5101:3-8-11 **Covered chiropractic physician services and limitations.**

For dates of service beginning on and after January 1, 2004, chiropractic services provided by chiropractic physicians will no longer be covered medicaid services for adults twenty-one years of age and older.

(A) Definitions:

(1) "Subluxation" means an incomplete dislocation, off centering, misalignment, fixation, or abnormal spacing of the vertebrae anatomically, and must be demonstrated by x-ray film or other diagnostic test; and

(2) "Maintenance therapy" means therapy that is performed to treat a chronic, stable condition or to prevent deterioration.

(B) Treatment by means of manual manipulation of the spine to correct a subluxation which exceeds normalcy is a covered service. The existence of the subluxation must be demonstrated either by a diagnostic x-ray or by physical examination, as described in paragraph (C) of this rule. Evidence must be retained as a part of the patient's medical record that a subluxation exists. The manual manipulation must have a direct therapeutic relationship to the patient's condition as documented in the medical record. The lack of documentation specifying the relationship between the patient's condition and treatment shall result in the service being nonreimburseable.

(C) At least two of the following criteria must exist and be documented to demonstrate a subluxation by physical examination. One of the two criteria must be asymmetry/misalignment or range of motion abnormality.

(1) Pain/tenderness evaluated in terms of location, quality and intensity;

(2) Asymmetry/misalignment identified on a sectional or segmental level;

(3) Range of motion abnormality; or

(4) Tissue, tone changes in the characteristics of contiguous or associated soft tissues, including skin, fascia, muscle and ligament.

(D) Covered chiropractic services shall be limited to the chiropractic procedures listed in paragraph (D)(1) of this rule and diagnostic x-rays meeting the provisions described in paragraph (D)(2) of this rule. The service must relate to the diagnosis and treatment of a significant health problem in the form of a neuromusculoskeletal condition necessitating manipulative treatment.

(1) The chiropractic procedures listed below are covered under the medicaid program if the service is deemed medically necessary. The limit is one unit of service for each patient for each date of service.

(a) Chiropractic manipulative treatment (CMT); spinal, one to two regions.

(b) Chiropractic manipulative treatment (CMT); spinal, three to four regions.

(c) Chiropractic manipulative treatment (CMT); spinal, five regions.

(2) Diagnostic x-rays to determine the existence of a subluxation are covered with certain limitations. Two units of service, as defined below, will be covered during any six-month period unless otherwise stated. For purposes of this rule, the six-month period begins on the date the diagnostic x-ray is taken and ends one hundred eighty days from the date. The covered units of service are as follows:

(a) Spine, entire; survey study, anterior-posterior, and lateral. Only two units per one year (three hundred and sixty five days) period are covered

(b) Spine, cervical; antero-posterior, and lateral.

(c) Spine, cervical; antero-posterior, and lateral; minimum of four views.

(d) Spine, cervical; antero-posterior, and lateral; complete, including oblique and flexion and/or extension studies.

(e) Spine, thoracic; anterior-posterior, and lateral views.

(f) Spine, thoracic; complete, including obliques; minimum of four views.

(g) Spine, thoracolumbar; antero-posterior lateral views.

(h) Spine, lumbosacral; antero-posterior, and lateral views.

(i) Spine, lumbosacral; complete, with oblique views; and

(j) Spine, lumbosacral; complete, including bending views.

(E) Limitations of coverage:

(1) Spinal axis aches, strains, sprains, nerve pains, and functional mechanical disabilities of the spine are considered to provide therapeutic grounds for chiropractic manipulative treatment. Most other diseases and disorders do not provide therapeutic grounds for chiropractic manipulative treatment. Examples of non-covered diagnoses are multiple sclerosis, rheumatoid arthritis, muscular dystrophy, sinus problems and pneumonia.

(2) Repeat x-rays or other diagnostic tests in patients with chronic, permanent conditions will not be considered medically necessary and are not a covered service.

(3) If there is no reasonable expectation that the continuation of treatment would improve or arrest deterioration of the condition within a reasonable and generally predictable period of time, coverage will be denied.

(4) Continued repetitive treatments without an achievable and clearly defined goal will be considered maintenance therapy and will not be considered covered services.

(5) Once the maximum therapeutic benefit has been achieved for any given condition, ongoing therapy is considered maintenance therapy which is not considered medically necessary.

(6) When services are performed more frequently than generally accepted by peers, chiropractic manipulation will be considered excessive and will be denied as not medically necessary.

(F) There must be documentation to support each service billed. Documentation should exist in the patient's medical record and must verify that the services billed were rendered and that the services were medically necessary.

(1) The following information should be documented in the patient's medical record on the initial visit for a new condition:

(a) Patient's history;

(b) Patient's chief complaint;

(c) Subjective findings from physical examination including evaluations of the musculoskeletal and nervous systems;

(d) Objective findings including x-ray results, if given;

(e) Diagnosis;

(f) Treatment plan which includes the following:

(i) Goals;

(ii) Plans for continued treatment including duration and frequency of visits; and

(iii) Objective measures that will be used to evaluate the effectiveness of treatment.

(2) The following information should be documented on periodic reassessments:

(a) Patient's status on each visit date including how the patient's condition has changed since the last treatment;

(b) Review of how the chief complaint has changed since the last visit; and

(c) Results of physical exam.

(3) On each visit, the treatment given on each visit date must be documented including the specific region(s) manipulated.

(G) The following services are not covered:

(1) Visits in excess of thirty dates of service per recipient per twelve-month period in an outpatient setting;

(2) Services rendered to patients in an inpatient or outpatient hospital setting are not covered in this rule but are covered in Chapter 5101:3-2 of the Administrative Code;

~~(3) Services provided to nursing facility patients are covered through the nursing~~

~~facility's cost report and shall not be billed directly by a chiropractor as specified in paragraph (G) of rule 5101: 3-3-19 of the Administrative Code;~~

~~(4)~~(3) Services unrelated to the treatment of the specific medical complaint, services unnecessary for the treatment of an ailment, and treatment of a preventative medicine nature;

~~(5)~~(4) Services determined by another third-party payer (especially medicare Title XVIII) as not medically necessary. Services denied by medicare will be considered medically unnecessary by the department and will not be considered covered services by medicaid;

~~(6)~~(5) X-rays, except for those delineated in paragraph (B)(2) of this rule;

~~(7)~~(6) Services which are not personally performed by the chiropractic physician with whom the department has a provider agreement:

(a) Services provided by licensed individuals with whom the department does not have an individual provider agreement are not reimbursable even though the covered services are provided under the personal supervision of a licensed chiropractic physician with whom the department does have a provider agreement.

(b) Services provided by unlicensed individuals under the personal supervision of a licensed chiropractic physician are not reimbursable.

(c) Services provided by students during an internship are not covered services.

~~(8)~~(7) Any service other than manual manipulation for treatment of subluxation of the spine and x-rays as described in paragraph (D) of this rule are not covered services. The following are examples of services (not an all-inclusive list) that, when performed or ordered by the chiropractor, are excluded from coverage:

(a) Maintenance therapy;

(b) Laboratory test;

(c) Evaluation and management services;

(d) Physical therapy;

(e) Traction;

(f) Supplies;

(g) Injections;

(h) Drugs;

(i) Diagnostic studies;

(j) Orthopedic devices;

(k) Equipment used for manipulation; and

(l) Any manipulation which the x-ray or other tests does not support the primary diagnosis.

(8) Services for adults twenty-one years of age and older when provided by a chiropractic physician.

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