A CHIROPRACTOR, HE SHOULD HAVE GONE TO SOME OTHER PRACTITIONER. JOHN DOE THEN CALLS UP HIS CHIROPRACTIC PHYSICIAN AND TELLS HIM WHAT IS HAPPENING. THE CHIROPRACTIC PHYSICIAN, WHO HAS NOT BEEN PAID IN THREE MONTHS, TELLS JOHN DOE ABOUT K.S.A. 40-2,101. JOHN DOE CALLS THE INSURANCE ADJUSTER BACK AND TELLS HIM ABOUT THE STATUTE. AFTER TWO OR THREE CONVERSATIONS WITH JOHN DOE AND HIS SUPERVISOR, THE ADJUSTER FINALLY INFORMS MR. DOE THAT THERE IS NOTHING HE CAN DO ABOUT IT

AND THE CLAIM IS DENIED.

UNDER OUR CURRENT SCHEME, THIS SCENARIO IS ALL TOO COMMON. THERE IS NOTHING JOHN DOE CAN DO UNLESS HE WANTS TO GO SPEND $300 OR MORE HIRING A LAWYER TO COLLECT HIS $300 BILL. HOUSE BILL 2499 WILL CORRECT THAT SCENARIO. JOHN DOE WILL BE ABLE TO GET ASSISTANCE FROM THE INSURANCE COMMISSIONER'S OFFICE IN THE EVENT THE CARRIER IS UNWILLING TO OWN UP TO ITS RESPONSIBILITIES UNDER 40-2,101 AND HOUSE BILL 2499. THERE NEED BE NO ADDITIONAL STATE DOLLARS SPEND ON ENFORCEMENT. FURTHER, IF ENFORCEMENT IS NECESSARY, THE PENALTY PROVISIONS SHOULD COVER ANY COST.

WE RECOGNIZE THAT THIS PROBLEM IS NOT SPECIFIC TO CHIROPRACTIC. THEREFORE, ADDITIONAL MEASURES FOR ENFORCEMENT HAVE BEEN PLACED IN THE TEXT OF HOUSE BILL 2499. IT IS BECAUSE WE RECOGNIZE THIS ENFORCEMENT PROBLEM IN OTHER STATUTES THAT WE REQUEST IT BE ADDRESSED IN ONE BILL. FURTHER, THE SITUATION OUTLINED ABOVE IS NOT THE ONLY WAY THESE DENIALS OCCUR. I HAVE TAKEN THE LIBERTY OF ATTACHING SEVERAL PIECES OF CORRESPONDENCE COLLECTED DURING THE LAST FEW YEARS FROM ACTUAL CONTROVERSIES TO THIS TESTIMONY FOR YOUR REVIEW. CERTAINLY, I WOULD BE HAPPY TO ADDRESS THOSE SITUATIONS.

I WILL NOW STAND FOR QUESTIONS.

Winfield Chiropractic Office

Brad J. Swanson, D. C. 1302 Main • Winfield, Kansas 67156 Telephone: 221-1990

September 22, 1989

Steven M. Dickson
700 Jackson Street
Jayhawk Tower Building
Roof Garden Suite
Topeka, KS. 66603

Dear Steve,

Enclosed you'll find the copies of some of the excerpts from the Gott Corporations Insurance policy manual. I just found out that the Parkside Hospital is a Psychological Hospital, and I am not sure how that effects the medical necessity or certification of care by a Chiropractor, but I thought that was interesting. I have the entire handbook if you are interested in a photocopy, but at this time I just pulled out the information that seemed to be relevant to the situation that we have here. If there are any further interest on more of the handbook or the entire handbook, just give me a call and I'll be glad to send it to you.

I will await your thoughts on this information.

Sincerely,

Brad J. Swanson, D.C.

Brad J. Swanson, D.C.

BJS:jlh
cc;KCA

If a confinement or treatments are going to extend beyond the number or type initially certified, you, your dependents, or your doctor must call the Patient Services Coordinator and obtain further certification.

All care must be medically necessary in order to be covered under the plan.

If certification of an in-patient hospitalization or admission into a residential/alternative site facility program is not obtained from Parkside, all non-certified charges will be reduced by 20%.

If certification of outpatient treatment is not obtained by the seventh (7th) visit, benefits will be reduced by 20% for visits not certified.

Any reduced amounts not payable will not be considered a covered expense and will not count toward the deductible or co-insurance maximum.

TECHNOLOGY AND OUTPATIENT REVIEW (TOR) PRECERTIFICATION

The availability of complex and expensive medical practices can make it difficult for you or your dependents to know if a proposed treatment is medically necessary. In order to address this issue, Rubbermaid has asked Parkside Health Management Corporation to administer the Technology and Outpatient Review (TOR) Program.

The Technology and Outpatient Review Program will assist you in evaluating the health effects of certain medical PROCEDURES, THERAPIES and TREATMENTS. Your case will be handled by a TOR Patient Coordinator working in conjunction with a panel of physician experts and your doctor.

How the Program Works

You and your dependents must obtain written pre-authorization and certification from the TOR Patient Coordinator prior to one of the following selected THERAPIES or non-emergency PROCEDURES:

THERAPIES

Occupational - treatment based on utilization of activities to encourage the physically or mentally disabled patient to contribute to his own recovery. A registered occupational therapist selects and directs the patient's activities.

Physical - treatment with physical and mechanical means such as massage, heat, light, water, exercise. Treatment is performed by a registered physical therapist after receiving a physician's order.

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Speech - treatment for improving speech disfunction or disability due to cerebral thrombosis or stroke, brain damage from bodily injury, removal of vocal cords, loss of ability to express or understand ideas associated because of an organic brain lesion.

PROCEDURES (NON-EMERGENCY)

Angioplasty - a procedure using a balloon-tipped tube to widen the narrowing in a heart artery and improve blood flow to the heart. No surgery is necessary.

Caesarean Section - a surgical incision through the abdominal wall and uterus performed to remove a fetus.

Coronary Artery Bypass Graft - a surgical procedure in which a blood vessel from the chest or leg is grafted beyond the narrowing in a heart vessel to "detour" blood past the narrowing to reach the heart.

Lithotripsy - a procedure for breaking up kidney stones in which shock waves are directed to the site of the stones to shatter them.

Magnetic Resonance Imaging (MRI scan) - a way to look inside the body without using x-ray. It uses a large magnet, radio waves and computer. It is used for early detection and treatment of disease.

Ultrasound Imaging During Pregnancy (sonogram) - a diagnostic scan used during pregnancy in which a transmitter is moved across the body in the area to be examined and produces an image similar to x-ray without using x-ray.

Upper Gastrointestinal (GI) Endoscopy - placement of a tube through the mouth into the stomach for the purpose of direct visualization of the stomach lining and uppermost part of the intestines.

TREATMENTS

You or your dependents must also obtain written pre-authorization and certification from the TOR Patient Coordinator prior to the third (3rd) visit for each episode for one of the following treatments:

Chiropractic - a branch of the healing arts based on the premise that good health depends, in part, upon a normally functioning nervous system. Doctors of chiropractic do not use drugs or surgery but focus primarily on the spinal structure and nerves.

Podiatric - treatment of foot disorders.

Certification Program

When you call Parkside, the TOR Patient Coordinator will review your medical condition with your physician/therapist. After the review is completed, you, your physician/therapist and The Travelers will receive written certification on the THERAPIES, PROCEDURES or TREATMENTS approved as medically necessary.

All medically necessary THERAPIES, PROCEDURES, or TREATMENTS approved by the TOR Patient Coordinator will be certified.

Benefits will be reduced for THERAPIES, PROCEDURES, or TREATMENTS not certified by Parkside.

In some cases, an independent medical evaluation may be required by Parkside as part of the certification process. If an evaluation is required, it will be paid at 100% by the plan.

When to Notify the TOR Patient Coordinator

You and your dependents must notify the TOR Patient Coordinator:

* Two (2) weeks before scheduled THERAPIES and non-emergency PROCEDURES, or as soon as scheduling has taken place

* Before the third (3rd) visit for each episode with a podiatrist or chiropractor

All care must be medically necessary in order to be covered under the plan.

If prior written authorization and certification from Parkside is not obtained and followed, benefits for THERAPIES, TREATMENTS and non-emergency PROCEDURES will be reduced by 20%.

Any reduced amounts not payable will not be considered a covered expense and will not count toward the deductible or co-insurance maximum.

PRE-EXISTING CONDITIONS

A pre-existing condition is any injury or sickness for which medical care and treatment has been (or should have reasonably been) received by you or your dependent during the 12-month period preceding the date of coverage. For such a condition, the medical plan benefits will be payable:

1. After the insured individual has been covered under the plan for a period of twelve (12) consecutive months, or

2. After the insured individual has paid $2,500 toward covered expenses due to the pre-existing condition.

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Farm Bureau Insurance

FARM BUREAU MUTUAL INSURANCE COMPANY • KFB INSURANCE COMPANY
KANSAS FARM BUREAU LIFE INSURANCE COMPANY • FB SERVICES INSURANCE AGENCY

HAYS CLAIMS OFFICE, 2716 Plaza Ave., P.O. Box 427, Hays, KS 67601 / (913) 625-6717

August 31, 1990

Betty Delzeit
1006 Cathedral
Victoria, KS 67671

RE: Policy# 0905195-26
Claim # 90-35710-26
D/A : 6-25-90

Dear Betty:

I am writing to you in regards to your medical bills with Dr. Arnett. As of this date we have received a total billing statement of $949.00. We were just curious as to how you were progressing with the pain in your body from the accident. We generally like to see improvement from the first date of treatment. By the looks of the itemized billing we are not sure if in fact you are improving. If you are not improving, perhaps we should consider sending you to a specialist who would be able to truly help you with your injuries.

Please let us know how you feel about this and we would be more than happy to set up some type of appointment with Dr. Wilcox or another physician of your choice.

Thank you ahead of time for your cooperation and assistance in this matter. Looking forward to hearing from you soon.

Sincerely,

Richard Gillispie
District Claims Representative

ls

cc: Master file

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DR. VINTON K. ARNETT

Practice of Chiropractic

NORTHRIDGE PLAZA
2705 VINE - #5
HAYS, KANSAS 67601
PHONE 913-628-3622

September 14, 1990

Richard Gillispie
District Claims Representative
Farm Bureau Insurance
P.O. Box 427
Hays, KS 67601

RE: Betty Delzeit
Policy # 0905195-26
Claim # 90-35710-26
D/A - 6-25-90

Dear Mr. Gillispie:

Your discrimnatory letter to Betty Delzeit dated August 31, 1990, has with her permission been sent to Steve Dickson, legal counsel for the Kansas Chiropractic Association for his review.

Ms. Delzeit is pleased with her progress. I am pleased with her progress. She is "truly" being helped and remains satisfied with the care she is receiving. In the event progress becomes unsatisfactory no hesitation will be made towards referral. She is currently being treated on a reduced frequency basis.

In the future should you question a patients progress or the quality of care they may be receiving, I would appreciate it if you would contact me personally rather than secretly attempting to disrupt a satisfactory doctor-patient relationship. Thank-you.

Sincerely,

Vinton K. Arnett, D.C.,P.A.

c.c. Steve Dickson
Betty Delzeit

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State of Missouri

State Board of Chiropractic Examiners
Kay Gunter, Executive Director
3523 North Ten Mile Drive
P.O. Box 672
Jefferson City, Missouri 65102-0672
Telephone 314/751-2104

Division of Professional Registration

June 21, 1990

Lewis E. Melahn
Commissioner of Insurance
Missouri Division of Insurance
Department of Economic Development
P. O. Box 690
Jefferson City, MO 65102-0690

Dear Mr. Melahn:

Re: Request for Investigation

I am writing to you on behalf of the Missouri State Board of Chiropractic Examiners to request an investigation into certain unlawful practices by certain insurance companies and their agents operating in the state of Missouri. The Missouri State Board of Chiropractic Examiners has received dozens of complaints concerning the practice of insurance companies in arbitrarily reviewing chiropractic billing where they are contractually bound to provide health care services. Although the practices, that I will describe for you, appear to be widespread, the complaints we have received primarily concern the following companies: Aetna, State Farm (Kansas City, Northtown, Grandview, Missouri), Automobile Interinsurance Exchange, Blue Cross-Blue Shield, Allstate, Farmers Mutual, and American Family. All of the complaints have centered around three insurance review companies: Diagnostic Science Laboratories, Inc., also doing business as Independent Health Care Reviewers; Professional Evaluation Services, also doing business as PES; and IntraCorp.

