STATE OF ARIZONA

DEPARTMENT OF INSURANCE

JANE DEE HULL
Governor

2910 NORTH 44th STREET, SUITE 210
PHOENIX, ARIZONA 85018-7256
602/912-8456 (phone) 602/912-8452 (fax)

CHARLES R. COHEN
Director of Insurance

Former Director Chris Herstam issued the following Circular Letter on August 10, 1995:

CIRCULAR LETTER 95-5

TO: INSURANCE TRADE ASSOCIATIONS AND INTERESTED PERSONS

FROM: CHRIS HERSTAM, DIRECTOR OF INSURANCE

DATE: AUGUST 10, 1995

RE: **DISCRIMINATORY EXCLUSIONS AND LIMITATIONS ON CHIROPRACTIC TREATMENT PROHIBITED BY A.R.S. § 20-461(A)(16) AND (B); WITHDRAWAL OF CIRCULAR LETTERS 90-5A AND 92-6**

Effective September 27, 1990, the Legislature amended A.R.S. § 20-461 by adding paragraph A. 16 and subsection B. These provisions were further amended by the Legislature in 1991 (Laws 1991, Chapter 299, HB 2027) and in 1993 (Laws 1993, Chapter 50, HB 2257). To address the questions and concerns generated by these statutory amendments, the Arizona Department of Insurance (ADOI) issued Circular Letters Number 90-12 on September 27, 1990, (renumbered as 90-5A) and Number 92-6 on August 25, 1992.

The volume of inquiries and comments from the insurance industry and health care professionals has caused the ADOI to review the circular letters, and to obtain further counsel from the Attorney General's Office as to certain recurrent issues arising out of the circular letters. Circular Letters Nos. 90-5A and 92-6 are hereby withdrawn and replaced with this circular letter.

The specific issues are:

1. Do A.R.S. §§ 20-461(A)(16) and 20-461(B) mandate chiropractic benefits in policies issued outside Arizona?

2. May an insurer subject to A.R.S. §§ 20-461(A)(16) and 20-461(B) limit chiropractic benefits, as long as the limitations apply equally to all physicians?

3. Do A.R.S. §§ 20-461(A)(16) and 20-461(B) require insurers to include chiropractors in a PPO network?

CHIROPRACTIC BENEFITS IN POLICIES ISSUED OUTSIDE ARIZONA

Coverage for chiropractic benefits is mandated in all medical service corporation policies (A.R.S. § 20-841.01), individual disability policies (A.R.S. § 20-1376.01) and group or blanket disability policies (A.R.S. § 20-1406.01) issued in Arizona. However, Arizona law does not mandate coverage for chiropractic benefits in policies issued outside Arizona for delivery of certificates of insurance within Arizona. See eg. A.R.S. § 20-1401.01(A). Of course, coverage for chiropractic benefits may be mandated by the law of the foreign state in which the policy is issued, and may be limited to the extent permitted by such mandates. A.R.S. §§ 20-461(A) and 20-461(B) do not establish additional mandates for coverage of chiropractic benefits. These statutes merely provide that failure to comply with policy provisions for chiropractic benefits, whether mandated by other applicable law or simply included in the coverage, is a violation of the Unfair Claims Settlement Practices Act which may result in administrative sanctions.

LIMITATIONS ON CHIROPRACTIC TREATMENT IN POLICIES ISSUED IN ARIZONA AND POLICIES ISSUED OUTSIDE ARIZONA THAT DO NOT PERMISSIBLY LIMIT CHIROPRACTIC BENEFITS

A.R.S. §§ 20-461(A)(16) and 20-461(B) prohibit discrimination as between medical doctors, osteopaths and chiropractors in the payment by insurers for services, diagnosis and treatment for covered conditions. These provisions do not create a position of superiority for any type of physician. They require equal treatment. Limitations on the payment for services, diagnosis and treatment are permitted if they do not discriminate against the usual and customary procedures of any type of physician, either patently or in effect. Therefore, in policies issued in Arizona and policies issued outside Arizona that do not permissibly limit chiropractic benefits it is not permissible to cast limitations on services, diagnosis or treatment in terminology that patently or effectively discriminates against chiropractic treatment for covered conditions.

