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.

(B) Providers.

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

(a) A chiropractor, defined in Chapter 4734. of the Revised Code.

(b) A mechanotherapist, 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;

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

(f) 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 is to be determined either by diagnostic imaging 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) 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;

(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.

(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 not chiropractic manipulation, 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;

(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.