The procedure complained of is that these insurance companies are routinely and arbitrarily referring chiropractic claims made by chiropractors on behalf of insureds to these third-party reviewers. These reviewers promise to substantially reduce all bills sent to them. Moreover, it appears that certain chiropractors' claims are routinely singled out for review. In no instance have the carriers provided a basis for referral of these claims for review.

The reviews themselves are not only inaccurate, they are libelous, and we believe, fraudulent. Every review we have received cuts claims substantially, and generally more than 50%. Often, the claims are cut 100%. We have received numerous examples of these reviews, despite the third-party reviewers' continued requests that they not be released to the chiropractors who are being reviewed. These reviews contain boilerplate language and often contain

allegations as to what is and is not within the scope of chiropractic. None of these reviewers have ever contacted the Missouri State Board of Chiropractic Examiners for a determination as to what procedures are included within our scope of practice, and most of their statements in this regard are inaccurate.

We are particularly concerned in that these are paper reviews wherein there is no actual examination of the patient. Many of the insureds have looked at the language in these reviews and have come to the conclusion that they have somehow been cheated by their chiropractor, when in fact the chiropractor has done nothing illegal or improper. We are also concerned that these reviews do not contain the name of the person making the review so that there is no way that this Board can determine whether non-licensees are in fact practicing chiropractic in violation of state statutes. Moreover, particularly with Diagnostic Science Laboratories, they have used fictitious addresses and fictitious names, and sometimes no letterhead at all, in an attempt to mislead those examining these documents.

This is clearly vexatious refusal to pay in violation of section 375.296 and section 375.420, RSMo. Several chiropractors have filed suit on this basis against the insurance companies and have received successful settlements in the case, but the practice continues to proliferate. The extent of complaints that we have seen indicates to us a pattern of refusal to pay the insureds' health care claims without reasonable cause or excuse.

These practices represent clear, unfair discrimination in violation of section 375.396(11)(b), RSMo, in that the companies have acted in such a way as to not permit the insured "... full freedom of choice in the selection of any duly licensed physician, suregon, optometrist, chiropractor...." These actions also represent an unfair claims settlement practice in violation of section 375.936(10)(b), (c), (d), (f), and (g), RSMo, in that the insurors have deliberately delayed payment of claims, have denied benefits properly payable, and have compelled insureds to institute litigation to recover amounts due under their policies. By arbitrarily reviewing all chiropractic bills, they are typically deferred for at least six weeks. While the practice does not call for review of all medical doctors and normally not of osteopathic physicians.

When the insurors deny these claims without just cause, payment for services rendered must come out of the insured's pocket. If the insured or the chiropractic physician wish to collect what they are rightfully owed, they must institute costly litigation. Many of our licensees have done so, but they rightfully ask, Cannot the state intervene to prevent this practice?

We would ask the Division to note the following: IntraCorp, one of the reviewing agencies listed above, is owned by Cigna. DSL, Inc., is primarily a diagnostic laboratory which has singled out one of its former partners for particular review. It is our belief that DSL is currently operating outside the scope of its Articles of Incorporation.

We have asked our members to report these violations to you, and we are writing this letter so that you will be aware of this problem. We have considerable

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documentation in support of these claims which we will be more than happy to provide at your request. We would also be more than willing to provide whatever assistance we can to you in prosecuting these claims. We ask that you investigate this matter in a thorough and diligent manner and take such action as may be required to insure compliance with the Missouri state statutes. I would request that you keep us advised as to how your investigation is proceeding. If you have any questions in this regard, you may contact me or our general counsel, Mr. Robert L. Hawkins, III, P. O. Box 1497, Jefferson City, MO 65102-1497, phone (314) 635-3000.

Thank you for your attention to this matter.

Very truly yours,

Thomas J. Curnutte, III, D.C.
President
State Board of Chiropractic Examiners

TJC:keg
cc: Board Members
Robert L. Hawkins, III

Paul Cosey
816-452-3030

1241

Anti-Trust

DR. JOHN T. PAPPAS, D.C.
1003 W. 4TH ST — PHONE 316 231-1340
P. O. BOX 62226
PITTSBURG, KANSAS 66762

April 25, 1990

Steve Dickson
Attorney At Law
400 West 8th, Suite #611
Topeka, Kansas 66603

Dear Mr. Dickson:

I was recently informed that you were considering legal action against insurance companies regarding there payment and there use of consultants.

I am enclosing a recent claim, with part of the payment is still pending, with Aetna Insurance. My insurance secretary has enclosed a phone log regarding her conversations with Aetna. We advised them that the length of time that they were taking to pay this claim, which you will note was almost sixty day, was going to make it difficult for us to bill and collect any amount which was not paid. You will note that they forwarded us a check on April 13, 1990 for 80% of the claim. I am enclosing a copy of check and letter which was enclosed.

I am certain that you are aware of this type action being done but I thought you might like to review our case. I also had a problem with Hartford Insurance recently with a workman's compensation case. The employer was very insistent that the employee, who initially came here, go to a doctor of there choice, which was approved by Hartford Insurance I did inform the employee of the unauthorized portion but he was concerned with jeopardizing his job if he continued treatment here. The discouraging part regarding this case was that he was showing marked improvement after three treatments and planned on releasing him to return to work when he stopped treatment. I submitted a compensation form and statement to Hartford for $250.00 which was paid.

Mr. Dickson, I have practiced in Pittsburg for twenty five years and I <u>have never</u> been questioned on a workman's compensation claim until this one described with Aetna. I consider it discrimination and a harassment more than I consider it an evaluation of my services. If I can be of further assistance please advise.

Respectfully yours,

John T. Pappas, D.C.

JTP/dw

Enclosure

1391

FROM THE DESK OF

JOHN T. F .PAS
CHIROPRACTOR
1003 W. 4TH ST.
PITTSBURG, KANSAS 66762
TELEPHONE:316 - 231-1340

DAVID ROBINSON

January 8, 1990 - Mailed in claim to Aetna Insurance. Workman's Compensation Claim

January 22, 1990 - Received letter statement requesting additional information. Copy of records.

February 19, 1990 - Mailed additional information to Aetna

March 19, 1990 - Called and spoke to Cheri (woman handling claim) she stated that letter was in Peer Review but that due to length of time that they had had claim she would send 80% of claim. Stated we should hear on other 20% in two weeks.

March 30, 1990 - Called Cheri had not received check for 80% or heard anything on claim. Stated would check into it and get check into mail

April 9, 1990 - Called to talk to Cheri away from desk Called an hour later still away from desk told me would give her message as soon as she returned and have her call me.

April 10, 1990 - Cheri returned call. Couldn't locate file on patient said she would locate it and call me back.

April 11, 1990 - Cheri called me stated that orders to mail check for 80% had gotten misplaced but she would personally see it was mailed today. Told me we should hear on other 20% in two weeks. Told her that was what she told me three weeks ago. Said she was sorry sometimes these things take time.

April 13. 1990 - Recieved check for 80% of claim with letter stating we would hear on other 20% in three weeks even though I was told two on phone previously.

Commercial Insurance Division
2024 N. Woodlawn, Suite 201
Wichita, Kansas 67208
(316) 688-9980

Apr. 11, 1990

J.T. Pappas, D.C.
1003 W. 4th St.
Pittsburg, Ks. 66762

RE: Insured: General Construction
Claimant: David Robinson
Claim #: W 30 CC - MO
DOL: 9-14-89

Dear Provider:

Please find our enclosed check which represents payment of a portion of your charges for chiropractic services rendered our claimant from 9-19-89 to 12-20-89 in the amount of $1120.00. We have referred your claim to Professional Evaluations Services of Peoria, IL for an independent audit. This review should be completed in 3 weeks. If you should have any questions please contact me.

Thank you for your cooperation.

Sincerely,

Cheri K. White
Senior Medical Cost Controller

cc: File

Ætna Life Insurance Company or The Ætna Casualty and Surety Company or
The Standard Fire Insurance Company or The Automobile Insurance Company of Hartford, Conn. or
Ætna Casualty & Surety Company of Illinois or Ætna Life Insurance Company of Illinois

CHECK NO. 33106251

Claim Number: W 03058488S6M0 094JC 862000890CAA
Policy Number:
Insured: GENERAL CONSTRUCTION CO
Date of Loss: 09-14-89
Aud.

Claimant Name and Address: ROBINSON, DAVID

Date of Check: 04-11-90

PAY ▶ $896.00*********

EIGHT HUNDRED NINETY-SIX AND 00/100********** Dollar

Pay to the Order of

DR. JOHN T. PAPPAS
1003 W. 4TH ST.
PITTSBURG, KS 66762

For
MEDICAL
CC
KH
480699958

By Authorized Representative

AI

⑈33106251⑈ ⑆011903620⑆ 000312 L⑈

SWIM CHIROPRACTIC OFFICE
M. A. SWIM, D.C.
206 SOUTH FIRST
HIAWATHA, KANSAS 66434

MEMBER
AMERICAN CHIROPRACTIC ASSOCIATION

MEMBER
KANSAS CHIROPRACTIC ASSOCIATION

April 9, 1990

Steve Dickson
700 Jackson
Jayhawk Tower Building
Topeka, Kansas 66603

Dear Steve;

Please find enclosed a copy of a letter received from Theresa Pieloch who is a nurse analyst for the Cooperative Benefit Administrators, post office box 6249, Lincoln, Nebraska 68506. The Cooperative Benefit Adminstrators Inc. is an insurance company selling insurance in the State of Kansas to the Rural Electric Cooperatives. However, they are not following the guidelines as set out by legislation for the insurance equality act in the State of Kansas. They have repeatedly excluded Chiropractic coverage in the past and are doing so at the present.

I have a number of files on this particular company and quite a number of patients and can document all of the claims that they have paid and the claims that they do pay reluctantly. This might be a interesting test case if you can see any evidence that would warrant going after them.

If you see this is interesting, please let me know and I will compile all of the information for you.

Respectfully,

M.A. Swim D.C.
MAS;rr

enclosure: letter concerning Edith Allen 3-30-90

Intra-Trust

G. ALLEN FITZNER, D.C., P.A.

3435 W. Central
Wichita, KS 67203
Telephone: (316) 943-3208

April 4, 1990

Steven M. Dickson
Attorney at Law
Dickson & Pope, P. A.
Jayhawk Tower
Roof Garden Suite
700 SW Jackson
Topeka, Kansas 66603

Re: Intracorp Medical Review

Dear Steve:

Please review these insurance reports denying payment for intersegmental traction, because it is duplicate service for the adjustment, and the denial of post x-rays, because they are duplicate services.

Intracorp is proving to be unjust to the services delivered by Chiropractic, I am very unhappy with the results of this latest ploy by the insurance companies. Is any relief from Intracorp review possible, would a Class Action suit prove worthwhile, if so let's stop the insurance carriers in Kansas from putting down Chiropractic care.

A few weeks ago we made an inquiry as to forms that would provide us with a more comprehensive worker's comp and P.I. case history and examination, so that all bases could be covered when and if the case is taken to court. Forms of this nature would be very helpful. If none are available, would you send me a brief breakdown of needed information so I can design a form for our use.

Thank you for your assistance.

Sincerely,

G. ALLEN FITZNER, D.C.,P.A.

GAF/mee

1791

THE Farmers Insurance Group OF COMPANIES

WICHITA WEST BRANCH CLAIMS OFFICE
P.O. BOX 9068
WICHITA, KS 67277
316-945-8065

April 2, 1990

Gehe Sims
P.O. Box 281
Goddard, Kansas 67052

RE.:
OUR INSURED: Gene Sims
POLICY NUMBER: 04 12642 44 77
LOSS DATE: 12/19/89

DEAR Mr. Sims:

Please be advised that we have sent your bills from 12/19/88 thru 3/9/90 to Intracorp Medical Review Services. We have asked them to give us their opinion as to the necessity of charges and whether or not the charges are reasonable.

As you should be aware, K.S.A. 40-3111 provides that medical charges shall not exceed the amount customarily charged and the charges must be reasonable and necessary. If the charges are not reasonable, your policy will only pay the reasonable charges and you could be liabile for the balance.

Once we receive Intracorp's report, we will advise our position regarding payment of the bill.

