

24-A §4236. CHIROPRACTORS IN HEALTH MAINTENANCE ORGANIZATIONS

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Every health maintenance organization shall include in every plan for health care services chiropractic services delivered by qualified chiropractic providers in accordance with this section. [1993, c. 669, §6 (NEW).]

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

[1993, c. 669, §6 (NEW) .]

2. Benefits. The health maintenance organization shall provide benefits covering care by chiropractic providers at least equal to and consistent with the benefits paid to other health care providers treating similar neuro-musculoskeletal conditions.

[1993, c. 669, §6 (NEW) .]

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

A. An enrollee may utilize the services of a participating chiropractic provider 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. [1995, c. 350, §1 (NEW).]

B. Within 3 working days of the first consultation, the participating chiropractic provider 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 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 for any unpaid fees. [1995, c. 350, §1 (NEW).]

C. If the enrollee and the participating chiropractic provider 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 shall discontinue treatment and refer the enrollee to the primary care provider. [1995, c. 350, §1 (NEW).]

D. If the chiropractic provider recommends treatment beyond 3 weeks or a maximum of 12 visits, the participating chiropractic provider 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. [1995, c. 350, §1 (NEW).]

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 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. [1995, c. 350, §1 (NEW).]

In the provision of chiropractic services under this subsection, a participating chiropractic provider is liable for a professional diagnosis of a mental or physical condition that has resulted or may result in the chiropractic provider 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.

[1997, c. 99, §1 (AMD) .]

SECTION HISTORY

1993, c. 669, §6 (NEW). 1995, c. 350, §1 (AMD). 1997, c. 99, §1 (AMD).

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