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Legislative Document	**No. 1236**
S.P. 430	In Senate, March 27, 2013

An Act To Amend the Maine Insurance Code To Ensure Fair and Reasonable Coverage and Reimbursement of Chiropractic Services

Reference to the Committee on Insurance and Financial Services suggested and ordered printed.

DAREK M. GRANT
Secretary of the Senate

Presented by President ALFOND of Cumberland.
Cosponsored by Representative CAMPBELL of Orrington and
Senators: CAIN of Penobscot, GERZOFSKY of Cumberland, HASKELL of Cumberland, TUTTLE of York, Representatives: BECK of Waterville, HOBBINS of Saco.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA §2748, as amended by PL 1993, c. 669, §2, is further amended to read:

§2748. Coverage for chiropractic services

1. Therapeutic, adjustive and manipulative services. Notwithstanding any other provisions of this chapter, every insurer ~~which~~ that issues health care contracts providing coverage for the services of a "physician" or "doctor" to residents of this State shall provide coverage with reasonable payment for medically necessary services to any subscriber or other person covered under those contracts for those services when performed by a ~~chiropractor~~ chiropractic doctor, to the extent that the services are within the lawful scope of practice of a ~~chiropractor~~ chiropractic doctor licensed to practice in this State. ~~Therapeutic~~ The insurer shall provide benefits covering and paying for care by chiropractic doctors at least equal to and consistent with the benefits paid to other health care providers treating similar conditions within the scope of practice of chiropractic doctors. All therapeutic, adjustive and manipulative services ~~shall~~ must be covered and paid for in a reasonable and consistent manner and using a fair and equitable methodology, whether performed by an allopathic, osteopathic or chiropractic doctor.

2. Limits; coinsurance; deductibles. Any contract ~~which~~ that provides coverage for the services required by this section may contain provisions for maximum benefits, reasonable copayment and coinsurance requirements and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section or the limitations, copayment and coinsurance requirements, deductibles or exclusions imposed on other providers. Insurers may not classify services provided by chiropractic doctors as physical therapy or place these services into other categories that unreasonably limit coverage or payments for such services, or impose copayments, coinsurance requirements or deductibles that are more burdensome or limiting than those imposed with respect to services provided by allopathic or osteopathic doctors. The copayment for each service provided in the course of a chiropractic office visit may not exceed $5 or 10% of the covered payment for such services, whichever is greater. The total copayment for the combined services provided in the course of a chiropractic office visit may not exceed $30 or 10% of the combined covered payment for such services, whichever is greater.

3. Report to the Superintendent of Insurance. Every insurer subject to this section shall report its experience for each calendar year to the Superintendent of Insurance not later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for health care contracts. The report must include complaints concerning access to services under this section and the results of those complaints. The report must also provide data and analysis of the manner in which insurers are classifying and paying for chiropractic services in compliance with the requirements of this section. The superintendent shall compile this data for all insurers in an annual report.

Sec. 2. 24-A MRSA §2840-A, sub-§§1 and 2, as enacted by PL 1985, c. 516, §5, are amended to read:

1. Therapeutic, adjustive and manipulative services. Notwithstanding any other provisions of this chapter, every insurer ~~which~~ that issues group or blanket health care contracts providing coverage for the services of a "physician" or "doctor" to residents of this State shall provide coverage and reasonable payment for medically necessary services to any subscriber or other person covered under those contracts for those services when performed by a ~~chiropractor~~ chiropractic doctor, to the extent that the services are within the lawful scope of practice of a ~~chiropractor~~ chiropractic doctor licensed to practice in this State. ~~Therapeutic~~ The insurer shall provide benefits covering and paying for care by chiropractic doctors at least equal to and consistent with the benefits paid to other health care providers treating similar conditions within the scope of practice of chiropractic doctors. All therapeutic, adjustive and manipulative services ~~shall~~ must be covered and paid in a reasonable and consistent manner and using a fair and equitable methodology, whether performed by an allopathic, osteopathic or chiropractic doctor.

2. Limits; coinsurance; deductibles. Any contract ~~which~~ that provides coverage for the services required by this section may contain provisions for maximum benefits and reasonable copayment and coinsurance requirements and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section or the limitations, copayment and coinsurance requirements, deductibles or exclusions imposed on other providers. Insurers may not classify services provided by chiropractic doctors as physical therapy or place these services into other categories that unreasonably limit coverage or payments for such services, or impose copayments, coinsurance requirements or deductibles that are more burdensome or limiting than those imposed with respect to services provided by allopathic or osteopathic doctors. The copayment for each service provided in the course of a chiropractic office visit may not exceed $5 or 10% of the covered payment for such services, whichever is greater. The total copayment for the combined services provided in the course of a chiropractic office visit may not exceed $30 or 10% of the combined covered payment for such services, whichever is greater.