Very truly yours,
MID CENTURY INSURANCE COMPANY

Harold W. Cole

Harold W. Cole
Branch Claims Manager

HWC:gh

CC: G. Allen Fitzner, D.C.
3435 W. Central
Wichita, Kansas 67203

FAST, FAIR, FRIENDLY SERVICE

1891

INTRACORP

February 14, 1990

RECEIVED MAR 0 5 1990

Delores Inman
Farm Bureau Mutual
P.O. Box 771068
Wichita, KS 67277

Patient: Noonan, Theresa

Provider: G. Allen Fitzner, D.C.

Account No: 1059658-87

Dates of Service: 9-26-89 to 12-20-89

Intracorp No: J52 5436

Bill Amount: $1910.00

Specialist: Sharon Cygan

Telephone: (913) 722-2085

Dear Ms. Inman:

The review of the materials submitted to this office regarding the above-named claimant has been completed. Available for review were the following:

1. Office notes from G. Allen Fitzner, D.C., dates of service 1-4-89 through 12-20-89.

2. Itemized billing from G. Allen Fitzner, D.C., dates of service 9-26-89 through 12-20-89 for $1910.00 - have previous billing for $640.00.

3. Letters from G. Allen Fitzner, D.C., dates 10-2-89 and 11-21-89.

4. Attending Physician's Report dated 10-21-89.

The purpose of this review was to evaluate the necessity of the Chiropractic care provided for Ms. Noonan in relation to the injuries sustained in the motor vehicle accident.

Ms. Noonan was involved in a motor vehicle accident on 5-17-89. The claimant was treated after the accident, by G. Allen Fitzner, D.C., from 9-26-89 through 12-20-89. The treatment consisted of Manipulations, Traction and Electrical Muscle Stimulation. The diagnosis submitted by Dr. Fitzner for Ms. Noonan was:

6701 W. 64th Street, Suite 220, Shawnee Mission, KS 66202
Phone (913) 722-2085 Fax (913) 722-6029

1991

Claimant: Noonan, Theresa
IC File #: J52 5436

"847.2 lumbar subluxation, 728.85 muscle spasm, 724.9 nerve root compression-lumbar, 847.0 cervical sprain/strain, 719.5 cervical restriction of motion, 739.1 segmental dysfunction-cervical, 728.85 hypermobility-cervical, 728.4 ligament instability-cervical, 724.9 nerve root compression-cervical."

The file was submitted to a Chiropractic Consultant for review. The Consultant was asked to evaluate the necessity of the care provided for Ms. Noonan in relation to the injuries sustained in the motor vehicle accident of 5-17-89. The Consultant made the following comments regarding this file:

"The diagnosis is consistent with a musculoskeletal condition involving the cervical and lumbar spine.

"Emergency care at a hospital after the injury was not indicated in the file. There is information in the file indicating a pre-existing condition: has received treatment by the same provider from 1-4-89 through 1-20-89.

"RECOMMENDATIONS: Based on the information presented in this file the following procedures and services appear appropriate for this claimant:

9-26-89	Initial exam
9-26-89	Comprehensive cervical spine
9-26-89	Cervical spine - 1 view
9-26-89	Lumbar x-ray
27 units of	Manipulation
22 units of	Electrical muscle stimulation (EMS)
10-18, 12-8	Re-exams
11-20-89	Massage unit
12-8-89	Cervical pillow

(Broken down)

Office visit	= $55.00
Traction	= 15.00
EMS	= 15.00
Manipulation	= 25.00

6701 W. 64th Street, Suite 220, Shawnee Mission, KS 66202
Phone (913) 722-2085 Fax (913) 722-6029

Claimant: Noonan, Theresa
IC File #: J52 5436

Based on the information presented in this file I cannot recommend consideration for:

10-18-89, 12-8-89,	Repeat cervical x-rays
12-8-89	Cervical spine, 1 view, repeat
10-18-89, 12-8-89	Repeat lumbar x-ray
9-26-89	Dietary supplement
27 units of Traction	

"Usual and customary recovery per diagnosis and other information in this file would normally occur within 22-28 treatments over a 2-3 month period of time. Continued treatment after a patient has achieved maximum medical improvement, resolution, and/or stabilization of a condition would constitute maintenance type care in nature, or be questionable as to necessity. Care after 12-20-89 is not substantiated by records provided for review.

"The primary type of treatment by a doctor of chiropractic for the type of condition described in this file is spinal manipulative therapy and/or adjustments. The traction should be considered a duplication of the therapeutic goal of the spinal manipulation procedure.

"The routine use of repeat x-ray studies is not considered a customary treatment practice or necessity for most conditions as determined by accepted guidelines. Repeat radiographic evaluation of a patient should not be undertaken without significant observable indication. Unless the provider can submit clinical documentation, the necessity for repeat radiation exposure has not been established.

"Should an impasse develop in this case, I would recommend the insurance company request the provider to submit office records, x-rays and other substantiating evidence to support the aspects of this claim that are not considered reasonable and customary."

Recommendations for payment are based on the opinion of the Chiropractic Consultant. Should a second Consultant's opinion be necessary, please advise this office. Charges recommended for payment appear to be related to the covered diagnosis. A detailed Recommended Payment Schedule is provided.

WHO? IS THIS CONSULTANT!

6701 W. 64th Street, Suite 220, Shawnee Mission, KS 66202
Phone (913) 722-2085 Fax (913) 722-6029

2191

INTRACORP

INTRACORP
CHIROPRACTIC BILL REVIEW REPORT

Claimant: Noonan, Theresa
Doctor: G. Allen Fitzner, D.C.

Insured: same
Treating Physician State and Zip Code: KS 67203

Intracorp File No.: J52 5436
Dates of Service: 9-26-89 to 12-20-89

Total Billed Amount: $1910.00
Date of Loss/Accident: 5-17-89

Date(s) of Service	Service and CPT Code	Unit Cost	Number Billed	Recomm. Unit Cost	Number Recomm.	Total	Rationale
9-26-89	90020 - initial exam and adjustment	$70.00	1	$70.00	1	$70.00	
9-26-89 12-8-89	72010 - comprehensive spine AP	60.00	2	60.00	1	60.00	Repeat x-ray is not substantiated as to necesssity
9-26-89 12-8-89	72020 - cervical 1 view	25.00	2	25.00	1	25.00	Repeat x-ray is not substantiated as to necesssity
9-26-89 10-18-89 12-8-89	72100 - lumbar 1 view	30.00	3	30.00	1	30.00	Repeat x-ray is not substantiated as to necesssity
9-26-89	90699 - dietary supplements	20.00	1	NA	0	0	Service not substantiated as to necessity
9-27-89 to 11-20-89	90070 - office visit	55.00	19	25.00 15.00 15.00	19 units manip 19 units EMS 0 units traction	475.00 285.00 0	Goal of traction is duplication of manipulation

2291

INTRACORP

RECEIVED MAR 0 5 1990

Claimant: Noonan, Theresa
IC File #: J52 5436

Date(s) of Service	Service and CPT Code	Unit Cost	Number Billed	Recomm. Unit Cost	Number Recomm.	Total	Rationale
10-18-89 12-8-89	99080 - re-exam and adjustment	50.00	2	30.00	2	60.00	Fee above usual and customary office visit and manipulation
10-18-89	72040 - cervical AP and lateral	50.00	1	50.00	0	0	Repeat x-ray is not substantiated as to necesssity
10-18-89 to 12-1-89	97012 - intersegmental traction	15.00	3	15.00	0	0	Goal of traction is duplication of goal of manipulation
10-18-89 to 12-1-89	97014 - electric muscle stimulation	15.00	3	15.00	3	45.00	
11-20-89	99070 - massage home unit	75.00	1	NA	1	75.00	
11-27-89 to 12-20-89	Manipulation	25.00	5	25.00	5	125.00	
12-8-89 to 12-20-89	97012 - intermittent traction	15.00	4	15.00	0	0	Goal of traction os duplication of goal manipulation
12-8-89	Cervical pillow	15.00	1	15.00	1	15.00	
	TOTALS		$1910.00			$1265.00	

2391

INTRACORP

March 13, 1990

Irene Russell
Farmers Insurance
P.O. Box 9068
Wichita, Kansas 67277

Patient: Canady, Betty

Provider: G. Allen Fitzner, D.C.

Account No: 04 12638 32 25

Dates of Service: 10/31/89 to 2/5/90

Intracorp No: J52 5388

Bill Amount: $1,548.25

Specialist: Sharon Cygan, R.N.

Telephone: (913) 722-2085

Dear Ms. Russell:

The review of the materials submitted to this office regarding the above-named claimant has been completed. Available for review were the following:

1. Office notes from G. Allen Fitzner, D.C. dates of service 10/31/89 through 2/5/90.

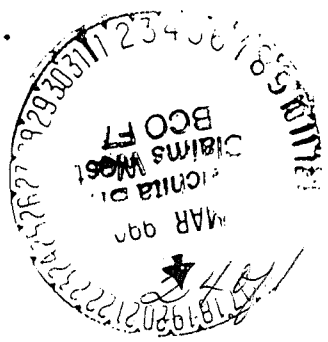
2. Itemized billing from G. Allen Fitzner, D.C. dates of service 10/31/89 through 2/5/90 for $1,548.25.

3. Itemized billing from HCA Wesley Medical Center date of service 10/27/89 for $220.50.

4. Medical report from G. Allen Fitzner, D.C. dated 12/21/89.

The purpose of this review, per your request, was to evaluate the necessity of the chiropractic care provided for Ms. Canady in relation to the injuries sustained in the motor vehicle accident.

Ms. Canady was involved in a motor vehicle accident on 10/27/89. The claimant was treated by G. Allen Fitzner, D.C. from 10/31/89 through 2/5/90. The treatment consisted of Manipulations, Electrical Muscle Stimulation, Ultrasound, and Traction. The diagnosis submitted by Dr. Fitzner for Ms. Canady was:



6701 W. 64th Street, Suite 220, Shawnee Mission, KS 66202
Phone (913) 722-2085 Fax (913) 722-6029

"847.0: Sprain/strain - cervical 739.1: Segmental dysfunction - cervical 722.0: Disc placement 847.0: Hyperflexion/hyperextension injury - thoracic 728.85: Muscle spasm 839.21: Thoracic subluxation unspecific 847.2: Sprain/strain - lumbar 839.20: Lumbar subluxation unspecific."

The file was referred to a Chiropractic Consultant for review. The Consultant was asked to evaluate the necessity of the chiropractic care provided for Ms. Canady in relation to the injuries sustained in the motor vehicle accident of 10/27/89. The Consultant made the following comments regarding this file:

"The diagnosis is consistent with a musculoskeletal condition involving the cervical, thoracic and lumbar spine."

"Emergency care at a hospital after the injury was indicated in the file. There is no information in the file indicating a pre-existing condition."

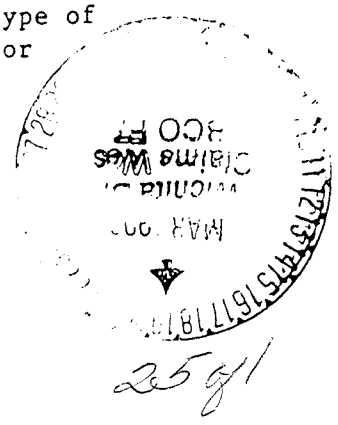
"RECOMMENDATIONS: Based on the information presented in this file the following procedures and services appear appropriate for this claimant:

10/31/89 Initial exam ($45.00)
10/31/89 All x-rays
13 Units of EMS ($15.00)
22 Units of office visit (manipulation)
12/4/89 Re-exam ($25.00)
9 units of ultrasound."

"Based on the information presented in this file I cannot recommend consideration for:

12/4/89 Repeat x-rays
10/31 and 11/8 Dietary supplements
Traction
11/6/89 Unidentified."

"The primary type of treatment by a doctor of chiropractic for the type of condition described in this file is spinal manipulative therapy and/or adjustments. The traction should be considered a duplication of the therapeutic goal of the spinal manipulation procedure."



"Usual and customary recovery per diagnosis and other information in this file would normally occur within 22-28 treatments after a patient has achieved maximum medical improvement, resolution and/or stabilization of a condition would constitute maintenance type care in nature, or be questionable as to necessity. Care after 1/29/90 is not substantiated by records provided for review."

"The routine use of repeat x-ray studies is not considered a customary treatment practice or necessity for most conditions as determined by accepted guidelines. Repeat radiographic evaluation of a patient should not be undertaken without significant observable indication. Unless the provider can submit clinical documentation, the necessity for repeat radiation exposure has not been established."

