State of Wisconsin
2005 - 2006 LEGISLATURE

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2005 SENATE BILL 614

February 20, 2006 - Introduced by Senators SCHULTZ, ZIEN and CARPENTER, cosponsored by Representatives KESTELL, FREESE, KREIBICH, MONTGOMERY, ALBERS, LOEFFELHOLZ, MUSSER, TOWNS, AINSWORTH, PETTIS, KRAWCZYK, OTT, BALLWEG, PETROWSKI and BIES. Referred to Committee on Agriculture and Insurance.

AN ACT ***to amend*** 632.87 (3) (b) 1., 632.875 (1) (b) and 632.875 (2) (g); and ***to create*** 446.04 (6), 601.31 (1) (kr), 632.27, 632.726, 632.87 (3) (b) 5., 632.874, 632.875 (1) (am), 632.875 (2) (i) and 632.875 (4m) of the statutes; **relating to:** persons to whom liability insurance claim settlement checks must be made payable; independent evaluations for insurance coverage of chiropractic treatment; current procedural terminology codes on health insurance claim forms; and direct payment to a chiropractor.

Analysis by the Legislative Reference Bureau

This bill specifies to whom a settlement check must be made payable if an insurer under a liability insurance policy settles a claim made under the policy by an insured or injured third party and pays the settlement amount in a lump sum. The check must be made payable to: 1) the insured or injured third party making the claim; 2) any attorney representing that person; and 3) any person who provided covered services to the insured or injured third party on account of the injury to which the claim relates, and who, before payment of the settlement, sent to the insurer by certified mail a completed assignment of benefits form that was signed by the insured or injured third party and that was in substantially the form set forth in the statute.

Under current law, an insurer may not restrict or terminate coverage for chiropractic treatment under a policy, plan, or contract covering treatment by a

licensed chiropractor within the scope of the practice of chiropractic except on the basis of an independent evaluation of the chiropractic treatment. An independent evaluation is an examination or evaluation by or recommendation of a chiropractor or a peer review committee. If, on the basis of an independent evaluation, the insurer restricts or terminates a patient's coverage for chiropractic treatment and the patient then becomes liable for payment of the treatment, the insurer must provide to the patient and the treating chiropractor a written statement that includes an explanation for the restriction or termination of coverage, a list of the records and documents reviewed as part of the evaluation, a statement that the patient may request an internal appeal of the restriction or termination of coverage, and a description of the insurer's internal appeal process that is available to the patient.

Under this bill, an independent evaluation must be done by a chiropractor who has been in practice at least ten years and who currently practices at least 20 hours per week on an annual average or by a peer review committee whose members include at least one chiropractor with the same qualifications. A chiropractor who performs an independent evaluation that does not follow acceptable guidelines may be subject to discipline by the Chiropractic Examining Board. Following an independent evaluation or any decision made on an appeal, the insurer must prepare a written statement that identifies the insurer and that lists all chiropractic treatment and the cost of the treatment for which coverage was approved, restricted, and terminated. The insurer must submit annually a summary, for each chiropractor or peer review committee that conducted an independent evaluation in the previous year, of all of the written statements to the Office of the Commissioner of Insurance (OCI) on a date that OCI determines. OCI must make the summaries available to the public on OCI's Web site.

This bill also prohibits an insurer, under a policy, plan, or contract covering treatment by a licensed chiropractor within the scope of the chiropractor's professional license, from establishing copayment or coinsurance requirements for the services of a chiropractor that are higher than copayment or coinsurance requirements for the services of a licensed physician or osteopath.

This bill requires an insurer that provides coverage of health care expenses to pay a chiropractor directly for any covered services the chiropractor provides to an insured who has assigned to the chiropractor his or her claim for payment, reimbursement, or benefits.

Current law does not regulate the use of current procedural terminology codes (numbers on a health insurance claim form that indicate the services that a health care provider performed). This bill requires an insurer who changes the current procedural terminology code that the health care provider put on the health insurance claim form to include on the explanation of benefits form the reason for the change and to cite the source for the change.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 446.04 (6) of the statutes is created to read:

446.04 **(6)** Conducting an independent evaluation under s. 632.875 that is not conducted under generally acceptable community standards or guidelines, or standards approved by the chiropractic examining board by rule.

SECTION 2. 601.31 (1) (kr) of the statutes is created to read:

601.31 **(1)** (kr) For maintaining, processing, and providing public access to the written statements under s. 632.875 (4m), an amount set by the commissioner, not to exceed actual costs.

SECTION 3. 632.27 of the statutes is created to read:

632.27 Persons to whom settlement checks payable. If an insurer under a liability insurance policy settles a claim made under the policy by an insured or injured 3rd party and pays the settlement amount in a lump sum, the insurer shall pay by a check or other draft that is made payable to all of the following:

(1) The insured or injured 3rd party making the claim.

(2) Any attorney representing the insured or injured 3rd party with respect to the claim.

