Ohio Administrative Code

Rule 5160-8-11 Chiropractic services.

Effective: November 1, 2022

(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, as defined in Chapter 4734. of the Revised Code.

(b) A mechanotherapist, as defined in Chapter 4731. of the Revised Code.

(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 nursing facility, rules for which are set forth in Chapter 5160-3 of the Administrative Code;

(f) A fee-for-service An ambulatory health care clinic, rules for which are set forth in Chapter 5160-13 of the Administrative Code.; or

(g) A federally qualified health center (FQHC), rules for which are set forth in Chapter 5160-28 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 is to be determined either by physical examination or by diagnostic imaging. If the determination is made by physical examination, the following criteria must be met: or by physical examination confirming that the following criteria are 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) Evaluation and management services.

(i) Office or other outpatient visit for the evaluation and management of a new patient, involving either straightforward medical decision-making or a total time of from fifteen to twenty-nine minutes.

(ii) Office or other outpatient visit for the evaluation and management of a new patient, involving

either low-level medical decision-making or a total time of from thirty to forty-four minutes.

(iii) Office or other outpatient visit for the evaluation and management of an established patient, for which the presence of a physician or other qualified healthcare professional may not be needed.

(iv) Office or other outpatient visit for the evaluation and management of an established patient, involving either straightforward medical decision-making or a total time of from ten to nineteen minutes.

(v) Office or other outpatient visit for the evaluation and management of an established patient, involving either low-level medical-decision making or a total time of from twenty to twenty-nine minutes.

(3) For a covered chiropractic service rendered at an FQHC, payment is made in accordance with Chapter 5160-28 of the Administrative Code.

(D) Requirements, constraints,Constraints and limitations.

(1) The following coverage limits 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) Evaluation and management, four sessions per benefit year; and

(e) 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.

() These limits may be exceeded with prior authorization as defined in rule 5160-1-31 of 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 neithernot chiropractic manipulation, nor diagnostic imaging to determine the existence of a subluxation, or evaluation and management, illustrated by the following examples:

(i) Diagnostic studies;

(ii) Drugs;

(iii) Equipment used for manipulation;

() Evaluation and management services;

(iv) Injections;

(v) Laboratory tests;

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

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

(viii) Orthopedic devices;

(ix) Physical therapy;

(x) Supplies; and

(xi) Traction.