"Should an impasse develop in this case, I would recommend the insurance company request the provider to submit office records, x-rays and other substantiating evidence to support the aspects of this claim that are not considered reasonable and customary."

Recommendations for payment are based on the opinion of the Physician Advisor. Should a second Consultant's opinion be necessary, please advise this office. Charges recommended for payment appear to be related to the covered diagnosis. A detailed Recommended Payment Schedule is provided.

6701 W. 64th Street, Suite 220, Shawnee Mission, KS 66202
Phone (913) 722-2085 Fax (913) 722-6029

2691

AUDIT RESULTS:

Total amount of bill(s)	$1,548.25
Less	
Undocumented treatments/services	15.00
Duplicate treatments/services	270.00
Medically unnecessary treatments/services	168.25
Charges above fair and reasonable/higher than state-mandated	0.00
Charges unrelated to carrier's responsibility	0.00
Other	0.00
Total Recommended Payment	$1,095.00
Less previous payment	Unknown
TOTAL DUE	$1,095.00

Thank you for the opportunity to serve you in your cost-containment efforts.

Sincerely,

Sharon Ann Cygan/mm

Sharon Ann Cygan, R.N.
Auditing Specialist

SAC/gh

INTRACORP

INTRACORP
CHIROPRACTIC BILL REVIEW REPORT

Claimant: Canady, Betty

Insured: Canady, Betty

Intracorp File No.: J52 5388

Total Billed Amount: $1,548.25

Doctor: G. Allen Fitzner, D.C.

Treating Physician State and Zip Code: KS 67203

Dates of Service: 10/31/89 to 2/5/90

Date of Loss/Accident: 10/27/89

Date(s) of Service	Service and CPT Code	Unit Cost	Number Billed	Recomm. Unit Cost	Number Recomm.	Total	Rationale
10/31/89	90020 - Initial Exam and Adjustment	$70.00	1	$70.00	1	$70.00	Exam $45.00 Manipulation $25.00.
10/31/89 12/4/89	72010 - Complete Spine AP	60.00	2	60.00	1	60.00	Repeat x-ray is not substantiated as to necessity.
10/31/89 12/4/89	72020 - Cervical 1 View	25.00	2	25.00	1	25.00	Repeat x-ray is not substantiated as to necessity.
10/31/89	72100 - Lumbar 1 View	30.00	1	30.00	1	30.00	
10/31/89	72070 - Thoracic 1 View	30.00	1	30.00	1	30.00	
10/31/89	97014 - Electrical Muscle Stimulation	15.00	1	15.00	1	15.00	

2891

INTRACORP

Claimant: Canady, Betty
IC File #: J52 5388

Date(s) of Service	Service and CPT Code	Unit Cost	Number Billed	Recomm. Unit Cost	Number Recomm.	Total	Rationale
10/31/89 11/8/89	90699 - Dietary Supplement	10.00	2	N/A	0	0.00	Service is not substantiated as to necessity.
11/1/89 11/3/89	90060 - Intermediate Office Visit	40.00	2	40.00	2	80.00	Manipulation and EMS.
11/8/89 to 2/5/90	90070 - Office Visit	55.00	19	25.00 manip	18	450.00	Care after 1/29/90 is not substantiated as to necessity. Goal of traction is duplication of goal of manipulation. F Service unidentified.
				15.00 EMS	10	150.00	
				15.00 Ultrasound	8	120.00	
				15.00 Traction	0	0.00	
				15.00 F	0	0.00	
12/4/89	90080 - Re-exam and Adjustment	50.00	1	50.00	1	50.00	
12/4/89	97128 - Ultrasound	15.00	1	15.00	1	15.00	

INTRACORP

Claimant: Canady, Betty
IC File #: J52 5388

Date(s) of Service	Service and CPT Code	Unit Cost	Number Billed	Recomm. Unit Cost	Number Recomm.	Total	Rationale
12/4/89	97012 - Intermittent Traction	15.00	1	15.00	0	0.00	Goal of traction is duplication of goal of manipulation.
2/1/90	Service Charge	8.25	1	0.00	0	0.00	
	Totals:		$1,548.25			$1,095.00	

/gh

COOPERATIVE BENEFIT ADMINISTRATORS, INC.

Branch Office: P.O. Box 6249, Lincoln, Nebraska 68506
Telephone (402) 483-7815

March 30, 1990

Mr. James Allen
C/O Brown-Atchinson Electric
P.O. Box 230
Horton, KS 64439

RE: Claim Number - 90-052-0879
Member Number - 511-24-6507
Member Name - James Allen
Patient Name - Edith Allen

Dear Mr. Allen:

You have requested reconsideration of Edith's chiropractic expenses.

The progress notes from the visits were submitted in support of this request. Medical necessity for continued care is not supported in the documentation. Additional benefits are not eligible at this time.

The plan of benefits under which Mrs. Allen is covered provides for medical care and treatment subject to the definitions, exclusions, and limitations contained in the plan. The following services are excluded from benefits under the plan:

"Charge for Unnecessary Services and Supplies - a charge for any services or supplies, including tests or check-up exams, that are not needed for medical care of a diagnosed sickness or injury. To be 'needed,' the service or supply must meet all of these tests:

(a) It is ordered by a Physician.
(b) It is commonly and customarily recognized throughout the Physician's profession as appropriate in the treatment and diagnosis of the sickness or injury.
(c) It is not educational or experimental in nature. For the purpose of this Plan, drugs not approved by the FDA and investigational procedures (surgical included) are considered experimental."

In addition, the following exclusion was added to the Plan effective September 1, 1986:

"Manipulation Therapy Charges - charges in connection with treatment of a chronic maintenance condition by manipulation therapy. 'Manipulation therapy' means treatment with hands or by mechanical means, of those bodily disorders which are: disorders of the spine or disorders involving both the muscles and the bones or their connective tissue."

Should you have additional information which you feel may alter this decision, please send it to us for further consideration.

If you wish to appeal this denial, you have the right to request a review by the Claims Manager. The request must be made in writing within 90 days of receiving this denial and should be sent to the Claims Manager at the address shown below:

Dudley Brown, Claims Manager
Cooperative Benefit Administrators
P.O. Box 6249
Lincoln, NE 68506

Sincerely,

Teresa Pieloch RN

Teresa Pieloch, R.N.
Nurse Analyst

cc: Brown-Atchinson Electric
Dr. M.A. Swim

3241

rr/4624

State Farm Insurance Companies

March 7, 1990

State Farm Insurance Claim Off
5725 Foxridge Drive
P.O. Box 2913
Mission, Kansas 66201

[redacted]

RE: Our Claim No.: 16-3491-648
Loss Date: [redacted] 02/28/89

Dear Mr. [redacted]

As you are aware from our previous communications, in review of medical records it was questionable whether or not the treatments you were receiving for medical care were in association to the automobile accident.

To date you have been examined by Diagnostic Science Laboratories and Dr. Joseph Lichtor, M.D., Orthopedic Surgeon, concerning the continuation of medical treatment.

As we had advised you on our July 14, 1989 correspondence, we would no longer be able to entertain for the medical. However, at the request of your attorney to give further consideration towards continued medical treatment we felt it necessary to have you examined by an orthopedic surgeon.

I am enclosing Dr. Lichtor's report for your review. As previously indicated on our July 14, 1989 correspondence, we will no longer be able to entertain or give further consideration to the continued medical care you are receiving.

Respectfully yours,

Chris Pool
Claim Specialist

CP/slh/A52-3

Enclosure

cc: Keith Martin
P.O. Box 25625
Overland Park, KS 66225-5625

cc: Bill Avery
P.O. Box 485
Osawatomie, KS 66064

3391

State Farm Insurance Companies

March 7, 1990

State Farm Insurance Claim Offi
5725 Foxridge Drive
P.O. Box 2913
Mission, Kansas 66201

Arthur V. Conner
536 Pacific
Osawatomie, KS 66064

RE: Our Claim No.: 16-3491-648
Loss Date: 02/28/89

Dear Mr. Conner:

As you are aware from our previous communications, in review of medical records it was questionable whether or not the treatments you were receiving for medical care were in association to the automobile accident.

To date you have been examined by Diagnostic Science Laboratories and Dr. Joseph Lichtor, M.D., Orthopedic Surgeon, concerning the continuation of medical treatment.

As we had advised you on our July 14, 1989 correspondence, we would no longer be able to entertain for the medical. However, at the request of your attorney to give further consideration towards continued medical treatment we felt it necessary to have you examined by an orthopedic surgeon.

I am enclosing Dr. Lichtor's report for your review. As previously indicated on our July 14, 1989 correspondence, we will no longer be able to entertain or give further consideration to the continued medical care you are receiving.

Respectfully yours,

Chris Pool
Claim Specialist

CP/slh/A52-3

Enclosure

cc: Keith Martin
P.O. Box 25625
Overland Park, KS 66225-5625

cc: Bill Avery
P.O. Box 485
Osawatomie, KS 66064

3491

State Farm Mutual Automobile Insurance Company

State Farm Insurance Claim Office
1701 Landon
P.O. Box 2045
Hutchinson, Kansas 67504-2045
Phone: 316 662-0549

MARCH 23, 1990

Greene Chiropractic
2100 Kansas Street
Great Bend, KS 67530

Attn: Mr. Paul Greene

RE: Our Insured: Goldsmith, David
Our Claim #: 16-3476-292
D/L: 12-12-88

Dear Mr. Greene:

As you are aware, we had previously forwarded documentation concerning our insured's treatment at your facility for an outside review to address your concerns. The findings of our review have in fact, confirmed several areas of our concerns and aspects of this particular claim and the treatment rendered to Mr. Goldsmith.

Specifically, we were attempting to clarify the diagnostic workup concerning our insured through your facility and the various other providers in which he sought treatment. The outside review that we arranged noted the particular areas of concern that have valid points on both sides of the coin. Since the findings from that review cannot conclusively state the treatments in question were not necessary or duplicative in nature, we will lend the benefit of the doubt in your favor.

It is not State Farm's position or desire to arbitrarily deny submitted services without clarification or sufficient reasoning. Since this particular case does involve some discrepancies that cannot be entirely determined, we will allow the benefit of the doubt and subsequently, reimburse the services in question.

The decision for reimbursement affects this particular case and the facts surrounding it and the areas of concern. This particular case does not indicate any future course of handling or lack of clarification and documentation concerning the areas in question.

3591

Enclosed, please find our payment to cover the remaining services not previously reimbursed. Should you have any questions concerning this matter or any other discussion, feel free to contact the undersigned. Thank you for your time and cooperation.

Sincerely,

Phillip Hoffman
Claim Supervisor

PH/F03kp

Enclosures

3691

GREENE CHIROPRACTIC CENTER, PA
PAUL T. GREENE JR. D.C., B.A., M.S., DIRECTOR

January 17, 1988

State Farm Mutual Automobile Insurance
Brad Blackim
P.O. Box 2045
Hutchinson, KS 67504-2045

RE: Your claim #: 16-3476-292
Client: David Goldsmith
D/L: 12/12/88

Dear Mr. Blackim:

Thank you for your letter of 1/10/89 concerning David Goldsmith. I am providing additional information concerning our x-ray charges. I believe you will understand why additional views were taken and pay the bill in its entirety.

On December 16, 1988, x-rays were taken. A full spine was taken, an open mouth cervical to check the adontoid process (this is not clearly seen on a full spine) a lateral cervical, thoracic and lumbar were taken specifically for bone position, disc spacing and any trauma that my have occurred in the area. As you well know, fractures may show up three to four days later even though the initial x-rays were negative for fractures. The x-rays taken 12/19/88 were taken because a piece of glass was noted on the full spine x-ray in the neck area. This was confirmed on 12/19/88. I am certain that a competent radiologist would not lead you to believe that an A-P full spine could in any way reveal the lateral aspect of the spine. You have either been misinformed or given improper information.

Please notify me promptly if you are going to continue to deny payment for the x-rays as being unnecessary. Enclosed is an up-to-date billing. Please call me if you have any questions or need additional information.

Sincerely,

Dr. P. T. Greene,Jr.

PTG/np

Enclosure

PRACTICE OF CHIROPRACTIC AND NUTRITION
2100 KANSAS STREET, P.O. BOX 983 • GREAT BEND, KANSAS 67530 • PHONE 316 792-1386

3791

State Farm Mutual Automobile Insurance Company

State Farm Insurance Claim Office
1701 Landon
P.O. Box 2045
Hutchinson, Kansas 67504-2045
Phone: 316 662-0549

P. T. Greene, Jr., D.C.
2100 Kansas
Great Bend, KS 67530

January 10, 1989

Re: Our Claim No: 16-3476-292
Your Client: David Goldsmith
D/L: 12-12-88

Dear Dr. Greene:

Attached to this letter you will find a draft payable to you in the amount of $277. which is for payment of services rendered to David Goldsmith.