(3) Any person with respect to whom all of the following apply:

(a) The person provided services to the insured or injured 3rd party on account of the injury to which the claim relates and the services are covered under the policy.

(b) Before payment of the settlement, the person sent to the insurer by certified mail an assignment of benefits form with respect to the services provided and the insurer received the assignment of benefits form.

(c) The assignment of benefits form was completed, signed by the insured or injured 3rd party, and in substantially the following form:

ASSIGNMENT OF BENEFITS OR PAYMENT

I, ... (insured or injured 3rd party), (have insurance with) (have a claim against) the .... insurance company. I have received services from .....

Describe the services provided, including the date(s), and the reason(s) for the services:

. . . . . .

. . . . . .

I hereby assign to .... (provider of the services) any right that I have to payment, including interest from the above insurance company for the services provided. I understand that I am still ultimately responsible for payment for the services.

Date: ....

Signature of insured or injured 3rd party: ....

I hereby accept the above assignment.

Signature of service provider: ....

SECTION 4. 632.726 of the statutes is created to read:

632.726 Current procedural terminology code changes. (1) In this section, "current procedural terminology code" means a number established by the American Medical Association that a health care provider puts on a health insurance claim form to describe the services that he or she performed.

(2) If an insurer changes a current procedural terminology code that was submitted by a health care provider on a health insurance claim form, the insurer shall include on the explanation of benefits form the reason for the change to the current procedural terminology code and shall cite on the explanation of benefits form the source for the change.

SECTION 5. 632.87 (3) (b) 1. of the statutes is amended to read:

632.87 **(3)** (b) 1. Restrict or terminate coverage for the treatment of a condition or a complaint by a licensed chiropractor within the scope of the chiropractor's professional license on the basis of other than an ~~examination or~~ independent evaluation ~~by or a recommendation of a licensed chiropractor or a peer review committee that includes a licensed chiropractor~~, as defined in s. 632.875 (1) (b).

SECTION 6. 632.87 (3) (b) 5. of the statutes is created to read:

632.87 **(3)** (b) 5. Establish copayment or coinsurance requirements for the services of a chiropractor that are higher than copayment or coinsurance requirements for the services of a licensed physician or osteopath.

SECTION 7. 632.874 of the statutes is created to read:

632.874 Payments to chiropractors. An insurer under a health care plan, as defined in s. 628.36, shall pay a chiropractor directly for any covered services the chiropractor provides to an insured under the health care plan who has assigned to the chiropractor his or her claim for payment, reimbursement, or benefits under the health care plan.

SECTION 8. 632.875 (1) (am) of the statutes is created to read:

632.875 **(1)** (am) "Evaluating chiropractor" means a chiropractor who has been in practice at least 10 years and, unless the chiropractor is unable due to disability, is practicing, on an annual basis, an average of 20 hours per week.

SECTION 9. 632.875 (1) (b) of the statutes is amended to read:

632.875 **(1)** (b) "Independent evaluation" means an examination or evaluation by or recommendation of ~~a~~ an evaluating chiropractor or a peer review committee ~~under s. 632.87 (3) (b) 1.~~ whose membership includes at least one evaluating chiropractor.

SECTION 10. 632.875 (2) (g) of the statutes is amended to read:

632.875 **(2)** (g) A ~~reasonable~~ detailed explanation of the ~~factual basis~~ clinical rationale and of the basis in the policy, plan, or contract or in applicable law for the insurer's restriction or termination of coverage.

SECTION 11. 632.875 (2) (i) of the statutes is created to read:

632.875 **(2)** (i) The name of the evaluating chiropractor or, if a peer review committee conducted the independent evaluation, the names of all of the evaluating chiropractors on the peer review committee.

SECTION 12. 632.875 (4m) of the statutes is created to read:

632.875 **(4m)** (a) Following an independent evaluation or any decision made during an appeal, an insurer shall prepare a written statement, containing all of the following:

1. All treatment and costs of the treatment, if any, for which coverage was approved.

2. All treatment and costs of the treatment, if any, for which coverage was restricted.

3. All treatment and costs of the treatment, if any, for which coverage was terminated.

4. The name of the insurer.

5. The name of the evaluating chiropractor or, if a peer review committee conducted the independent evaluation, the names of all of the evaluating chiropractors on the peer review committee.

(b) The insurer shall submit annually a summary, for each evaluating chiropractor or peer review committee that conducted an independent evaluation in the previous year, of all of the written statements required under this subsection to the office on a date that the office determines.

(c) The office shall make the information submitted under par. (b) available to the public on the office's Internet site within a reasonable time period after the insurer submits it.

(d) Every insurer required under this subsection to submit a written statement shall pay the fee required by s. 601.31 (1) (kr).

SECTION 13. Initial applicability.

(1) SETTLEMENT CHECKS. The treatment of section 632.27 of the statutes first applies to settlements of claims made under liability insurance policies that are issued or renewed on the effective date of this subsection.

(END)