Minnesota Department of Human Services

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# Health Care

### Our Mission

The Minnesota Department of Human Services, working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.

### Our Values

- We focus on people, not programs.
- We provide ladders up and safety nets for the people we serve.
- We work in partnership with others; we cannot do it alone.
- We are accountable for results, first to the people we serve, and ultimately to all Minnesotans.

*We practice these shared values in an ethical environment where integrity, trustworthiness, responsibility, respect, justice, fairness and caring are of paramount importance.*

## Report to the Legislature

# Chiropractic Coverage

Laws of Minnesota 2007
Chapter 147, article 5, section 39

**February 2008**

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## Chiropractic Coverage

## January 2008

**Cost of completing this report:**
**Minnesota Statutes, section 3.197, requires the disclosure of the cost of preparing this report.**

**Report preparation** $4000.00

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## Introduction

The 2007 laws of Minnesota, Chapter 147, Article 5, Section 39 directs the commissioner of human services, through the Health Service Policy Committee to study whether medical assistance coverage for chiropractic services should be expanded to include initial and progress exams, and shall report recommendations to the legislature by January 15, 2007.

> Sec. 39. **CHIROPRACTIC COVERAGE.**
> The commissioner of human services, through the Health Services Policy Committee established under Minnesota Statutes, section 256B.0625, subdivision 3c, and using existing funding, shall study whether medical assistance coverage for chiropractic services should be expanded to include initial and progress exams, and shall report recommendations to the legislature by January 15, 2008.

## Executive Summary

This report to the legislature will provide a background of the current fee-for-service (FFS) chiropractic coverage policy under the Minnesota Health Care Programs (MHCP), a comparison with coverage offered by commercial plans in Minnesota and Medicare, as well as a discussion of the present Medicare pilot project.

## Existing MHCP Chiropractic coverage policy

Minnesota Rule 9505.0245 (Appendix A) governs the coverage for chiropractic services under the Minnesota Health Care Programs. Chiropractic services are narrow in focus in that, services are limited to medically necessary manual manipulations of the spine for treatment of incomplete or partial dislocations and the x-rays needed to support the diagnosis of subluxation. Coverage is limited to an annual benefit of 24 manipulations, not to exceed six manipulations per month. If additional chiropractic services are required, authorization must be submitted to determine the medical necessity of those services.

Services that are specifically excluded from coverage in Rule include laboratory services, diathermy, vitamins, ultrasound treatment, treatment for a neurogenic or congenital condition that is not related to a diagnosis of subluxation, medical supplies or equipment supplied or prescribed by a chiropractor, and x-rays not listed in 9505.0245.

## MHCP Expenditures for Chiropractic Services

The chart below shows the total expenditures for chiropractic manipulation treatments under the fee-for-service (FFS) programs within MHCP, the number of recipients receiving those services and the average expenditure per recipient for calendar years 2004, 2005, and 2006.

| Calendar Year | Total MCHP Expenditures | Number of Unduplicated Recipients | Average Expenditure per Recipient |
|---|---|---|---|
| **2004** | $1,204,922.75 | 13,216 | $91.17 |
| **2005** | $1,223,738.46 | 13,545 | $90.35 |
| **2006** | $1,318,014.91 | 14,201 | $92.81 |

Chiropractors also bill for a limited number of diagnostic radiology services. The chart below shows the total expenditures for radiology services billed by chiropractors under the FFS programs with MHCP, the number of recipients receiving diagnostic radiology services from chiropractors, and the average expenditure per recipient for calendar years 2004, 2005, and 2006.

| Calendar Year | Total Payments for Radiology Services | Number of Unduplicated Recipients | Average Expenditure per Recipient |
|---|---|---|---|
| **2004** | $86,636.73 | 1,399 | $61.93 |
| **2005** | $86,334.06 | 1.427 | $60.50 |
| **2006** | $84,118.30 | 1.424 | $59.07 |

Occasionally a recipient will require more chiropractic services than the limit of 24 treatments per year, not to exceed six treatments per month. In those cases, authorizations are submitted to determine the medical necessity of additional services. The chart below shows the number of chiropractic units requested, the number of units approved and the number of recipients requesting additional units of service for calendar year 2004, 2005, and 2006.

| Calendar Year | Requested Units | Units Approved | Number of Unduplicated Recipients | Distinct Number of Authorizations | Total Expense for Processing Authorizations |
|---|---|---|---|---|---|
| **2004** | 1,820 | 953 | 179 | 239 | $6608.35 |
| **2005** | 1,586 | 603 | 155 | 223 | $6165.95 |
| **2006** | 1,591 | 422 | 124 | 185 | $5115.25 |