After having received your bill and reviewing the charges, we feel that the charges for all of the xrays done on December 16th of 1988 are duplicative in nature and will be paying only for the full spinal xray charge of $40. In talking to a local radiologist, they say that the full spinal xray should have encompassed the other three charges and are duplicative so therefore will not be paid. The $34.00 charges for xrays on December 19th, 1988 we feel are not necessary as they would have been taken only three days prior to that and do not feel are a reasonable and necessary charge so we will not be making payment for those charges. We therefore feel that $277.00 of your $399.00 charges are reasonable and necessary charges and are making payment for the $277.00.

If you have any problems with the amount in which we are paying you, please contact me and I will be more than happy to discuss this matter with you. Thank you for your consideration in this matter.

Very truly yours,

Brad Blackim

Brad Blackim
Sr. Claim Representative

BB/kp

Enclosure: Draft

3891

GREENE CHIROPRACTIC CENTER, PA

PAUL T. GREENE JR. D.C., B.A., M.S., DIRECTOR

September 27, 1989

Patient: David Goldsmith
Your Claim#: 16-3476-292
D/L: 12/12/88

ITEMIZED STATEMENT FOR X-RAYS TAKEN ON DAVID GOLDSMITH

12/16/88	One 8x10 open mouth cerivcal-adontoid	72020	$17.00
12/16/88	One 8x10 lateral cervical	72020	17.00
12/16/88	One 14x17 lateral lumbar	72020	27.00
12/16/88	One 14x17 lateral thoracic	72020	27.00
12/16/88	One 14x36 anteroposterior full spine	72020	40.00
12/19/88	Two 8x10 anteroposterior and lateral cervical	72040	34.00

TOTAL OF X-RAY CHARGES: $162.00

Dr. P. T. Greene, Jr.
Dr.'s ID#: 48-0894934

np

PRACTICE OF CHIROPRACTIC AND NUTRITION

2100 KANSAS STREET, P.O. BOX 983 ● GREAT BEND, KANSAS 67530 ● PHONE 316 792-1386

3901

GREE , CHIROPRACTIC C TER, PA
PAUL T. GREENE JR, D.C., B.A., M.S., DIRECTOR
2100 KANSAS STREET
GREAT BEND, KS 67530
PHONE (316) 792-1386

October 4, 1989

State Farm Mutual Automobile Insurance
Brad Blackim
P.O. Box 2045
Hutchinson KS 67504-0245

RE: Claim #: 16-3476-292
Client: David Goldsmith
D/L: 12/12/88

Dear Mr. Blackim:

Please find enclosed an itemized statement for X-Rays taken on David Goldsmith. After obtaining an independent radiologist report of the X-Rays I believe you will see that there were no duplicative X-Rays. Procedure coding often does not allow for an individual X-Ray. Your company is the first one that has questioned this procedure of billing and I trust the new information I am providing will allow you to see that no unnecessary X-Rays were taken nor were any duplicative x-Rays taken. Please give us consideration of payment of $162.00. If you have any additional questions or need other information please contact our office.

Sincerely,

Dr. P. T. Greene, Jr.

PTG/ncd

Enclosure
Copy: David Goldsmith

4091

GREENE CHIROPRACTIC CENTER, PA
PAUL T. GREENE JR. D.C., B.A., M.S., DIRECTOR

December 1, 1989

State Farm Insurance
Claims Supervisor
P.O. Box 2045
Hutchinson, KS 67504-2045

RE: Your claim #: 16-3476-292
Client: David Goldsmith
D/L: 12/12/88

Dear Claims Supervisor:

Please find enclosed copies of correspondence concerning David Goldsmith. Please advise me whether or not you intend to pay this claim. It is my opinion that you have had more than adequate time to make a decision. Should you decide not to respond within 21 days, I will pursue appropriate avenues to assure satisfactory results for myself and David Goldsmith.

Sincerely,

Dr. P. T. Greene, Jr.

PTG/np

PRACTICE OF CHIROPRACTIC AND NUTRITION
2100 KANSAS STREET, P.O. BOX 983 ● GREAT BEND, KANSAS 67530 ● PHONE 316 792-1386

4/89

State Farm Mutual Automobile Insurance Company

State Farm Insurance Claim Office
1701 Landon
P.O. Box 2045
Hutchinson, Kansas 67504-2045
Phone: 316 662-0549

DECEMBER 11, 1989

P.T. Greene, Jr.
PO Box 983
Great Bend, KS 67530

Re: Your client: David Goldsmith
Our claim #: 16-3476-292
D/L: 12-12-88

Dear Mr. Greene:

This letter is in follow up to our various correspondence outlining the treatment for David Goldsmith, in regard to the injuries he sustained in the above mentioned loss.

We are still of the opinion that the charges we previously denied were either duplicative or unreasonable and unnecessary charges, and it is our position that they are not covered under our policy.

We, therefore, feel that you either drop these charges from your bill and try to collect the charges directly from our insured, David Goldsmith.

If you would like to discuss this matter further, you can contact me at 792-6862, Monday through Friday, between the hours of 8:00 a.m. and 4:30 p.m. Thank you for your cooperation in this matter.

Sincerely,

Brad Blackim

Brad Blackim
Sr. Claim Representative

BB/ml3cb

4291

GREE... CHIROPRACTIC C... ER, PA
PAUL T. GREENE JR, D.C., B.A., M.S., DIRECTOR
2100 KANSAS STREET
GREAT BEND, KS 67530
PHONE (316) 792-1386

January 3, 1990

Fletcher Bell
Insurance Commissioner
420 S. W. 9th
Topeka KS 66612

RE: David Goldsmith
RE: State Farm Insurance
Brad Blackim-Sr. Claim Representative

Dear Fletcher Bell:

Would you please review the enclosed copies of correspondence and read the letter I have enclosed. I believe Greene Chiropractic Center has been damaged by State Farm Mutual Automobile Insurance Company and Mr. Brad Blackim. I also believe Greene Chiropractic Center has provided all necessary information and State Farm has only verbiage and "feelings" that support their position, please consider the 9 points listed and render an opinion concerning should the $162.00 balance be paid to Greene Chiropractic Center, claim assigned by David Goldsmith.

1. State Farm Agent-Brad Blackim fails to supply hard copy of radiologist stating X-Rays were unnecessary or duplicative.

2. State Farm didn't request X-Rays to allow a radiologist to make an evaluation, but said X-Rays were deemed duplicative. This is unbelievable!

3. A full spine fee and X-Ray film never has included the side view spinal X-Rays. Absolutely no duplicative X-Rays were taken or billed for.

4. State Farm has ignored the itemized breakdown we sent them with procedure codes.

5. State Farm has ignored the independent radiology report I sent them.

4341

STATE OF KANSAS

KANSAS
INSURANCE DEPARTMENT

420 S.W. 9th
Topeka 66612-1678 913-296-3071

1-800-432-2484
Consumer Assistance
Division calls only

FLETCHER BELL
Commissioner

February 5, 1990

Dr. Paul T. Greene, Jr.
2100 Kansas Street
Great Bend, KS 67530

State Farm Mutual Automobile
Insurance Company
Insured: David Goldsmith
Department File No. 01000250

Dear Dr. Greene:

This department has received correspondence from State Farm Mutual Automobile Insurance Company concerning the claim for treatment for injuries David Goldsmith suffered in an auto accident.

The company states they have received Dr. Cavanaugh's report and are now of the opinion that a comprehensive second opinion regarding diagnosis, treatment, submitted billings and reports are in order.

I am sure the company has been in touch with the insured and the examination for the second opinion is being obtained.

As soon as we have more information we will be back in touch with you.

Very truly yours,

Fletcher Bell
Commissioner of Insurance

Betty Vanderslice

Betty Vanderslice, Representative
Property/Casualty Unit
Consumer Assistance Division

BV:llca
5795

4491

THE Farmers Insurance Group OF COMPANIES

TOPEKA BRANCH CLAIMS OFFICE
P.O. BOX 2849
TOPEKA, KS 66601
913-264-4653

12/12/89

Ronald Weibert
Rt. 1, Box 24
Durham, KS 67438

RE: Our Insured — Ronald Weibert
Policy Number — 04 2693 95 12
Date of Loss — 10/1/88
Our File Number — E7 038514

Dear Mr. Weibert,

We have received the results of your second opinion examination with Dr. Ali Manguoglu. Dr. Manguoglu recommended that a home exercise program be utilized rather that chiropractic care. This being the case we are unable to pay for any further chiropractic treatments as of the date of this letter.

If you have any questions or need further assistance, please do not hesitate to let us know.

Sincerely,

FARMERS INSURANCE COMPANY, INC.

James W. Rempe
Branch Claims Manager

JWR/llf

cc: Dr. D.R. Scharenberg
304 E. D St.
Hillsboro, KS 67063

454/1

FAST, FAIR, FRIENDLY SERVICE

James M. Vander Yacht, D.C.
2316 Planet Avenue
Salina, Kansas 67401
(913) 823-1060

November 29, 1989

Mr. Fletcher Bell
Commissioner of Insurance
420 S.W. 9th
Topeka, Kansas 66612-1678

Dear Mr. Bell:

I am writing to make an official complaint against the State Farm Mutual Automobile Insurance Company, in particular the behavior of Mr. Hank Doss and Mr. Gordon Reist in Salina.

In brief, I am actively treating a Mrs. Mary Ann Adams for injuries sustained in an automobile accident of 7-06-89. On November 28, 1989, State Farm issued a letter jointly to my office and to the patient, a copy of which is attached.

My prime objection to the letter is the fact that the indicated chiropractic consultant made his determination that my care was not reasonable and necessary **without benefit of any office notes, examination notes, x-rays, independent medical examination, or seeing the patient.** The only material available to this "consultant" would be insurance claim forms which in no way imaginable is sufficient to determine appropriateness of care.

The facts are that the patient was injured in the accident and was told by State Farm to seek care of her choice. I have considerable examination data and x-rays to substaniate my diagnosis. Mrs. Adams has made considerable progress toward healing, but in my opinion is not yet at a pre-accident state, or maximum medical improvement. The frequency of her visits has in fact reduced with her progress.

I welcome any legitimate review process. In fact we recommended to State Farm that in order to have a proper review our office notes and x-rays would be required, Mr. Gordon D. Reist stated that they would be asked for if needed.

I have advised the patient to seek council of an attorney.

I do hope there is some sort of sanction that can be made against State Farm for what I believe is grossly improper behavior, including lying to a patient that a review had been performed with aid of office and physical examination notes, when such is not the case.

4691

If nothing else I hope that the use of consultants to determine the appropriateness of care can be legitimized, similar to what was done in the State of Texas.

Thank you for your time.

Respectfully,

James M. Vander Yacht, D.C.

enc.

4781

Brady Chiropractic Clinic
"WE PROVIDE AFFORDABLE HEALTH CARE"

DR. JAMES TIMOTHY BRADY
1104 E. 23RD ST.
LAWRENCE, KS 66046

CLINIC: 749-0130

HOME 1-432-7341

November 16, 1989

Steve Dickson
Attourney at Law
Jayhawk Tower Building
Roof Garden Suite
700 Jackson
Topeka, Kansas 66603

Dear Mr. Dickson,

We recently called one of our patient's employers to find out what their worker's compensation carrier's address is, and they informed us that we should not have seen the patient because they do not send their employees to a chiropracter; that they have their own medical doctor to whom they send them. I received no carrier information.

We were astounded at this reaction, for Manpower is, to our knowledge, a state agency. The name of the person with whom I spoke is Mr. Darrel Daniel. He seemed quite surprised and attempted to get the name of the patient from me. I did not divulge this information to him for fear that she would incur problems with the employer. We are shocked at this reaction and I could not believe it when he said "Well I'm not sure exactly what's going on here, but the employee shouldn't have come to you in the first place because we don't send them to chiropractors; they are all told to go to our medical doctor." I asked what I should do now and he said "Well, the patient would have to come and fill out a standard worker's compensation form with us and then we would refer them to our doctor."

This is an extremely biased reaction and we consider it an injustice. It is no wonder that our patient had fears about whether to report this accident to her boss. We just thought we would notify you of this particular instance in hopes that there is something that can be done about it. If you have any questions or need further information, please contact our office.

