State of Wisconsin
2005 – 2006 LEGISLATURE

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ASSEMBLY SUBSTITUTE AMENDMENT 1,

TO 2005 ASSEMBLY BILL 1039

April 25, 2006 – Offered by Representative KESTELL.

AN ACT ***to amend*** 632.875 (2) (g); and ***to create*** 632.726 of the statutes; **relating to:** independent evaluations for insurance coverage of chiropractic treatment and current procedural terminology codes on health insurance claim forms.

Analysis by the Legislative Reference Bureau

Under current law, an insurer may not restrict or terminate coverage for chiropractic treatment under a health insurance policy that covers chiropractic treatment except on the basis of an examination or evaluation by, or the recommendation of, a chiropractor or a peer review committee (independent evaluation). 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, among other things, a reasonable explanation of the factual basis for the restriction or termination of coverage. Under this substitute amendment, the written statement must provide a detailed, rather than merely reasonable, explanation of the clinical rationale, rather than the factual basis, for the restriction or termination of coverage.

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 substitute amendment 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.

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

SECTION 1. 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 2. 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 3. Initial applicability.

(1) Except as provided in subsection (2), this act first applies to claims for insurance coverage that are submitted to an insurer on the effective date of this subsection.

(2) If a health insurance policy that is in effect on the effective date of this subsection contains a provision that is inconsistent with the treatment of section 632.726 or 632.875 (2) (g) of the statutes, the treatment of section 632.726 or 632.875

(2) (g) of the statutes, whichever is applicable, first applies to that health insurance policy on the date on which it is renewed.

(END)