A phenomenon the department has observed in the past with other service areas that have annual service thresholds is maximum utilization of those thresholds, year to year. For this reason, a review of chiropractic service threshold utilization was also completed.

| Calendar Years | Number of Distinct Recipients | Number of Distinct Recipient Using Max Units of 24 per calendar year |
|---|---|---|
| Repeat services in 2004 and 2005 | 5893 | 77 |
| Repeat services in 2005 and 2006 | 5997 | 59 |

The chart below combines the total expenditures for chiropractor services from the charts above.

| Calendar Year | Total FFS Payments for Radiology Services | Total Cost of Processing Authorizations | Total FFS Payments for Chiropractic Manipulative Treatments | Total Annual Expenditures for Services Related to Chiropractic Care |
|---|---|---|---|---|
| **2004** | $86,636.73 | $6608.35 | $1,204,922.75 | $1,298,167.83 |
| **2005** | $86,334.06 | $6165.95 | $1,223,738.46 | $1,316,238.47 |
| **2006** | $84,118.30 | $5115.25 | $1,318,014.91 | $1,407,248.46 |

Chiropractic expenditures represent the following percentage of the total MHCP FFS expenditures:

| Calendar Year | MHCP FFS Program Expenditures | Annual FFS Expenditures Related to Chiropractic Care | Chiropractic Service = Percentage of MHCP FFS Program Budget |
|---|---|---|---|
| 2004 | $4,854,902,648.12 | $1,298,167.83 | .0267% |
| 2005 | $3,425,397,641.88 | $1,316,238.47 | .0384% |
| 2006 | $3,314,230,441.07 | $1,407,248.46 | .0424% |

## Federal Regulations Governing MHCP Chiropractic Services

Chiropractic services are an optional Medicaid service as defined in Federal Regulations. However, states that do provide chiropractic coverage do so as defined in 42 CFR 440.60:

**§ 440.60 Medical or other remedial care provided by licensed practitioners.**

(a) "Medical care or any other type remedial care provided by licensed practitioners" means any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law.

(b) Chiropractors' services include only services that—

(1) Are provided by a chiropractor who is licensed by the State and meets standards issued by the Secretary under § 405.532(b) of this chapter, and

(2) Consists of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform.

Because chiropractic services are optional Medicaid services according to Federal Regulations, each State determines whether chiropractic services will be included in their Medicaid State Plan or not. There is a wide range of coverage options among the States, everything from no coverage of chiropractic services in some states, to coverage of chiropractic service for recipients that are under 21 years of age, to chiropractic services that exceed the services offered under the Minnesota State Plan. (Appendix B)

## Chiropractic Scope of Practice

Chiropractic is defined in Minnesota Statute 148.01 as the "science of adjusting any abnormal articulations of the human body, especially those of the spinal column . . .." Included in the definition of practice of chiropractic are "noninvasive mean of clinical physical, and laboratory measure and analytical x-rays of the bones of the skeleton which are necessary to make a determination of the presence or absence of a chiropractic condition. The practice of chiropractic may include procedures which are used to prepare the patient for chiropractic adjustment or to complement the chiropractic adjustment."

Minnesota Rule 2500.0100, Subp. 9b. further defines the practice of chiropractic:

> "Practice of chiropractic" includes the examination, diagnosis, prognosis, and treatment by chiropractic methods, or the rendering of opinions pertaining to those methods, for the purposes of determining a course of action in the best interests of the patient, such as a treatment plan or appropriate referral, or both. The methods may include those procedures preparatory or complementary to a chiropractic adjustment or other normal chiropractic regimen and rehabilitation of the patient as taught in accredited chiropractic schools or programs pursuant to Minnesota Statutes, section 148.06.