Sincerely,

Anne C. Basile, C.A.

Builders' Association
Self-Insurers' Fund

3801 S.W. TRAFFICWAY • P.O. BOX 32246 • KANSAS CITY, MO 64111
PHONE 816/531-2642

November 3, 1989

Dr. Mark S. Balderston D.C.
6225 Lucille Lane
Shawnee, KS 66203

RE: Employee: Patrick M. Schleicher
Employer: Reynolds Electric
Date of Injury: 10-5-89

Dear Dr. Balderston:

The employer of Mr. Schleicher has advised us that he wishes the treatment of this employee to be transferred to another facility. Therefore, you are advised that from and after 10-3-89 we will take the position that you are not the authorized treating physician and that your bills are not owed by this insurer under the Workers' Compensation Law. You certainly may continue treating Mr. Schleicher as you wish. Our position will be that because of the employer's decision we will not have to pay for that treatment.

Your payment for $150.00 for services from 10-11-89 to 10-23-89 will soon be forwarded.

If you have any questions, please feel free to contact me.

Sincerely,

Sheri Lockwood

Sheri Lockwood
Claims Processor

4991

MARK S. BALDERSTON D.C.
CHIROPRACTIC PHYSICIAN
6225 TUCKAHOE LANE
SHAWNEE, KANSAS 66203
TELEPHONE (913) 631-8866

November 20, 1989

Builders' Association
Sheri Lockwood
Claims Processor
3801 S.W. Trafficway
P.O. Box 32246
Kansas City, MO 64111

RE: Patrick M. Schleicher

Dear Sheri:

In response to your letter dated 11-3-89, there are some items that need to be cleared up.

First of all, we have a signed Letter of Authorization by Reynolds Electric, Inc. dated 10-10-89. If his employer did not want our office to treat his employee then why did they give us a signed authorization? Did not Mr. Schleicher respond to conservative treatment and was able to continue to work? Was the care not satisfactory? Was the care to expensive? Or did your office influence Reynolds against chiropractic treatment that could have the flavor of discrimination? Could this be a possibility? Why would they want him transferred to another facility when the patient was getting better and still able to work? These questions deserve an answer.

Under Kansas Workers' Compensation Law, the patient is entitled to care of his choosing up to $350.00. So therefore, we will take the position that our fees will be paid in full.

Sincerely,

Mark S Balderston D.C.

Mark S. Balderston, D.C.

MSB/ks

cc: Patrick M. Schleicher
Reynolds Electric
Steve Dickson, Kansas Chiropractic Association
Legal Counsel

5091

WORKERS' COMPENSATION

LETTER OF AUTHORIZATION TO EMPLOYER

DATE 10-9-89

Employer Reynods Electric Inc.
5424 Antioch Drive
Merriam, Kansas 66202

Employee Patrick M. Schleicher

Date of Accident 10-6-89

Insurance Carrier Send Billing to above.

Policy #

Pat Schleicher has reported to our office for examination and treatment due to an injury he/she received on the job and states that you are his/her employer. This office needs verification that his/her injury did occur on the job and that his/her treatment will be covered by Workers' Compensation Insurance in accordance with provisions of and conditions prescribed by the Workers' Compensation Act. Please sign and return this authorization for treatment to our office.

Thank You,

If this acknowledgement is not signed and returned to the office or we do not hear from you within seven (7) days; and if patient continues under treatment after seven (7) days, it will be assumed and relied upon that the above company has agreed to and acknowledges medical coverage and authorization for treatment.

Date October 10, 1989

Authorized Signature Gary P. Yeager

5/of1

KCA
Ant. Trust

Dr. Evan Mladenoff
Chiropractic Physician, Applied Kinesiologist
11021 Metcalf
Overland Park, KS 66210
(913) 491-1071

July 17, 1989

A.C. Cooke
5401 College Blvd., Suite 106
Leawood, KS 66211

RE: Kevin Shawver

Dear Mr. Cooke,

Mr. Shawver has not complied with my treatment and examination recommendations. It is my opinion that State Farm Ins. has intentionally interrupted doctor-patient relationships for the express purpose of cutting this claim. It is my recommendation that legal proceedings be started to close this case, with the provision that State Farm be held liable and accountable for future treatment deemed necessary as a result of their intentional interference of doctor-patient relationship.

I will furnish a full medical report of all injuries sustained at your request. If I may be of any further assistance, please do not hesitate to call.

Sincerely,

Evan MLadenoff, B. Sc., D.C.

c.c. Insurance Commissioner
Dickson, Pope, & Pope

52 of 1

Hill City Chiropractic Clinic

205 WEST MAIN
HILL CITY, KANSAS 67642
(913) 674-2137

August 2, 1990

Mr. Steve Dickson Esq.
Dickson & Pope PA
700 Jackson, Roof Garden Ste.
Topeka, KS 66603

Dear Steve:

I was told to send a copy of the policy for Great-West Life Assurance Company to you for your review by Gene Davidson. Apparently they limit chiropractic to 50% co-insurance after deductible, but do not credit it to the balance of the co-insurance so that the 100% amount never kicks in.

If there is anything that you usually do with these companies, let me know otherwise you can keep the copy or return it. Whatever you want.

Sincerely,

D.C. M.J. Miller

Micheal J. Miller D.C.
Doctor of Chiropractic

MJM\wrc

5381

Dr. Karen J. Miller Dr. Micheal J. Miller

COINSURANCE PE[illegible]AGE (continued)

- The following Covered Expenses will always be payable at a coinsurance percentage of 50% after you satisfy the Deductible:

  - Outpatient treatment of alcoholism; outpatient treatment of drug addiction; outpatient psychiatric treatment or psychotherapy;
  - Services related to the adjustment of the spine.

- All other Covered Expenses incurred in any calendar year will be payable at a coinsurance percentage of 80% after you satisfy the Deductible.

The following applies to all Covered Expenses except those which are payable at 100% or 50%:

- After you or one of your **Dependents** incurs $2,500 (your Individual Coinsurance Breakpoint) of Covered Expenses which are more than the Deductible, then any further Covered Expenses incurred in that calendar year will be payable at 100%.
- If in any calendar year, Covered Expenses for your family exceed $5,000 (your Family Coinsurance Breakpoint), then Covered Expenses for you and all your Covered **Dependents** will be payable at 100% for the remainder of that calendar year. However, Covered Expenses used by any one family member to satisfy the amount shown in this paragraph cannot be more than $2,500 (your Individual Coinsurance Breakpoint).

A full description of all Covered Expenses is included in the section WHAT YOUR PLAN PAYS FOR.

5481

Rec 8-1-10

4. Substance Abuse and Mental Conditions Covered expences include:

Charges for Convulsion or Shock Treatments & Surgical Charges

A. 30 days per calendar year for confinement in a licensed medical facility, alcoholic facility, treatment center for drug abusers, community mental health center, or psychiatric hospital.

B. Outpatient treatment by a physician or psychologist licensed by the State of Kansas, or in a facility listed above, for 100% of the first $100 of covered expenses, 80% of the next $100, and 50% of the next $1640 on a calendar year basis, and up to $7500 per each insured person per lifetime while covered by the policy.

C This benefit does not cover any assessment against an insured person by a diversion agreement or by order of a court to attend a certified alcohol and drug safety action program. However, coverage is provided for any treatment that is required pursuant to such assessment up to the dollar limits specified above.

5. Chiropractic Care. Chiropractic care includes charges for x-rays and other services authorized or recommended by a chiropractor operating within the scope of his license. Maintenance and preventive care are not covered. No benefits for chiropractic care will be paid except as prescribed by a physician.

Prescription by physician required

6. Extended Convalescent Care. If the insured is confined to an Extended Convalescent Care Facility, the Plan will pay for the expense during the confinement. The Plan will not, however, pay for more than the maximum of 30 days per calendar year. The Plan will make such payments only if the insured is confined:

60 days

(a) because of accident or sickness upon the recommendation and under the general supervision of same a doctor;

This is what we recieved. I don't know who wrote the Note in the Borders

55 of 1

CW Ramey

40-2,101. No policies, contracts or agreements for medical service shall deny reimbursement or indemnification for any service within scope of practice licensed under Kansas healing arts act. Notwithstanding any provision of any individual, group or blanket policy of accident and sickness, medical or surgical expense insurance coverage or any provision of a policy, contract, plan or agreement for medical service, issued on or after the effective date of this act, whenever such policy, contract, plan or agreement provides for reimbursement or indemnity for any service which is within the lawful scope of practice of any practitioner licensed under the Kansas healing arts act, reimbursement or indemnification under such policy contract, plan or agreement shall not be denied when such service is rendered by any such licensed practitioner within the lawful scope of his license.

History: L. 1973, ch. 195, § 1; July 1.

House Insurance
March 6, 1991
Attachment 2

KDA
KANSAS DENTAL ASSOCIATION

Statement by David Hanzlick
House Committee on Insurance
House Bill 2499
March 6, 1991

Mr. Chairman and members of the Committee, my name is David Hanzlick. I am the Assistant Executive Director of the Kansas Dental Association. I appreciate the opportunity to express the KDA's support of House Bill 2499.

The purpose of the legislation is to strengthen the effectiveness of the "Insurance Equality" statutes. As a result of the Insurance Equality statutes, the patient with a broken jaw has the right to seek treatment from either a dentist or a physician, and be eligible to receive reimbursement by a third party payor. Without that protection, the patient might lose the right to seek care from his or her selected provider.

House Bill 2499 would enforce the Insurance Equality statutes through the application of the Unfair Trade Practices Act. Current law contains no enforcement mechanism.

Mr. Chairman, it is important to note that the Insurance Equality statutes do not mandate payment for particular procedures by third party payors. They do, however, help assure access to care by increasing the number of health care providers who are available to treat patients with third party coverage.

Again, thank you for the opportunity to appear in support of House Bill 2499.

5200 Huntoon
Topeka, Kansas 66604
913-272-7360

House Insurance
March 6, 1991
Attachment 3

TESTIMONY ON HOUSE BILL 2499
BLUE CROSS AND BLUE SHIELD OF KANSAS, INC.
HOUSE COMMITTEE ON INSURANCE
MARCH 6, 1991

Good afternoon, Mr. Chairman and Committee members. My name is Ralph Weber, M.D. I am the Vice President of Medical Affairs at Blue Cross and Blue Shield of Kansas. I would like to offer testimony in opposition to House Bill 2499. Blue Cross and Blue Shield of Kansas is concerned that the intent of this legislation is to circumvent managed care programs where benefits are available only upon referral by a primary care physician, the often referred to "gatekeeper." It appears that the purpose of this bill is to prohibit the imposition of conditions which describe or arrange for referral policies which limit subscriber's access to covered services lawfully performed within the scope of any license, registration, or certificate of identified health care personnel.

Prior to coming to Topeka in 1988, I practiced pediatrics in Salina. I participated as a primary care physician for three managed care programs: HMO Kansas, Blue Select, and Health Care Plus. I had over 500 patients who were enrolled in these programs. As their physician, I readily recognized the attractiveness to the patients of an insurance program with lower premium costs yet which provided a full range of comprehensive benefits.

Of course, as a condition of enrollment in these programs, the subscribers have to seek all of their health care services and referrals through their designated primary care physician (PCP) or else risk either the loss of, or reduction of, benefits through increased deductibles and/or copays. Admittedly, these managed care programs with their restrictions on access to health care do not meet the needs of all insurance subscribers and obviously these people should continue to seek health care insurance through traditional insurance programs which do not require PCP coordination. However, to enact legislation prohibiting the

House Insurance
Attachment 4
March 6, 1991

operation of primary care physician gatekeeping systems would deny a substantial number of Kansas citizens the ability to avail themselves of the benefits offered by managed care programs. The Blue Cross and Blue Shield of Kansas Blue Select and HMO Kansas managed care programs continue to grow annually in attractiveness with currently over 126,000 subscribers enrolled in these product lines.

This country's health care system is an illness-driven system. Employer insurance benefit programs traditionally have encouraged illness rather than preventive care. Insurance claim payment systems are designed to make rapid, accurate payment with no provision to assess the quality of care that was provided. Subscribers in traditional programs often seek multiple consultations with repeated tests and procedures which drive up the cost of health care and are a source of poor quality because of repeated exposure to risk of these procedures. Managed care programs were developed during the 1980's out of employer's concerns over their increasing health care costs as well as their increasing demand for assurances that the health care dollars they were spending were for necessary and high quality services.

