REIMBURSEMENT POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Chiropractic Care-OH MCD-PY-1328	03/01/2026
Policy Type	
REIMBURSEMENT	

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

B. Background
Chiropractic is a healthcare field that focuses on disorders affecting the musculoskeletal and nervous systems, along with their effects on overall health. Doctors of Chiropractic (DCs) utilize a conservative approach to healthcare that includes patient assessment, diagnosis, and treatment. In addition to manual therapies such as spinal manipulation, DCs are trained to recommend therapeutic and rehabilitative exercises and to offer advice on nutrition, lifestyle, and dietary habits. They address a variety of conditions, including but not limited to back pain, neck pain, joint pain in the arms or legs, and headaches.

The core services provided by chiropractors are a key strategy for the prevention, diagnosis, and conservative (non-drug) management of back pain and spinal disorders. This approach can help some patients minimize or avoid the need for more invasive interventions, such as prescription opioid pain medications and surgery.

C. Definitions
- **Acute Subluxation** – Treatment for a new injury defined by x-ray or physician exam resulting in an expected improvement in, or arrest of, progression in the member's condition.
- **Billing Provider** – A chiropractor, mechanotherapist, professional medical group, hospital, or fee-for-service clinic as noted by the Ohio Administrative Code (OAC).
- **Maintenance Therapy** – A therapy that is performed to treat a chronic, stable condition or to prevent deterioration.
- **Rendering Providers** – A chiropractor or a mechanotherapist eligible to provide spinal manipulation.

D. Policy
I. CareSource follows the OAC for payment of spinal manipulation.

II. Payment may be made for manual correction to correct a spinal subluxation determined by x-ray or physician exam for a condition that is acute and episodic in nature. When the maximum therapeutic benefit has been met, ongoing therapy is considered maintenance therapy and is not medically necessary.

III. Payment may be made for the following services:
   A. spinal manipulation
      1. chiropractic manipulative treatment (CMT); spinal, 1 to 2 regions
      2. chiropractic manipulative treatment (CMT); spinal, 3 to 4 regions
      3. chiropractic manipulative treatment (CMT); spinal, 5 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. All services 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 (ie, lumbar and/or sacral)
      2. a secondary diagnosis that supports the treatment provided (eg, osteoarthritis, congenital musculoskeletal deformities of the spine)
   B. 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	04/12/2023	Annual review: Title modified. Updated references. Approved at Committee.
	01/31/2024	Annual review. Updated references. Approved at Committee.
	11/19/2025	Periodic review. Updated the background and references. Approved at Committee.
Date Effective	03/01/2026	
Date Archived		

H. References

1. Chiropractic Services, OHIO ADMIN. CODE 5160-8-11 (2022).

ODM approved 12/01/2025

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