Complementary and Alternative Medicine

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Instructions for Use

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Related Benefit Interpretation Policy

- Rehabilitation Services (Physical, Occupational, and Speech Therapy)

Federal/State Mandated Regulations

Note: The most current federal/state mandated regulations for each state can be found in the links below.

Oklahoma

Oklahoma Statutes Title 36 Section 6933 Chiropractic Services

http://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=436580

(C) With respect to chiropractic services, such covered services shall be provided on a referral basis within the network at the request of an enrollee who has a condition of an orthopedic or neurological nature if:
1. A referral is necessitated in the judgment of the primary care physician; and
2. Treatment for the condition falls within the licensed scope of practice of a chiropractic physician.

Oregon

Rule 836-053-0017

https://oregon.public.law/rules/oar_836-053-0017

Additions to Essential Health Benefits for Plan Years Beginning on and after January 1, 2022

(1) In addition to any other benefits required under state or federal law, a health benefit plan required to provide essential health benefits within the meaning of ORS 731.097 ("Essential health benefits") must, at a minimum, provide coverage for the following items and services:
   (a) Up to 20 visits per year for spinal manipulation if within the scope of license of the healthcare provider;
   (b) Up to 12 visits per year for acupuncture;
   (c) Coverage of Buprenorphine or brand equivalent products for medication-assisted treatment of opioid use disorder without prior authorization, dispensing limits, fail first policies, or lifetime limits; and
   (d) At least one intranasal opioid reversal agent for initial prescriptions of opioids with dosages of 50 or more morphine milligram equivalents (MME).

(2) The requirements of this rule apply to health benefit plans issued or renewed on or after January 1, 2022.

Washington

WAC 284-170-270 Every Category of Healthcare Providers

https://app.leg.wa.gov/wac/default.aspx?cite=284-170-270

(1) Issuers must not exclude any category of providers licensed by the state of Washington who provide health care services or care within the scope of their practice for services covered as essential health benefits, as defined in WAC 284-43-5640 and 284-43-5642 and RCW 48.43.715, for individual and small group plans; and as covered by the basic health plan, as defined in RCW 48.43.005 (4), for plans other than individual and small group.

For individual and small group plans, the issuer must not exclude a category of provider who is licensed to provide services for a covered condition, and is acting within the scope of practice, unless such services would not meet the issuer's standards pursuant to RCW 48.43.045 (1)(a). For example, if the issuer covers outpatient treatment of lower back pain as part of the essential health benefits, any category of provider that provides cost-effective and clinically efficacious outpatient treatment for lower back pain within its scope of practice and otherwise abides by standards pursuant to RCW 48.43.045 (1)(a) must not be excluded from the network.

(2) RCW 48.43.045 (1)(a) permits issuers to require providers to abide by certain standards. These standards may not be used in a manner designed to exclude categories of providers unreasonably. For example, issuers must not decide that a particular category of provider can never render any cost-effective or clinically efficacious services and thereby exclude that category of provider completely from health plans on that basis.

(3) (Health plans are not prohibited by this section from placing reasonable limits on individual services rendered by specific categories of providers based on relevant information or evidence of the type usually considered and relied upon in making determinations of cost-effectiveness or clinical efficacy. However, health plans must not contain unreasonable limits, and must not include limits on the type of provider permitted to render the covered service unless such limits comply with RCW 48.43.045 (1)(a).

(4) This section does not prohibit health plans from using restricted networks. Issuers offering plans with restricted networks may select the individual providers in any category of provider with whom they will contract or whom they will reimburse. An issuer is not required by RCW 48.43.045 or this section to accede to a request by any individual provider for inclusion in any network for any health plan.
   (a) Health plan networks that use "gatekeepers" or "medical homes" for access to specialist providers may use them for access to specified categories of providers.
   (b) For purposes of this section:
      (i) "Gatekeeper" means requiring a referral from a primary care or direct access provider or practitioner to access specialty or in-patient services.
      (ii) "Medical home" means a team based health care delivery model for patient centered primary care that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes as modified and updated by the Agency for Healthcare Research and Quality, the U.S. Department of Health and Human Services (HRSA), and other state and federal agencies.

(5) Issuers must not offer coverage for health services for certain categories of providers solely as a separately priced optional benefit.

(6) The insurance commissioner may grant reasonable temporary extensions of time for implementation of RCW 48.43.045 or this section, or any part thereof, for good cause shown.

RCW 48.44.310 Chiropractic Care, Coverage Required, Exceptions

https://app.leg.wa.gov/RCW/default.aspx?cite=48.44.310

1. Each group contract for comprehensive health care service which is entered into, or renewed, on or after September 8, 1983, between a health care service contractor and the person or persons to receive such care shall offer coverage for chiropractic care on the same basis as any other care.
2. A patient of a chiropractor shall not be denied benefits under a contract because the practitioner is not licensed under chapter 18.57 or 18.71 RCW.
3. This section shall not apply to a group contract for comprehensive health care services entered into in accordance with a collective bargaining agreement between management and labor representatives. Benefits for chiropractic care shall be offered by the employer in good faith on the same basis as any other care as a subject for collective bargaining for group contracts for health care services.

State Market Plan Enhancements

Some members may have chiropractic, acupuncture or other alternative care benefits. Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB) or contact the Customer Service Department to determine coverage eligibility.