For example, the characterization of a dislocation as “subluxation” is fundamentally associated with chiropractic treatment for the condition. Therefore, in policies issued in Arizona and policies issued outside Arizona that do not permissibly limit chiropractic benefits, treatment for subluxation may not be excluded because the effect would be to discriminate against chiropractic treatment through the use of terminology. However, treatment for subluxation may be excluded in policies issued outside Arizona if permissible to so limit chiropractic benefits under the laws of the states where the

policies were issued. A.R.S. §§ 20-461(A)(16) and 20-461(B) do not mandate chiropractic benefits. They merely enforce existent policy benefits.

On the other hand, an insurer may not impose exclusions or limitations directed at "manipulation" as a treatment modality. Such treatment is generally performed only by chiropractors. Thus, the exclusion or limitation would clearly discriminate against chiropractic treatment in favor of another form of treatment. Likewise, it may be impermissible to limit the number of office visits to treat a covered condition if the effect of the limitation would be to preclude chiropractic treatment as a viable option for treatment of the condition. A.R.S. § 20-461(B) would, however, allow a non-discriminatory limitation on physical therapy benefits. Because medical doctors, osteopaths and chiropractors may all provide physical therapy treatment, such a limitation would not necessarily be discriminatory.

Insurers may apply pre-authorization and utilization review procedures to ensure that treatment is medically necessary and appropriate. While the standards for pre-authorization and utilization review may not favor any specific type of provider nor any specific form of treatment, the standards may vary by provider according to the standards applicable to each specialty.

It is not possible to list all permissible and impermissible exclusions and limitations on service, diagnosis and treatment. The circumstances in each case must be analyzed in light of the applicable non-discrimination standards. Often, the appropriateness of treatment modalities will involve medical judgments and other factual issues which cannot be prejudged, and may best be resolved between the insurer, the insured and the physician.

PREFERRED PROVIDER ORGANIZATION REQUIREMENTS

A.R.S. § 20-461(B) specifically permits an insurer to establish PPO organization requirements that do not discriminate against medical doctors, osteopaths or chiropractors. This standard prohibits PPO credentialing criteria that either patently excludes chiropractors from a PPO network, or would effectively exclude chiropractors through the use of terminology and criteria that single out chiropractic treatment modalities. PPO benefit provisions must similarly be without discrimination to the usual and customary procedures of any type of physician. Application fees and payment mechanisms must be uniform for all physicians.

The statute does not require that medical doctors, osteopaths and chiropractors must all be included in an insurer's formal PPO network. The statute does not establish any quotas for the types of physicians to be included in the network. It merely prohibits discrimination in the criteria or process for accepting physicians in the network. However, this standard certainly does not relieve an insurer from the statutory requirement that it not deprive insureds of their choice of the type of physician to treat a covered condition, as long as the services are within the lawful scope of the practice of the physician (whether coverage for the condition is mandatory or voluntary).

Consequently, if there are no chiropractors included in the PPO network, or there are insufficient chiropractors in the network to meet the needs of the insured population, taking into account geographic dispersion of physicians, doctor/patient ratios and other pertinent factors, in appropriate cases the insurer must cover out of network chiropractic services for covered conditions at the same benefit level as it would for a provider in the network. Importantly, the insurer must provide adequate notice to insureds of the availability of out of network chiropractic services at PPO benefit levels in appropriate cases. Otherwise, insureds may be misled into choosing care only from those providers listed in the PPO directly.

Though the requirements discussed in this circular letter apply directly to insurers and not directly to independent PPO networks, insurers may not circumvent the requirements by contracting with independent PPO networks.