

MAINE STATE LEGISLATURE

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126th MAINE LEGISLATURE

FIRST REGULAR SESSION-2013

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.

A handwritten signature in black ink, appearing to read 'D M Grant'.

DAREK M. GRANT
Secretary of the Senate

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

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

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

4 **§2748. Coverage for chiropractic services**

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

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

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

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

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

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

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

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

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

3 **§4236. Chiropractic doctors in health maintenance organizations**

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

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

10 **2. Benefits.** The health maintenance organization shall provide benefits covering
11 and paying for care by chiropractic ~~providers~~ doctors at least equal to and consistent with
12 the benefits paid to other health care providers treating similar neuro-musculoskeletal
13 conditions within the scope of practice of chiropractic doctors. The health maintenance
14 organization may not classify services provided by chiropractic doctors as physical
15 therapy or place these services into other categories that unreasonably limit coverage or
16 payments for such services, or impose copayments, coinsurance requirements or
17 deductibles that are more burdensome or limiting than those imposed with respect to
18 services provided by allopathic or osteopathic doctors. The copayment for each service
19 provided in the course of a chiropractic office visit may not exceed \$5 or 10% of the
20 covered payment for such services, whichever is greater. The total copayment for the
21 combined services provided in the course of a chiropractic office visit may not exceed
22 \$30 or 10% of the combined covered payment for such services, whichever is greater.

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

26 A. An enrollee may utilize the services of a participating chiropractic ~~provider~~ doctor
27 within the enrollee's health maintenance organization for 3 weeks or a maximum of
28 12 visits, whichever occurs first, of acute care treatment without the prior approval of
29 a primary care provider of the health maintenance organization. For purposes of this
30 subsection, "acute care treatment" means treatment for accidental bodily injury or
31 sudden, severe pain that affects the ability of the enrollee to engage in the normal
32 activities, duties or responsibilities of daily living.

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

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

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

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

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

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

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

19 This subsection takes effect January 1, 1996.

20 **SUMMARY**

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