

BULLETIN

Docket No.: INS NO. 00-010-AB

**TO:** All Licensed Health Carriers Offering a Managed Care Plan in this State  
Subject to the Provisions of RSA 420-J and All Licensed Accident and Health Insurers

**FROM:** Paula A. Rogers  
Insurance Commissioner

**DATE:** April 26, 2000

**RE: THE IMPLEMENTATION OF SB 147 (Ch. 14, LAWS OF 2000)  
RELATIVE TO SELF-REFERRALS FOR CHIROPRACTIC CARE  
UNDER MANAGED CARE ORGANIZATIONS**

Health carriers and doctors of chiropractic have both recently sought guidance from the Insurance Department regarding the interpretation and enforcement of specific provisions within SB 147. This Bulletin will serve as guidance for the proper implementation of SB 147 with respect to the specific points of inquiry that have been raised.

1. **Question:** Is a health carrier now required to offer a chiropractic benefit in all health benefit plans?

**Answer:** No. SB 147 defines the minimum chiropractic benefit a health carrier must provide if it chooses to include a chiropractic benefit in any of its health benefit plans. It does not require carriers to include this benefit in the first instance.

2. **Question:** Given SB 147, what is the status of the Insurance Department Bulletin dated August 26, 1993 in which the Commissioner stated that individual and group accident and health insurance forms that contained exclusions for chiropractic services would not be approved?

**Answer:** With SB 147, the legislature has now specifically addressed the question of chiropractic benefits. For this reason, the Insurance Department Bulletin dated August 26, 1993 is no longer effective.

3. **Question:** If a health benefit plan does include chiropractic benefits, is the health carrier required to offer coverage for at least 12 visits?

**Answer:** Yes, if a health benefit includes a chiropractic benefit, the benefit must include coverage for at least 12 visits on a self-referral basis.

4. **Question:** Is the health carrier permitted to limit access to the first 12 visits based on medical necessity or utilization review requirements?

**Answer:** Yes, but only as follows. The health carrier may require that within 10 working days of the first visit or consultation, the doctor of chiropractic shall send to the health carrier the case findings. If the case findings are sent within 10 working days, and if they include a statement by the doctor of chiropractic that further visits are medically necessary, then up to 12 visits must be covered with no further review or conditions.

5. **Question:** Are there any other limitations that a health carrier may place on access to the first 12 visits?

**Answer:** Yes, health carriers may exclude from coverage any wellness care visit, even within the first 12 visits.

6. **Question:** If a chiropractic benefit is provided, does the covered person have access to 12 self-referred visits per spell of illness, per contract year, or just once?

**Answer:** 12 self-referred visits per contract year.

7. **Question:** Must more than 12 visits be covered when the chiropractor is performing medically necessary services in compliance with the terms of RSA 316-A?

**Answer:** No, SB 147 places no obligation on the health carrier to cover services beyond 12 visits. In other words, the chiropractic benefit could have a 12-visit limit. If a health benefit plan provides additional coverage beyond 12 visits, then the health carrier may condition those visits on compliance with utilization review standards.

8. **Question:** Could a health carrier impose annual dollar limits on chiropractic coverage?

**Answer:** Yes, annual dollar limits may be imposed on the chiropractic benefit, but any such limit may not be imposed in such a way as to limit covered visits to less than 12. Coverage must be available for at least 12 visits. In other words, the annual dollar benefit cannot be less than 12 times the per visit benefit. The per visit benefit, however, may be set at any level and may be conditioned on any level of co-payment or other cost-sharing requirements so long as it does not run afoul of the anti-discrimination provision in II of the bill. (See Question 12 and Answer regarding the anti-discrimination provision.)

9. **Question:** Could a health carrier impose annual visit maximums on chiropractic coverage?

**Answer:** Yes, so long as the maximum is not less than 12.

10. **Question:** If annual dollar or visit limits on chiropractic coverage are permissible, is there a minimum dollar or visit limit?

**Answer:** The minimum visit limit is 12. The dollar limit can be no less than 12 times the per visit benefit.

11. **Question:** Can chiropractic coverage be limited to in-network providers?

**Answer:** Yes, the benefit can be limited to in-network providers.

12. **Question:** What is the meaning of the statement in II of SB 147 that “a covered person may utilize the services of a doctor of chiropractic as defined in RSA 316-A, without discrimination relative to access and fees, subject to the terms and conditions of the policy?”

**Answer:** This is an anti-discrimination provision. It prohibits health carriers from treating the services of chiropractors differently from the services of other health care providers with respect to scope of practice. If a health carrier does not generally limit coverage or provider reimbursement to a specified subset of the activities or procedures that are within the scope of a provider’s license to practice, then the carrier may not do so for doctors of chiropractic. Since health carriers do not generally limit coverage or provider reimbursement to a specified subset of the activities or procedures that are within the scope of a provider’s license (other than excluding coverage for experimental or investigational procedures), the practical effect of this provision is to prohibit carriers from limiting the chiropractic benefit by limiting reimbursement to a subset of the activities or procedures as defined in RSA 316-A that are within the scope of a chiropractor’s license. Regarding the meaning of the phrase, “subject to the terms and conditions of the policy,” it would be contradictory to read this phrase as creating an exception to the prohibition on discrimination against the services of a chiropractor—that is, as allowing such discrimination so long as it is achieved through the terms and conditions of the policy. Accordingly, this phrase must be read as simply allowing the health carrier to include in a health benefit plan terms and conditions on the chiropractic benefit such as co-payments or prior authorizations. These terms and conditions may not, however, go so far as to limit access to and reimbursement for chiropractic services to a specified subset of the activities that are within the scope of practice of a licensed chiropractor as this scope is defined in RSA 316-A. Access and reimbursement for wellness care visits may be excluded despite this prohibition against discrimination with respect to scope of practice, since it is specifically allowed in the legislation.