Managed care programs are built around the concept of providing medically necessary services. HMO's licensed in Kansas are required by state law to have externally certified quality assurance programs that guarantee that their members receive necessary care. Because of my belief in the effectiveness of managed care, I left my active pediatric practice to join HMO Kansas as its Medical Director. During my tenure, my staff and I developed a Quality Assurance/Utilization Review Program which meets the requirements of the law and passes external certification. A major component of this QA program is the member concerns/complaint and grievance process by which they may appeal denials by their PCP's of requests for referral to other providers. They also have the option of requesting at any time transfer to another PCP whose treatment philosophies and hence, referral policies, would be more consistent to their own. In point of service managed care programs like Blue Select, the

subscriber always has the option to by-pass his PCP and self-refer to another licensed health care provider although the benefit payment will be subjected to a higher copay and deductible limit. Obviously, this provision is in place to encourage subscribers to seek referrals with the advice and recommendations of their PCP.

Managed care programs have successfully lowered the cost of health care for their members. They have achieved this accomplishment primarily because of the management by their PCP of their access to and utilization of the health care system. It is the designed intent of any managed care system that the patient and their PCP consult together to decide what is for them the most appropriate, cost-effective utilization of the health care system at any given time for any given condition. Managed care programs do not and would not selectively prohibit through contractual exclusion access to licensed health care providers. I wish to emphasize, however, that in order to continue to accomplish their goals, managed care programs must retain the primary care physician controlled referral process.

Ladies and Gentlemen, I would also point out that several pieces of other alternative legislation being considered today by this and many other state legislatures, as well as the United States Congress, embrace the concept of managed care within their proposals. Managed care is a reality of today and will most certainly be even more so in the future. Increasing numbers of major employers are demanding it in their insurance programs. The public appears to be demanding it as reflected by the legislation currently being considered throughout this country. The State of Kansas needs to actively support the concepts of managed care---not weaken them as is being proposed by House Bill 2499. I respectfully urge you not to approve this piece of legislation.

I would be happy to answer any questions you might have. Thank you.

RW/lsh

TESTIMONY OF MEYER L. GOLDMAN, KANSAS HMO ASSOCIATION, MARCH 6, 1991

BEFORE HOUSE INSURANCE COMMITTEE,

ON HB 2499

I am Meyer L. Goldman, of Kansas City, president of the Kansas HMO Association. I am employed by Humana Prime Health, Kansas City's oldest and largest health maintenance organization.

Health maintenance organizations provide a broad range of services to subscribers for a fixed monthly payment. Services are typically much more comprehensive than those covered by indemnity plans. HMOs are able to provide these services at a competitive price because care is furnished by providers employed by or under contract with the organizations. Appropriateness of care, continuity and quality are regulated through case supervision under guidance of a primary care physician. The essence of an HMO's success rests in its ability to organize its delivery system and control costs through selection of providers through appropriate contracts.

We are concerned whenever legislation seeks to interfere with contractual or operating freedom of an HMO. Mandates to offer specific services or contract with or employ specific classes of providers add directly to the cost of health care delivery. For that reason our members supported last year's passage of KSA 40-2248, Supp 1990, requiring impact reports and justification for any proposed mandates.

Sections 2 and 3 of HB 2499 could be construed as mandates to require use of members of the professions cited in the bill, whether or not they are under contract with the HMO. They could be construed to prohibit HMOs from selecting providers with whom they contract on the basis of appropriateness to render the needed services.

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Section 2, in effect, prohibits exclusive contracting of providers by HMOs, thereby removing the benefits offered by the HMO. While the exceptions listed in Section 3 would appear to legitimize such contracting, the requirement that contractual arrangements are applied equally "to all types of health care personnel. . . without discrimination to the usual customary and lawful procedures of any type of medical care provider" puts any selection of providers by the HMO at risk.

Further, the bill puts the burden of proof that no violation has occurred on the HMO rather than on the complainant, a provision that would give rise to trivial complaints and extensive litigation. As in the case of other mandates, this would add to the cost of health care without any corresponding advantage to the citizen.

Failure to pay contracted costs is an unfair practice already proscribed by legislation. It doesn't need further action and, in any case, should not be tied to a mandate to use specified providers.

MEMORANDUM

TO: Representative Larry Turnquist
Chairman, House Insurance Committee

FROM: William W. Sneed
Health Insurance Association of America

DATE: March 6, 1991

RE: House Bill 2499

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for the Health Insurance Association of America ("HIAA"). The HIAA is a health insurance trade association consisting of over 325 insurance companies that write over 85% of the health insurance in the United States today. Please accept this memorandum as our testimony in regard to H.B. 2499.

Initially, when this bill was requested by the chiropractic association, their explanation of the bill asserted was to provide some additional or new policing power against insurance companies who fail to pay chiropractic bills. I believe once you review the entire bill, you will see that the bill does substantially more than the introductory explanation would lead one to believe.

My client would contend that K.S.A. 1990 Supp. 40-2248 and K.S.A. 1990 Supp. 40-2249 would require a financial impact report on House Bill 2499. Although it may be argued that since this is not a "new" mandate, but an extension of a current mandate, these two 1990 statutes may be inapplicable. However, it is our contention that the intent of the Legislature was to require fiscal impact reports so that the Legislature

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could fairly evaluate social benefit versus social cost for such mandates. Thus, we would respectfully request that such a fiscal impact report be prepared.

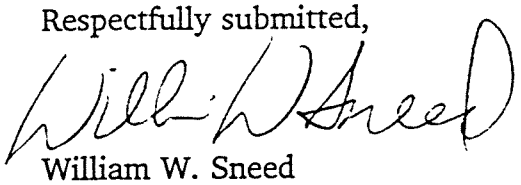
Next, we believe the proposed bill is simply inappropriate and over-reaching in today's marketplace. In times when companies such HMO's and PPO's are attempting to reduce costs, we see no reason to expand the delivery system costs regardless of the situation.

Section 3 seems to indicate that regardless of the type of service, the cost of those services must be equally applied to all types of personnel referred to in Section 2. We believe this is inappropriate inasmuch as payment for these types of services should be equivalent to what is performed, by whom, experience of the provider, etc.

Finally, chiropractors are currently protected by the Unfair Claim Settlement and Practices Act in the Kansas statutes. If individuals are having problems with the payment of valid claims, it would be our recommendation that there is a system already available for their relief. By contacting the Kansas Insurance Department's Consumer Affairs Division, individuals who believe their carrier is not paying proper benefits can go to the Department for assistance.

Thus, on behalf of my client, I respectfully request that the Committee act disfavorably on this bill. I appreciate the opportunity to appear before the Committee, and if you have any questions, please feel free to contact me.

Respectfully submitted,



William W. Sneed
Legislative Counsel
Health Insurance Association of America

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Kansas Employer Coalition on Health, Inc.
1271 S.W. Harrison • Topeka, Kansas 66612 • (913) 233-0351

Testimony to House Committee on Insurance
re: HB 2499

by James P. Schwartz Jr.
Consulting Director
March 6, 1991

The Kansas Employer Coalition on Health (KECH) is 100 employers across the state who share concerns about the cost-effectiveness of healthcare purchased for our 350,000 Kansas employees and dependents.

KECH is concerned about HB 2499 because the ramifications of the bill seem unclear. If the effect of the bill is merely to enforce existing law, then our only objection is our general objection to mandates within a voluntary market. If, however, the effect of the bill (whether intended or not) is to restrict third party payers in their ability to contract with a subset of providers on the basis of cost and quality, then we have a very large problem with the bill. While new section 3 appears to be something of a disclaimer in this regard, we remain unclear about the significance of the wording "without discrimination to the usual, customary and lawful procedures of any type of medical provider."

Because these are extremely difficult times for healthcare funding, efforts are accelerating to manage the funding and delivery of healthcare in ways that may **not** be exactly usual and customary for any type of medical provider. For example, if a provider's "usual and customary procedure" includes billing undiscounted fees, then the effect of the bill may be to prohibit HMO and PPO arrangements that involve discounted fees.

Until these questions can be resolved, we must consider ourselves opposed to HB 2499.

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KAISER PERMANENTE

March 5, 1991

Representative Larry Turnquist
Chairman, House Insurance Committee
State Capitol
Topeka, Kansas 66612

Re: **House Bill No. 2499**

Dear Representative Turnquist:

I am writing to express Kaiser Permanente's opposition to House Bill No. 2499. This bill appears to tamper with some of the basic tenants of the managed care approach to health care. Managed care works because we are able to contract selectively with providers on the basis of quality and cost effectiveness. In addition, in the case of Kaiser Permanente, our members select a personal primary care physician who provides and coordinates all their care. It is not clear how the language at pg. 1, line 24 "or otherwise attempt to elude compliance" may interfere with the physician-patient relationship.

House Bill 2499 appears to interfere with our ability to contract and/or refer to certain designated providers. It also appears to put us in the position of having to prove that we are not discriminating against certain provider groups.

This legislation seems to raise more questions than it answers. I regret that I cannot testify in person, but Kaiser Permanente would be willing to be part of an expanded discussion of this legislation, perhaps, during interim session.

Sincerely,

Cheryl Dillard

Cheryl Dillard
Government and Community Relations Manager

CD/to

cc: Members of the
House Insurance Committee

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Kaiser Foundation Health Plan of Kansas City, Inc.
6900 Squibb Road, Suite 201 Shawnee Mission, Kansas 66202 (913) 722-8400

KAHA
Kansas Association of Homes for the Aging

Enhancing the quality of life of those we serve since 1953.

MEMORANDUM

TO: House Insurance Committee
Honorable Larry Turnquist, Chairman

FROM: John R. Grace, President/CEO
Kansas Association of Homes for the Aging

RE: House Bill No. 2420

The Kansas Association of Homes for the Aging represents over 130 not-for-profit nursing and retirement homes in rural and urban areas across the state.

Our members' mission is to provide quality services to older adults in an efficient and planned way. We can achieve this goal by exploring innovative ways of providing services to our residents and developing progressive long term care financing options.

KSA-40-2278 (b)(1)(2) re: long term care insurance states: "Rules and regulations adopted by the commissioner shall: recognize the unique developing and experimental nature of long term care insurance; and recognize the appropriate distinctions necessary between group and individual long term care insurance policies."

The concept of the Continuing Care Retirement Community (CCRC) is a growing response to the idea of a "continuum of care" in the delivery of long term care services. Retirement communities provide a range of services including independent living, home health care, assisted living, personal care and traditional nursing home services.

The issue we are addressing today is the use of activities of daily living (ADL's) to determine benefit eligibility for long term care insurance. ADL's simply are those activities we perform daily such as bathing, personal hygiene, eating, toileting and so on. In other words, the insured's appropriate benefit for long term care services would be based upon his/her ability to perform ADL's independently. We believe that

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functional and cognitive triggers provide a more objective measure of need and result in more consistent and reliable determinations of need across different professionals (e.g. nurses, social workers) who are doing the assessments. We believe objective measures of benefit determination provide a more reliable mechanism for cost-control compared to a physician's certification only.

Two Blue Ribbon Federally appointed panels who have made health care reform recommendations to congress have suggested using ADL's in determining the need for services. Furthermore, the vast majority of legislative proposals expanding or reforming the current health care system use ADL's in determining the need for Long Term Care services. (Pepper Commission Final Report; Medi-Plan Long Term Care Act - to provide universal access to long term care services.)

We believe two changes may need to be made to the Bill:

1) Recognize cognitive disability as a trigger for benefit, however ADL's are not the appropriate measure.

   Activities of daily living are used to measure functional ability, but not to measure cognitive ability. There are other assessment tools such as the Short Portable Mini Mental Status Instrument that can be used to measure cognitive ability.

Therefore we would suggest amending the language of the Bill on page 3, line 21 and 22, to read:

". . . . benefit eligibility on functional measures of disability, such as an individual's ability to carry out activities of daily living independently and without human assistance, as well as cognitive measures of disability."

2) Recognize CCRC's as an eligible group.

   We believe that CCRC's should be considered as an eligible group and long term care insurance should be modeled as a managed care concept. In a letter dated June 14, 1990, from Richard Huncker, Accident & Health Supervisor, Kansas Insurance Department, he states: "In regard to the acceptability of the residents of a CCRC qualifying as an eligible group for the

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issuance of group of group insurance, it would appear that this could be accomplished, with the Commissioner's approval, through the discretionary provisions of K.S.A. 40-2209(A)(6)." As an eligible group CCRC's could then design their specific features in a plan that would best benefit their residents.

