REIMBURSEMENT POLICY STATEMENT
OHIO MEDICAID

Policy Name		Policy Number	Effective Date
Chiropractic Care – Spinal Manipulation		PY-1328	10/01/2021
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policy Statement: Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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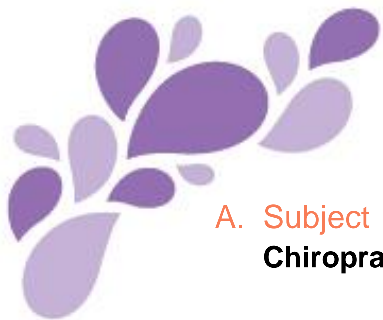


A. Subject

Chiropractic Care – Spinal Manipulation

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS/ICD-10 code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Chiropractic is a licensed healthcare profession where treatment typically involves manual therapy, often including spinal manipulation.

C. Definitions

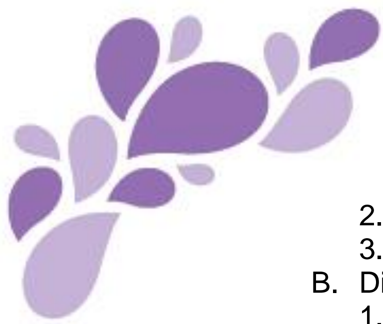
- **Maintenance therapy** – A therapy that is performed to treat a chronic, stable condition or to prevent deterioration.
- **Acute Subluxation** – Member is being treated for a new injury, defined by x-ray or physician exam which results in an expected improvement in, or arrest of progression in the member's condition.
- **Rendering providers** - A chiropractor or a mechanotherapist is eligible to provide spinal manipulation.
- **Billing provider** - A chiropractor, mechanotherapist, a profession medical group, a hospital or a fee-for-service clinic as noted by the Ohio Administrative Code.

D. Policy

I. CareSource follows the Ohio Administrative Code for payment of spinal manipulation.

II. Payment may be made only for:
   A. The manual correction to correct a spinal subluxation;
   B. A condition that is acute and episodic in nature.
      1. When the maximum therapeutic benefit has been met, ongoing therapy is considered maintenance therapy and this is considered not medically necessary; and
   C. A subluxation of the spine that was determined by x-ray or physician exam.

III. Payment may be made for the following services:
   A. Spinal manipulation.
      1. Chiropractic manipulative treatment (CMT); spinal, one to two regions.



2. Chiropractic manipulative treatment (CMT); spinal, three to four regions.
3. Chiropractic manipulative treatment (CMT); spinal, five regions.

B. Diagnostic imaging to determine the existence of a subluxation.
1. Spine, entire; survey study, anteroposterior and lateral.
2. Spine, cervical; anteroposterior and lateral.
3. Spine, cervical; anteroposterior and lateral; minimum of four views.
4. Spine, cervical; anteroposterior and lateral; complete, including oblique and flexion and/or extension studies.
5. Spine, thoracic; anteroposterior and lateral views.
6. Spine, thoracic; complete, with oblique views; minimum of four views.
7. Spine, thoracolumbar; anteroposterior and lateral views.
8. Spine, lumbosacral; anteroposterior and lateral views.
9. Spine, lumbosacral; complete, with oblique views.
10. Spine, lumbosacral; complete, including bending views.

IV. A service performed must be medically necessary and related to the treatment of a specific medical complaint.

A. To determine medical necessity, CareSource requires all of the following:
1. A primary diagnosis of subluxation
   a. Examples include lumbar and sacral; and
2. A secondary diagnosis that supports the treatment provided.
   a. Examples include osteoarthritis and congenial musculoskeletal deformities of the spine.

B. The manual manipulation must have a direct therapeutic relationship to the member’s condition as documented in the medical record. The lack of documentation specifying the relationship between the member’s condition and treatment shall result in the service being ineligible for reimbursement.

E. Conditions of Coverage

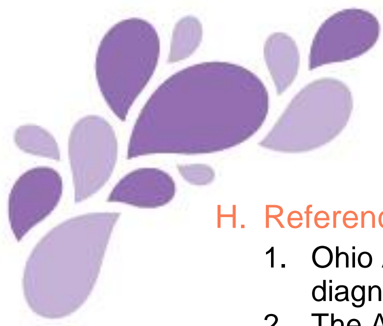
Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

F. Related Policies/Rules

Medical Necessity Determination Policy

G. Review/Revision History

	DATE	ACTION
Date Issued	05/26/2021	
Date Revised		
Date Effective	10/01/2021	
Date Archived		



H. References

1. Ohio Administrative Code. (2016, May, 8) 5160-8-11 Spinal manipulation and related diagnostic imaging services. Retrieved April 15, 2021 from www.codes.ohio.gov
2. The Association of Chiropractic Colleges. (n.d.). Chiropractic Paradigm/Scope & Practice. Retrieved April 15, 2021 from www.chirocolleges.org

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.