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Oklahoma

- **Acupuncture and Acupressure**: Coverage for acupuncture and acupressure may be available if purchased by the Subscriber's employer group as a supplemental benefit.
- **Chiropractic Care**: Care and treatment is limited to treatment of neurological and orthopedic conditions determined by the Contracting Primary Care Physician to be Medically Necessary.(Coverage for additional Chiropractic Care may be available if purchased by the Subscriber's employer as a Supplemental Benefit)
- **Complementary and Alternative Medicine** may be available if purchased by the Subscriber's employer as a supplemental benefit/rider.

Oregon

- **Acupuncture** may be available if purchased by the Subscriber's employer as a supplemental benefit/rider.
- **Chiropractic Care** may be available if purchased by the Subscriber's employer as a supplemental benefit/rider.
- **Complementary and Alternative Medicine** may be available if purchased by the Subscriber's employer as a supplemental benefit/rider.

Texas

- **Acupuncture and Acupressure** may be available if purchased by the Subscriber's employer as a supplemental benefit.
- **Chiropractic Care** may be available if purchased by the Subscriber's employer as a supplemental benefit.
- **Complementary and Alternative Medicine** may be available if purchased by the Subscriber's employer as a supplemental benefit/rider.
- **Massage Therapy** is covered when Medically Necessary and authorized by the Member's Contracting Primary Care Physician.

Washington

- **Chiropractic Services:** Outpatient chiropractic treatment and services are covered. (Refer to member's EOC for additional coverage details).
- **Complementary and Alternative Medicine** is covered. Members have direct access to Contracting Chiropractic, Acupuncture and Naturopathic Providers without obtaining a referral. In all cases, however, the Complementary Alternative Care Provider must be affiliated with UnitedHealthcare.
- **Massage Therapy**: Members need to receive a written referral and Preauthorization for Massage therapy services from the Member's Primary Provider.
    - The Member will submit the referral and Preauthorization to the massage therapist at the first visit. The massage therapist will notify UnitedHealthcare of the referral and Preauthorization as part of the treatment plan.
    - The contracting massage therapist, in order to determine the nature of the Member's problem, performs an initial assessment and, if Covered Services appear warranted, prepares a treatment plan of services to be furnished. One initial assessment is provided for each new patient.
    - The contracting massage therapist, in order to assess the need to continue, extend or change an approved treatment plan, may perform a reassessment. A reassessment may be performed during a subsequent office visit or separately. If performed separately, a

- Subsequent sessions, as set forth in an approved treatment plan, may involve a massage therapy session and/or a brief reassessment. The subsequent session includes all services related to the massage therapy, a brief reassessment if necessary and any consultative services

- **Naturopath**: Services provided by a licensed naturopathic physician are covered, to the extent that the services are included in the scope of the Naturopathy Physician N.D. license, without referral by a Primary Care Provider. If referral for other services is required, the naturopath must provide a report and recommendations for those services to the member's Primary Care Provider, and may not make the referral in place of the Primary Care Provider's referral.

  Refer to the Member's EOC for additional Naturopath inclusions.

Not Covered

Complementary and Alternative therapies are not covered unless the member has the benefit as stated in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, or *Covered Benefits* sections. Also refer to the member's EOC/SOB for specific information regarding exclusions and limitations.

Oklahoma and Oregon

- **Massage therapy**: unless mandated by State or Federal law and/or covered as Market Plan Enhancements (Refer to Sections A & B)
- **Religious non-medical healthcare**

Washington

Massage Therapy Services Exclusions/Limitations

The following services are not covered:

- Any services or treatments not authorized, except for an initial assessment
- Any services or treatment not delivered by contracting massage therapists or other contracted Providers for the delivery of massage therapy care to Members
- Services for assessments and/or treatments for conditions other than those related to myofascial, neuromusculoskeletal pain syndromes provided by contracting massage therapists
- Hypnotherapy, behavior training, sleep therapy and weight programs
- Thermography
- Services and/or treatments not documented as clinically necessary, appropriate or classified as Experimental/Investigational and/or as being in the research stage
- Education programs, nonmedical self-care or self-help or any self-help physical exercise training or any related diagnostic testing
- Services or treatments for pre-enrollment physicals or vocational rehabilitation
- Therapeutic devices, appliances, supplies or durable medical equipment
- Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order
- Services provided outside the scope of a massage therapist's license
- Hospitalization
- Adjunctive therapy whether or not associated with massage therapy
- Vitamins, minerals, nutritional supplements or other similar products

Chiropractic Services Exclusions/Limitations:

- Any services or treatments not authorized, except for an initial examination and Emergency Services.
- Any services or treatments not delivered by contracting chiropractors or other contracted Practitioners for the delivery of chiropractic care to Members, except for Emergency Services.

(Refer to member's EOC for additional exclusion/limitation details).

Oklahoma, Oregon, Texas and Washington

Examples of non-covered services include, but are not limited to:

- Oriental massage, Swedish massage (Refer to the Benefit Interpretation Policy titled Rehabilitation Services (Physical, Occupational, and Speech Therapy)
- Energy therapies
- Meditation
- Herbal therapy
- Yoga
- Tai Chi
- Spiritual healing
- Community based approaches (e.g., Alcoholics Anonymous, Overeaters Anonymous)
- Medical intuition
- Pilate's method
- Light and color therapy
- Colonics
- Applied kinesiology
- Neural therapy
- Therapeutic touch
- Electromagnetic fields for medical purposes (e.g., magnetic chairs)
- Reiki
- Hypnosis
- Homeopathic

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
12/01/2023	All	**Supporting Information** • Removed *Definitions* section • Archived previous policy version BIP030.J

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.