5160-8-11 **Spinal manipulation and related diagnostic imaging services.**

(A) Scope. This rule sets forth provisions governing payment for professional, non-institutional spinal manipulation and related diagnostic imaging services. Provisions governing payment for such services performed in a federally qualified health center are set forth in Chapter 5160-28 of the Administrative Code.

(B) Providers.

(1) Rendering providers. The following eligible providers may render a service described in this rule:

(a) A chiropractor ~~(an individual who holds a valid license as a chiropractor under~~ as defined in Chapter 4734. of the Revised Code~~. and works within the scope of practice defined by state law); or~~

(b) A mechanotherapist ~~(an individual who holds a valid license as a mechanotherapist under~~ as defined in Chapter 4731. of the Revised Code ~~and works within the scope of practice defined by state law)~~.

(2) Billing ("pay-to") providers. The following eligible providers may receive medicaid payment for submitting a claim for a covered service on behalf of a rendering provider:

(a) A chiropractor;

(b) A mechanotherapist;

(c) A professional medical group, which is described in rule 5160-1-17 of the Administrative Code;

(d) A hospital, rules for which are set forth in Chapter 5160-2 of the Administrative Code; or

(e) A fee-for-service clinic, rules for which are set forth in Chapter 5160-13 of the Administrative Code.

(C) Coverage.

(1) Payment for manual manipulation of the spine may be made only for the correction of a subluxation, the existence of which must be determined either by physical examination or by diagnostic imaging. If the determination is made by physical examination, the following criteria must be met:

(a) At least one of the following two conditions exists:

(i) Asymmetry or misalignment on a sectional or segmental level; or

(ii) Abnormality in the range of motion; and

(b) At least one of the following two symptoms is present:

(i) Significant pain or tenderness in the affected area; or

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

(2) Payment may be made only for the following services:

(a) Spinal manipulation.

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

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

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

(b) Diagnostic imaging to determine the existence of a subluxation.

(i) Spine, entire; survey study, anteroposterior and lateral.

(ii) Spine, cervical; anteroposterior and lateral.

(iii) Spine, cervical; anteroposterior and lateral; minimum of four views.

(iv) Spine, cervical; anteroposterior and lateral; complete, including oblique and flexion and/or extension studies.

(v) Spine, thoracic; anteroposterior and lateral views.

(vi) Spine, thoracic; complete, with oblique views; minimum of four views.

(vii) Spine, thoracolumbar; anteroposterior and lateral views.

(viii) Spine, lumbosacral; anteroposterior and lateral views.

(ix) Spine, lumbosacral; complete, with oblique views.

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

(c) Acupuncture services in accordance with rule 5160-8-51 of the Administrative Code.

(D) Requirements, constraints, and limitations.

(1) The following coverage limits~~, which may be exceeded with prior authorization,~~ are established for the indicated services:

(a) Spinal manipulation, one treatment per date of service;

(b) Diagnostic imaging of the entire spine to determine the existence of a subluxation, two sessions per benefit year;

(c) All other imaging, two sessions per six-month period; and

(d) Visits in an outpatient setting, thirty dates of service per benefit year for an individual younger than twenty-one years of age, fifteen dates of service per benefit year for an individual twenty-one years of age or older.

(e) These limits may be exceeded with prior authorization as defined in rule 5160-1-31of the Administrative Code.

(2) Payment will not be made under this rule for any of the following services:

(a) A service that is not medically necessary, examples of which are shown in the following non-exhaustive list:

(i) A service unrelated to the treatment of a specific medical complaint;

(ii) Treatment of a disease, disorder, or condition that does not respond to spinal manipulation, such as multiple sclerosis, rheumatoid arthritis, muscular dystrophy, sinus problems, and pneumonia;

(iii) Preventive treatment;

(iv) Repeated treatment without an achievable and clearly defined goal;

(v) Repeated imaging or other diagnostic procedure for a chronic, permanent condition;

(vi) Treatment from which the maximum therapeutic benefit has already been achieved and the continuation of which cannot reasonably be

expected to improve the condition or arrest deterioration within a reasonable and generally predictable period of time; and

(vii) A service performed more frequently than the standard generally accepted by peers;

(b) A service that is performed by someone other than a chiropractor or mechanotherapist who is an eligible provider; and

(c) A service that is performed by a chiropractor or mechanotherapist who is an eligible provider but that is neither chiropractic manipulation nor diagnostic imaging to determine the existence of a subluxation, illustrated by the following examples:

(i) Diagnostic studies;

(ii) Drugs;

(iii) Equipment used for manipulation;

(iv) Evaluation and management services;

(v) Injections;

(vi) Laboratory tests;

(vii) Maintenance therapy (therapy that is performed to treat a chronic, stable condition or to prevent deterioration);

(viii) Manual manipulation for purposes other than the treatment of subluxation;

(ix) Orthopedic devices;

(x) Physical therapy;

(xi) Supplies; and

(xii) Traction.

Effective:

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Certification

Date

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