Sec. 3. 24-A MRSA §2840-A, sub-§3, as amended by PL 1993, c. 669, §3, is further amended to read:

3. Report to the Superintendent of Insurance. Every insurer subject to this section shall report its experience for each calendar year to the Superintendent of Insurance not later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for health care contracts. The report must include complaints concerning access to services under this section and the results of those complaints. The report must also provide data and analysis of the manner in which insurers are classifying and paying for chiropractic services in compliance with the requirements of this section. The superintendent shall compile this data for all insurers in an annual report.

Sec. 4. 24-A MRSA §4236, as amended by PL 1997, c. 99, §1, is further amended to read:

§4236. Chiropractic doctors in health maintenance organizations

Every health maintenance organization shall include in every plan for health care services chiropractic services delivered by qualified chiropractic ~~providers~~ doctors in accordance with this section.

1. Qualifications of chiropractic doctors. The health maintenance organization shall determine the qualifications of chiropractic ~~providers~~ doctors using reasonable standards that are similar to and consistent with the standards applied to other providers.

2. Benefits. The health maintenance organization shall provide benefits covering and paying for care by chiropractic ~~providers~~ doctors at least equal to and consistent with the benefits paid to other health care providers treating similar ~~neuro-musculoskeletal~~ conditions within the scope of practice of chiropractic doctors. The health maintenance organization may not classify services provided by chiropractic doctors as physical therapy or place these services into other categories that unreasonably limit coverage or payments for such services, or impose copayments, coinsurance requirements or deductibles that are more burdensome or limiting than those imposed with respect to services provided by allopathic or osteopathic doctors. The copayment for each service provided in the course of a chiropractic office visit may not exceed $5 or 10% of the covered payment for such services, whichever is greater. The total copayment for the combined services provided in the course of a chiropractic office visit may not exceed $30 or 10% of the combined covered payment for such services, whichever is greater.

3. Self-referrals for chiropractic care. A health maintenance organization must provide benefits to an enrollee who utilizes the services of a chiropractic ~~provider~~ doctor by self-referral under the following conditions.

A. An enrollee may utilize the services of a participating chiropractic ~~provider~~ doctor within the enrollee's health maintenance organization for 3 weeks or a maximum of 12 visits, whichever occurs first, of acute care treatment without the prior approval of a primary care provider of the health maintenance organization. For purposes of this subsection, "acute care treatment" means treatment for accidental bodily injury or sudden, severe pain that affects the ability of the enrollee to engage in the normal activities, duties or responsibilities of daily living.

B. Within 3 working days of the first consultation, the participating chiropractic ~~provider~~ doctor shall send to the primary care provider a report containing the enrollee's complaint, related history, examination, initial diagnosis and treatment plan. If the chiropractic ~~provider~~ doctor fails to send a report to the primary care provider within 3 working days, the health maintenance organization is not obligated to provide benefits for chiropractic care and the enrollee is not liable to the chiropractic ~~provider~~ doctor for any unpaid fees.

C. If the enrollee and the participating chiropractic ~~provider~~ doctor determine that the condition of the enrollee has not improved after 3 weeks of treatment or a

maximum of 12 visits the participating chiropractic ~~provider~~ doctor shall discontinue treatment and refer the enrollee to the primary care provider.

D. If the chiropractic ~~provider~~ doctor recommends treatment beyond 3 weeks or a maximum of 12 visits, the participating chiropractic ~~provider~~ doctor shall send to the primary care provider a report containing information on the enrollee's progress and outlining a treatment plan for extended chiropractic care of up to 5 more weeks or a maximum of 12 more visits, whichever occurs first.

E. Without the approval of the primary care provider, an enrollee may not receive benefits for more than 36 visits to a participating chiropractic ~~provider~~ doctor in a 12-month period. After a maximum of 36 visits, an enrollee's continuing chiropractic treatment must be authorized by the primary care provider.

In the provision of chiropractic services under this subsection, a participating chiropractic ~~provider~~ doctor is liable for a professional diagnosis of a mental or physical condition that has resulted or may result in the chiropractic ~~provider~~ doctor performing duties in a manner that endangers the health or safety of an enrollee.

The provisions of this subsection apply to all health maintenance organization contracts, except a contract between a health maintenance organization and the State Employee Health Insurance Program.

This subsection takes effect January 1, 1996.

SUMMARY

This bill requires that coverage and payment by health insurers and health maintenance organizations for services within the scope of practice of chiropractic doctors be at least equal to and consistent with coverage for services provided by allopathic or osteopathic doctors. It requires insurers to provide benefits covering and paying for care by chiropractic doctors at least equal to and consistent with the benefits paid to other health care providers treating similar conditions within the scope of practice of chiropractic doctors. Under the bill, these carriers may not classify services provided by chiropractic doctors as physical therapy or place these services into other categories that unreasonably limit coverage or payments for such services, or impose copayments, coinsurance requirements or deductibles that are more burdensome or limiting than those imposed with respect to services provided by allopathic or osteopathic doctors. The copayment for each service provided in the course of an office visit to a chiropractic doctor may not exceed $5 or 10% of the covered payment for such services, whichever is greater. The total copayment for the combined services provided in the course of an office visit to a chiropractic doctor may not exceed $30 or 10% of the combined covered payment for such services, whichever is greater.