## Commercial Plans

The chiropractic coverage policy of various commercial health plans was reviewed for preparation of this report. Below is a general description of chiropractic coverage of the health plans that were reviewed, keeping in mind that benefits are contract driven, are group specific, and may vary from group to group.

| Insurance Company | Initial Exams and/of Progress Exams Covered? |
|---|---|
| Blue Cross Blue Shield | Initial exams and progress exams are covered, depending on the terms of the specific contract. |
| Medica | Initial exams and progress exams are covered, depending on the terms of the specific contracts, but prior authorized is required. |
| Preferred One | Initial exams and progress exams are covered as a chiropractic service if chiropractic coverage is selected as a covered service by the group. Group plans may or may not include chiropractic service and determine the limits of chiropractic service if selected. |
| HealthPartners | Diagnosis by physical exam generally covered, dependent on the terms of the specific plan. |

## Medicare Demonstration Project

Section 651 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required that the Centers for Medicare and Medicaid Services (CMS) conduct a two-year *Demonstration of Coverage of Chiropractic Services Under Medicare*. Specifically, CMS was required to expand coverage for services to include "care for neuromusculoskeletal conditions typical among eligible beneficiaries and diagnostic and other services that a chiropractor is legally authorized to perform by the State of jurisdiction in which such treatment is provided."[1] Since the expanded services included in the Demonstration Project extend beyond the current Medicare coverage, the purpose of the Demonstration Project was to "evaluate the feasibility and advisability of covering chiropractic service under Medicare."[2]

In preparing for the Demonstration Project, CMS "conducted a literature review of the evidence of the effectiveness of chiropractor services."[3] CMS also held discussion with the American Chiropractic Association (ACA), the Department of Defense and the Veterans Administration. Based on the information gathered through these processes, Medicare developed the following guidelines for the Demonstration Project:

1. Service must be related to active treatment, not maintenance.
2. CMS found no literature that provided conclusive evidence that chiropractic care is effective for treatment of diagnosis other than subluxation, hence, chiropractors in the Demonstration Project are allowed to provide treatment of neuromusculoskeletal conditions, but no other conditions.
3. Chiropractors can provider plain x-rays, electromyography (EMG) tests and nerve conduction studies; order magnetic resonance imaging (MRI) scans and computed tomography (CT); as well as order or provide laboratory tests depending if State laws allows and if the diagnostic service is related to the diagnosis and treatment of the neuromusculockeltal condition.
4. The Demonstration Project will expand to allow chiropractors to bill CPT code 98943 for extraspinal manipulation and include other services State laws may allow chiropractors to perform including electrotherapy, ultrasound, transcutaneous electrical nerve stimulation (TENS), and other services that are medically necessary for the treatment of neurmuscoloskeletal conditions.

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[1] Medlearn Matters Number: SE0514 Revised
[2] Federal Register/Vol. 70, No. 18/Friday, January 18, 2005, pg 4131 [CMS-5037-N]
[3] Ibid

5. Under the Demonstration Project, chiropractors are allowed to bill chiropractic treatments in addition to certain evaluation and management (E & M) services delivered on the same day. The E & M visits are limited to new patient assessments and reassessments when separate problems not currently being treated are presented. [4]

The Medicare Demonstration Project was a two-year study that began April 1, 2005 and extended through March 31, 2007. It was limited to chiropractors practicing in the states of Maine, New Mexico, and specified counties in Illinois, Iowa and Virginia; two urban areas and two rural areas. Chiropractors within these designated areas were allowed to provide services according to the guidelines listed above, within the chiropractic scope of practice of the State in which they practice. Although the Medicare Demonstration Project expanded chiropractic services beyond the scope of the current Legislative consideration, the results of the Medicare Project will be valuable for the department to review, specifically the results of the Project concerning the E & M services. CMS is preparing a report for Congress on their finding following completion of the Demonstration Project. Unfortunately, their report is due to Congress until late April. Their report to Congress with be available to the general public shortly thereafter.

## Health Services Advisory Committee

The Minnesota Department of Human Services (DHS) Health Services Advisory Committee (HSAC) was created to advise the department regarding health services covered under the Medical Assistance, General Assistance Medial Care and MinnesotaCare. The committee advises the department regarding evidence-based decision-making and provides leadership designing health care benefit and coverage policies for MHCP.

Dr. Richard Branson, D.C., a member of the HSAC, supplied department staff with a number of reports from past studies on chiropractic care.

