OIC and Kaiser/Aetna Nonpayment of E&M Services

Since November 2018 the WSCA has been working with the Office of the Insurance Commissioner (OIC) specific to the unfair practice of Kaiser Permanente and their refusal to pay chiropractors for Evaluation and Management (E&M) Services. The formal complaint was filed even before their fee schedule went into effect, January 1, 2019; in an effort have the problem corrected before the implementation date.

Even before we filed our formal complaint, several chiropractors who have connections with in-house Kaiser medical directors made great efforts to educate and clarify the appropriate payment methodology to avoid the implementation of their unfair practice, to no avail.

The WSCA challenged the following 6 statutes:

	WA Statute or Rule	Requirement	Alleged Violation
1)	RCW 48.44.310	Each group contract for comprehensive health care service which is entered into, or renewed, on or after September 8, 1983, between a health care service contractor and the person or persons to receive such care shall offer coverage for chiropractic care on the same basis as any other care.	**Licensee #2** fails to offer coverage for chiropractic care on the same basis as any other care by paying some types of licensed providers for evaluation and management of patient care but not chiropractors.
2)	RCW 48.43.083	A health carrier must reimburse a chiropractor who has signed a participating provider agreement for services determined by the carrier to be medically necessary if: (a) The service is: (i) Covered chiropractic health care, as defined in RCW 48.43.515, by the health plan under which the enrollee received the services… RCW 48.43.515 defines "covered chiropractic health care" as covered benefits and limitations related to chiropractic health services as stated in the plan's medical coverage agreement.	**Licensees #1 & #2** fail to pay contracted chiropractors for medically necessary evaluation and management of patient care. Licensee health plans do not contain exclusions for such care. Provider contracts do not prohibit such care. Licensees administer plans with widely varying standards for payment of such services based upon plan, geography, and provider type.
3)	RCW 48.43.190	A health carrier may not pay a chiropractor less for a service or procedure identified under a particular physical medicine and rehabilitation code, **evaluation and management code**, or spinal manipulation code … than it pays any other type of provider licensed under Title 18 RCW for a service or procedure under the same or substantially similar code...	Licensees #1 & #2 pay contracted chiropractors less than or nothing for evaluation and management code services than the licensees pay other types of providers such as physicians.
4)	RCW 48.43.730	A carrier must file all provider contracts and provider compensation agreements with the commissioner thirty calendar days before use. When a carrier and provider negotiate a provider contract or provider compensation agreement that deviates from a filed agreement, the carrier must also file that specific contract or agreement with the commissioner thirty calendar days before use. [*If the provider or facility agreement references or*	Licensees #1 & #2 have failed to file and make available to providers in advance of contracting administrative policies and procedures referenced in provider agreements. Licensees provide inconsistent or outdated instructions. Reimbursement for evaluation and management codes depend variously upon the network manager, licensee internal standards, or plan specific

		incorporates by reference additional documents, administrative manuals, or procedures, such documents, manuals, and procedures must be submitted to the OIC for approval.] OIC provider contract filing instructions	instructions. In some instances, providers can access two or more conflicting instructions.
5)	RCW 48.43.085	Notwithstanding any other provision of law, no health carrier subject to the jurisdiction of the state of Washington may prohibit directly or indirectly its enrollees from freely contracting at any time to obtain any health care services outside the health care plan on any terms or conditions the enrollees choose.	Licensees #1 & #2 prohibit chiropractors from charging patients for evaluation and management services that licensees refuse to cover.
6)	RCW 48.43.045 WAC 284-170-270	Health plans must not contain unreasonable limits, and *must not include limits on the type of provider permitted to render the covered service* unless such limits comply with RCW 48.43.045. [WAC 284-170-270]	Licensees #1 & #2 cover office visits and generally cover medically necessary services related to the evaluation and management of patient care; but deny payment of such visits or services when chiropractors provide the service.

Reference to Licensee Documents:

- ***Payment Policies*** *– Code Editing (Policy Effective Date: 03/01/2014)*
    - Frequently Asked Questions

  Q1**:** Why is my E&M code receiving a denial as a bundled service?

  A1**:** The E&M code has a bundled relationship with other codes billed on the same date of service. Check the codes billed against the NCCI column 1/column 2 of the correct coding edits table to verify.
  The column 1/column 2 correct coding edits table contains two types of code pair edits. One type contains code pairs that should not be billed together where one code is assigned as the column 1 code and the code is assigned as the column 2 code. The other type contains a column 2 (component) code which is an integral part of the column 1 (comprehensive) code. If clinical circumstances justifies allowing a CCI associated modifier, the modifier should be appended to the column 2 code of the code pair.
- ***Payment Policies*** *– Manipulative Services (Chiropractic) (Policy Change Date: 12/19/2018)*
    - Chiropractic treatment codes include a pre-manipulation patient assessment. Kaiser Permanente recognizes that an additional evaluation and management service may be needed if the patient's condition requires a significant separately identifiable E&M service above and beyond the usual pre- and post-service work associated with the chiropractic service. The medical record documentation needs to support all procedure codes billed.
- ***Important changes in Pre-Authorization*** *requirements Kaiser Permanente Washington's Access PPO, Elect PPO or Omni PPO plans (Effective May 1, 2018)*
    - Please refer to the provisions of your agreement with Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., including obtaining the member's prior written agreement to be financially responsible for the specific non-covered service, to determine when providers may bill a member for non-covered services.

- ***Tivity/WholeHealth Network Notice*** *Re: Group Summary and Fee Schedule Update for Chiropractors (Effective January 1, 2019) (Footer: KFHPWA Group Summary-Fee Schedule State of Washington 10/2018 - 2011-HWHN)*

The OIC reported to the WSCA in July, 2019, that Kaiser had:

- missed deadlines imposed by OIC
- requested extensions
- continually ignored the OIC requests for payment methodology details

The OIC reported in July that they escalated the concern to their legal department and that the process would take more time, but that they would be continuing to pursue the unfair practice.

In November, WSCA representatives met with the OIC again to learn that Kaiser had finally submitted several inches of paperwork declaring that their practice is appropriate. The OIC legal division will need to review all of the presented materials before a determination can be made. They reflected their understanding of the delays that chiropractors are experiencing and share our frustration. We want the OIC to get it right so we will be as patient as possible, and report to chiropractors as soon as we have more information.

In July, we learned that Aetna was acting in the same manner as Kaiser and we reported that to the OIC as well. The OIC shared that the response by Aetna s completely different than that of Kaiser and they are responding timely and with details. There is a possibility that the benefit manager, Tivity, is using a different fee schedule than what Aetna expects and they are working through that detail as well.

We are also aware of the Aetna/Tivity fee schedule for 2020 and see that Aetna, or Tivity on their behalf, is limiting evaluation and management and x-ray allowances to one per patient, per year. This is interrupting the provider patient relationship and you should file a complaint with the OIC telling them that you disagree with their operation. Be sure to challenge the payment for manipulation and evaluations and challenge the payment to other providers for the same services.

Is Aetna/Tivity limiting E&M and X-ray services delivered by other professions?
Is Aetna/Tivity paying others more for manipulation services that exceeds the 8-10% RVU allowance?
Is Aetna/Tivity paying others for E&M services at a higher rate that exceeds the 8-10% RVU allowance?

The WSCA will continue to monitor the practice of these two carriers and work to resolve the issues positively for our members.