Stricken language would be deleted from and underlined language would be added to law as it existed prior to the 82nd General Assembly.

State of Arkansas
82nd General Assembly
Regular Session, 1999

A Bill

HOUSE BILL 1610

By: Representative Pappas

For An Act To Be Entitled

"AN ACT TO AUTHORIZE SELF-REFERRALS FOR CHIROPRACTIC CARE; AND FOR OTHER PURPOSES."

Subtitle

"TO AUTHORIZE SELF-REFERRALS FOR CHIROPRACTIC CARE."

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code 11-9-508 is amended to read as follows:

"11-9-508. Medical services and supplies - Liability of employer.

(a) The employer shall promptly provide for an injured employee such medical, surgical, hospital, chiropractic, optometric, podiatric, and nursing services and medicine, crutches, ambulatory devices, artificial limbs, eyeglasses, contact lenses, hearing aids, and other apparatus as may be reasonably necessary in connection with the injury received by the employee.

(b) If the employer fails to provide the medical services set out in subsection (a) of this section within a reasonable time after knowledge of the injury, the Workers' Compensation Commission may direct that the injured employee obtain the medical service at the expense of the employer, and any emergency treatment afforded the injured employee shall be at the expense of the employer. In no circumstance may an employee, his family, or dependents, be billed or charged for any portion of the cost of providing the benefits to which he is entitled under this chapter.

(c) In order to help control the cost of medical benefits, the commission, on or before July 1, 1994, following a public hearing and with the assistance and cooperation of the State Insurance Department, is authorized

and directed to establish appropriate rules and regulations to establish and implement a system of managed health care for the State of Arkansas.

(d) For the purpose of establishing and implementing a system of managed health care, the commission is authorized to:

(1) Develop rules and regulations for the certification of managed care entities to provide managed care to injured workers;

(2) Develop regulations for peer review, service utilization, and resolution of medical disputes;

(3) Prohibit ‘balanced billing’ from the employee, employer, or carrier;

(4) Establish fees for medical services as provided for in Rule 30 and its amendments. The commission shall make no distinction in approving fees from different classes of medical service providers or health care providers for provision of the same or essentially similar medical services or health care services as defined herein; and

(5)(A) Give the employer the right to choose the initial treating physician, with the injured employee having the right to petition the commission for a one-time only change of physician to one who is associated with a managed care entity certified by the commission or is the regular treating physician of the employee who maintains the employee's medical records and with whom the employee has a bona fide doctor-patient relationship demonstrated by a history of regular treatment prior to the onset of the compensable injury, but only if the primary care physician agrees to refer the employee to a certified managed care entity for any specialized treatment, including physical therapy, and only if such primary care physician agrees to comply with all the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer.

(B) A petition for change of physician shall be expedited by the commission.

(e) Any section or subsection of this chapter notwithstanding, the injured employee shall have direct access to any optometric or ophthalmologic medical service provider who agrees to provide services under the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer for the treatment and management of eye injuries or conditions. Such optometric or ophthalmologic medical service provider shall be considered a certified provider by the commission.

(f)(1) Any section or subsection of this chapter notwithstanding, an injured employee shall have direct access to the services of a chiropractic physician under the following conditions:

(A) An employee may utilize the services of a participating chiropractic physician for three (3) weeks or a maximum of twelve (12) visits, whichever occurs first, of acute care treatment without the prior approval of a primary care physician of the managed care system. For purposes of this subsection, 'acute care treatment' means treatment for accidental bodily injury or sudden, severe pain that affects the ability of the employee to engage in the normal activities, duties or responsibilities of daily living.

(B) Within seven (7) working days of the first consultation, the chiropractic physician shall send to the primary care physician a report containing the employee's complaint, related history, examination, initial diagnosis and treatment plan. If the chiropractic physician fails to send a report to the primary care physician within seven (7) working days, the managed care system is not obligated to provide benefits for chiropractic care and the employee is not liable to the chiropractic physician for any unpaid fees.

(C) If the employee and the chiropractic physician determine that the condition of the employee has not improved after three (3) weeks of treatment or a maximum of twelve (12) visits, the chiropractic physician shall discontinue treatment and refer the employee to the primary care physician.

(D) If the chiropractic physician recommends treatment beyond three (3) weeks or a maximum of twelve (12) visits, the chiropractic physician shall send to the primary care physician a report containing information on the employee's progress and outlining a treatment plan for extended chiropractic care of up to five (5) additional weeks or a maximum of twelve (12) additional visits, whichever occurs first.

(E) Without the approval of the primary care physician, an employee may not receive benefits for more than thirty-six (36) visits to a chiropractic physician in a twelve-month period. After a maximum of thirty-six (36) visits, an employee's continuing chiropractic treatment shall be authorized by the primary care physician.

(2) The Workers' Compensation Commission shall submit a report to the House and Senate Interim Committees on Insurance and Commerce and to the

House and Senate Interim Committees on Public Health, Welfare and Labor by January 1, 2001, on the claims experience related to self-referrals of chiropractic care under this section. The report shall include the total amount of claims paid for chiropractic services by the managed care system, the total amount of claims paid for self-referred chiropractic services, the total number of self-referrals for chiropractic care, the average cost of those claims and the number of complaints received by the Workers' Compensation Commission regarding access to chiropractic care in the managed care system.

~~(f)~~(g) The commission is authorized to promulgate any other rules or regulations as may be necessary to carry out the provisions of this section and its purpose of controlling medical costs through the establishment of a managed care system."

SECTION 2. All provisions of this act of a general and permanent nature are amendatory to the Arkansas Code of 1987 Annotated and the Arkansas Code Revision Commission shall incorporate the same in the Code.

SECTION 3. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

SECTION 4. All laws and parts of laws in conflict with this act are hereby repealed.