State and federal dollars currently pay for approximately 50% of the cost of nursing home care in Kansas. Favorable passage of this legislation would help provide movement towards shifting the responsibility of payment of long term care from government to the private sector.

We ask the Committee for favorable passage of House Bill No. 2420.

Thank you Mr. Chairman and members of the Committee.

Testimony

Date: March 6, 1991

Given By: Paul Bell, M.D., Assistant Medical Director for UNUM Life Insurance Company of Portland, Maine.

Re: HB 2420

Good afternoon Mr. Chairman and members of the committee. I am here to speak in support of HB 2420, amending the long term care insurance act.

As way of background, UNUM is a 140 year old company domiciled in Portland Maine and doing business in every state. We are the largest disability income insurer in the nation. In the past 3 years, UNUM has introduced a family of long term care insurance products covering residents of retirement communities and other senior groups, employer and provider groups, and individuals.

In developing our long term care policies, we transferred our vast experience and leadership in disability insurance to long term care. In doing so, we have created a rather unique insurance product that seems to be increasing in its attractiveness to consumers because of its flexibility. We base our benefit payment on an insured's inability to function in certain activities of daily living (ADL's), such as bathing, eating, toileting, dressing, transferring, and continence. When an insured cannot perform two of these functions, we pay a defined benefit without regard to any services being provided to the insured. This permits insureds the flexibility of utilizing benefits for the services that best meet their needs. In particular, our benefits can be used to offset the costs of informal care, or care provided by family or friends. Most insurance companies do not pay for informal care, which is the most common method for providing long term care services in the nation.

Our products protect people from the risk of losing function, in other words from being disabled. It is <u>not</u> based on receipt of specific long term care services or the place where services are provided; it is <u>not</u> based on medical necessity. If the insured is disabled, he receives benefits. It is the most flexible product on the market today. Indeed, our product has been endorsed by the American Association of Homes for the Aging, representing non-profit retirement communities and nursing homes serving over 600,000 senior citizens.

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Why did we choose ADL's and how do they work? Because we are a disability insurance carrier, we looked for a relationship between disability and need for long term care services. In Activities of Daily Living (ADL's), we found the most objective way of assessing disability. Through standard assessment tools, nurses, doctors, and social workers can measure functional disability in a very objective manner. By using objective assessment standards, the long term care system can avoid the sometimes subjective assessments of need for care associated with the service-based methods of long term care insurance currently allowed in Kansas law.

ADL's were developed more than 25 years ago as a measure of function that could be used in evaluations of chronically ill and aging populations. The tool has been used by physicians and other providers to assess the need for care and to determine effectiveness of treatment. The Index of ADL has been used extensively by clinicians as the best measure of functional disability and is an accepted standard in the field. Objective measures of function such as provided through ADL's is vital to assuring that insureds who need care have the resources to determine and obtain the most appropriate care for their circumstances. By means of a series of questions and observations, the assessor has an objective measure of the ability of an individual to perform each of these activities. Research clearly indicates that increasing dependence in ADL's put individuals at high risk for service use.

With this as background about the use of ADL's to determine disability and need for long term care services, let me address the specific issues before you today.

As has been stated by previous speakers, current law in Kansas states that insurers cannot use medical necessity as a condition for long term care insurance benefits; insurers may use a physicians recommendation that services are necessary. The Insurance Department has interpreted this restriction to mean that insurers may not use ADL's as a condition for benefits. The Department believes that ADL's are tantamount to medical necessity. HB2420 would permit ADL's, which are commonly used in the long term care insurance in virtually every state, in the nursing home industry and in the medical field to assess the level of disability of a person.

In asking for a change in the State's long term care law, we want to address several issues:

1) Based on the 1985 National Nursing Home Survey and the 1985 National Nursing Home Discharge Survey, it is estimated that under ADL definitions, combined with the use of cognitive impairment

assessment standards which we also use, approximately 95% of current nursing home residents would qualify for benefits.

What about the other 5%? From my experience as a practicing physician and from anecdotal evidence, it is clear that a number of nursing home patients do not belong in a nursing home because they can be cared for at home where they would much rather be or are not sufficiently functionally impaired to be determined disabled.

Please remember that long term care insurance does not insure the risk of having to live in a nursing home, it insures the risk of becoming disabled and needing long term care services, including care at home and in a nursing home. It is asset protection in case one becomes disabled.

2) There are insurers whose long term care insurance products reflect the old medical model of health insurance. Benefits are paid when the insured proves he is receiving services by producing a bill, etc. However, throughout the country, many newer models of long term care policies are disability based, providing more flexibility for the consumer while also recognizing that long term care services relate better to a persons inability to function normally.

It is clear from KAHA's testimony that there is at least one segment of the population, residents of retirement communities, and we would argue, other groups, such as employee groups, who want a greater selection of products, who want more flexibility in how they use benefits. That is not currently available in Kansas, but with passage of HB 2420, the market will expand and consumers will have greater choice. Under current law, only about 15% of the 140 insurers who sell long term care, are doing business in Kansas. That number needs to increase for the public to have a real choice of long term care insurance products.

We urge you to pass this bill and I will be pleased to answer any questions you might have.

MEMORANDUM

TO: Representative Larry Turnquist
Chairman, House Insurance Committee

FROM: William W. Sneed
Health Insurance Association of America

DATE: March 6, 1991

RE: House Bill 2420

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for the Health Insurance Association of America ("HIAA"). The HIAA is a health insurance trade association consisting of over 325 insurance companies that write over 85% of the health insurance in the United States today. Please accept this memorandum as our testimony and support of H.B. 2420.

As you will recall, the Kansas Association of Homes for the Aging requested of this Committee the introduction of H.B. 2420. I am confident that the sponsors of H.B. 2420 will give you a more detailed explanation of allowing the use of "activities of daily living" ("ADL's") as a trigger for benefits in long-term care insurance policies.

The HIAA actively supports provisions on long-term care which expand the long-term care insurance market in the State of Kansas, and ultimately provide a more wide-range selection to the Kansas consumers for available options of long-term care insurance.

Therefore, please accept this memorandum as my client's support of H.B. 2420, and we urge your favorable consideration of this bill.

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I appreciate the opportunity to appear before the Committee, and if you have any questions, please feel free to contact me.

Respectfully submitted,

William W. Sneed
Legislative Counsel
Health Insurance Association of America

Testimony By
Dick Brock, Kansas Insurance Department
Before the House Insurance Committee
on House Bill No. 2420
March 6, 1991

As some members of this committee will vividly recall, the 1987 legislature enacted a new body of laws pertaining to the regulation of long-term care insurance which became effective January 1, 1988. These laws and the complementary regulations were developed by a study group comprised of a broad cross-section of persons and organizations who were quite concerned about the design of long-term care policies. At that time not all but too many long-term care policies required a person to spend 3 days in a hospital, then if they met the qualifications, they could receive benefits for a specified number of days of skilled nursing care. Following the skilled nursing care, if they met another set of conditions, they could receive benefits for a lesser number of days of intermediate care. Then, if they met another set of qualifications, they might even be eligible for as much as 30 days of custodial care. Needless to say, underlying every step in the process was the requirement that the benefits were medically necessary.

Needless to say, many and perhaps most, purchasers either weren't told or didn't understand all the requirements they had to satisfy in order to receive the benefits they thought they were paying for. Moreover, if they were told and/or did understand it, they realized such products did not serve their needs or desires. Consequently, even though the totality of the 1987 legislation and subsequent regulations were necessary, the provisions having the greatest direct impact were those which (1) precluded a long-term care policy from requiring a prior hospital confinement or prior confinement for a greater level of nursing care as a condition precedent to the receipt of benefits; and, (2) permitted such policies to require a recommendation by a physician that the services are necessary but prohibited the long-term care benefits from being conditioned on medical necessity.

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At the time this legislation was under consideration, this committee heard all kinds of dire predictions from insurers that with its enactment companies could not and would not sell long-term care products in Kansas. Similar complaints were heard and are heard from some agents because it is true that some insurers have not designed a long-term care product that meets the Kansas requirements. There are, however, over 20 insurers who have such products approved either as free-standing policies or as riders that can be added to a life insurance policy. So there is a competitive market and, more important, since implementation of the 1987 legislation and the regulations, consumer complaints regarding the sale and value of long-term care products have decreased dramatically.

Generally speaking, House Bill No. 2420 proposes to again open the door to pre-conditions for benefit eligibility. We believe the existing ability to require a physician's recommendation adequately recognizes the situations accommodated by the proposed amendment. However, even more important is the clear attempt by the proposed amendment to literally strip the 1987 legislation and accompanying regulations of any meaning or effect. With the "notwithstanding" introduction in the proposed amendment, an insurer would be free to condition benefit eligibility on such functional and cognitive assessments as it deems appropriate regardless of the safeguards regarding such things as coverage for alzheimer's disease, senile dementia or other real problems experienced by policyholders and others prior to 1988.

Therefore, the Insurance Department must oppose House Bill No. 2420.

M E M O R A N D U M

TO: Dick Brock
Administrative Assistant

FROM: Richard G. Huncker
Accident & Health Supervisor

SUBJECT: House Bill No. 2420

DATE: February 27, 1991

(1) House Bill No. 2420 is an act amending the Kansas Long Term Care Insurance Act. K.S.A. 1990 Supp. 40-2228 is being amended by adding the following provision: "(i) Notwithstanding any other provision of the act of which this act is amendatory, or, any rule or regulation adopted pursuant to authority therein, long-term care insurance policies may contain benefit eligibility on functional and cognitive assessments such as activities of daily living.

(2)(3) This act will have an administrative effect upon the operations of this department. Pursuant to K.S.A. 40-2227(a) and K.A.R. 40-4-37(g), we do not allow medical necessity requirement in long term care policies with regard to the payment of nursing home benefits. The amendment made by House Bill #2420 would allow an insurer to include medical necessity requirements in such provisions of long term care policies. Enclosed you will find a memorandum dated April 24, 1989 to Carol Olson of the NAIC from the Brookings Institute. This memorandum points out the administrative difficulties with Activities of Daily Living (ADLs) provisions in long term care policies. As a result of including ADLs requirements in the nursing home provisions of long term care policies, some insureds who have Alzheimers Disease may not be able to collect benefits from their long term care policies. I believe that the amendment proposed by House Bill 2420 is not in the best interest of long term care insureds of the state. The amendments to House Bill No. 2420 will have no fiscal or administrative effect on the operations of this department.

(4) No comment.

(5) No comment.

Respectfully submitted,

Richard G. Huncker

Richard G. Huncker

RGH:dbah
3981

Suite 1100
Kansas City
816-842-3600

National
Association
of Insurance
Commissioners

DATE: April 24, 1989

TO: Members of the Long-Term Care Insurance Task Force

FROM: Carole Olson

RE: Brookings Institution Recommendations

A representative of the Brookings Institution is unable to attend the meeting. However, in speaking with Mr. Josh Weiner, he asked me to communicate several of his concerns as follows:

1. Activities of Daily Living (ADLs)

Moving to ADLs as triggers is a good idea, but there are some things to consider. Because ADLs are not like measuring mortality rates, one can arrive at dramatically different estimates, depending on how the ADLs are defined. Companies are not providing specific definitions of ADLs. There is a potential for consumer dissatisfaction and unacceptable conduct on the part of insurers. Complicating the issue is recent research which indicates the limited relationship between ADLs and Alzheimers disease. Cognitively impaired individuals will not meet 2 ADLs. Therefore, up to at least 20 percent of the people in nursing homes may not benefit from their long-term care coverage.

2. Inflation Adjustment

The biggest gap in long-term care insurance policies is the lack of an inflation adjustment. Either the policies should be fully indexed or should provide full disclosure of an individual's buying power at age 85. This is of particular concern with the group policies now being sold to people under age 65. Absent from the NAIC's recent revisions is a requirement that some estimate of what the nursing home cost will be in the future, i.e. a sample calculation of what a day in a nursing home will cost at age 85. In addition, Mr. Weiner suggested that the outline of coverage contain a reminder that an individual's income declines over time.

3. Lapse Rates

Mr. Weiner strongly recommends that insurance regulators should collect information on lapse rates. Mr. Weiner believes that policies are priced based on large lapse rates. He also said that a long-range question is whether people are willing to pay premiums year after year for a product that will not pay an immediate benefit. What happens to all the premiums paid in?