*Clinical and Cost Outcomes of an Integrative Medicine IPA*: Richard L. Sarnat, MD, and James Winterstein DC, published June 2004, Journal of Manipulative and Physiological Therapeutics

*Assessment of Knowledge of Primary Care Activities in a Sample of Medical and Chiropractic Students*: Ruth Sandefur, DC, PhD, Theresa A. Febbo, DC, and Ronald L. Rupert, MS, DC, published June 2005, Journal of Manipulative and Physiological Therapeutics

*Cost-Effectiveness of Medical and Chiropractic Care for Acute and Chronic Low Back Pain*: Mitchell Haas, DC, MA, Rajiv Sharma, PhD, and Miron Stano, PhD, published October 2005, Journal of Manipulative and Physiological Therapeutics

*Clinical Utilization and Cost Outcome from an Integrative Medicine Independent Physician Association: An Additional 3-Year Update*: Richard L. Sarnat, MD, James Winterstein, DC, and Jerrilyn A. Cambron, DC, PhD, published May 2007, Journal of Manipulative and Physiological Therapeutics

While these studies provided valuable information to consider, they also represented studies that encompass issues well beyond the scope of the discussion identified by the 2007 legislation; whether MHCP should expand to include initial and progress exams. No study has been found that demonstrates a cost/benefit (outcomes) relationship between chiropractors performing initial exams/progress exams vs. chiropractic care delivered without initial and/or progress exams as part of the over all treatment plan.

[4] Federal Register/Vol. 70, No. 18/Friday, January 18, 2005, pg 4131 [CMS-5037-N]

The existing Chiropractic Manipulation Treatment (CMT) codes, 98940 – 98943, first published for use on January 1, 1997, by the American Medical Association, include a "premanipulation patient assessment."[5] Current MHCP rates reflect the inclusion of the premanipulation patient assessment; however, there is a distinction between the premanipulation assessment and an initial exam and progress exams.

The premanipulation assessment primarily involves the clinical impression or diagnosis for the presenting patient encounter, specific to the patient's complaint and is not comprehensive in nature, it does include a review of previously gathered data including exam, test findings, treatment plan, and patient's response to treatment, changes since last treatment, evaluating newly developed complaints, mechanical assessment, correlating physical findings, diagnosis evaluation and coordination and modifying current treatment plan.

While the above description of the premanipulation assessment sound exhaustive, the new patient exam (initial exam) or progress exam are comprehensive in nature and include the chief complaint, review of any other care the patient might be receiving, review of patient's medications, diagnosis evaluation, prognosis assessment and evaluation, review of medications the patient is using, and coordination of care with other practitioners and/or facilities/agencies as determined appropriate, etc.

Further, the intent of the AMA, in its definition of the CMT codes, has provided that "Evaluation and Management services may be reported separately . . ., if the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the procedure." [6]

## Options

After thorough review of the materials and information obtained and compiled to complete this report, the Department has the following options to offer for consideration. These options were submitted to HSAC for their review and recommendation at their February 2008, meeting.

- **No change to current policy:** Chiropractic services are an optional service under the Medicaid program, pursuant to Federal Regulations. Because chiropractic care is an optional Medicaid service, they have been the object of Legislative consideration for elimination from MHCP or a reduction of benefits, as a cost saving; in 2003, the Legislature considered cutting chiropractic care as a covered service under MHCP, and in 2005, the Legislature considered reducing the number of service units from 24 to 10 per year. After consideration of the wide range of chiropractic services offered across the country (see Appendix B), chiropractic services under MCHP are reasonable and there is no need for change to Minnesota's policy.

- **Make no recommendations or changes to policy until the results of the Medicare Demonstration Project are available:** The Medicare Report to Congress on the results of the Demonstration Project will not be available until it is presented to Congress in late April of this year. After review of the Demonstration Project report, department staff would, in consultation with the Health Services Advisory Committee, develop policy changes as deemed appropriate and report back to the 2009 Legislature.

- **Require authorization for all E & M services delivered by chiropractors:** Similar to some of the commercial plans, MCHP would require authorization to determine the medical necessity for chiropractors to perform initial exams and progress exams. How this is implemented will have to be determined.

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[5] 2008 AMA CPT Professional Edition, Copyright © 2007 American Medical Association
[6] Ibid

- **Expand chiropractic services to include a limited number of initial and progress exams:** As indicated earlier, no studies have been found that demonstrate a cost/benefit (outcomes) relationship between chiropractors performing initial exams/progress exams vs. chiropractic care delivered without initial and/or progress exams as part of the over all treatment plan. Due to the lack of available literature, the department could embark on its own limited study by expanding chiropractic services to include a limited number of initial exams and/or progress exams over a three year period. At the end of that time period, the department would review data to determine if any savings are realized; e.g., rather than receiving more expensive health care services such as physical therapy, a recipient benefits from chiropractic care, or, during an initial exam, the chiropractor determines the recipient's condition is not related to a diagnosis of subluxation and then refers the patient to an appropriate practitioner. Should the department expand coverage to include initial and progress exams, chiropractic care under MHCP will continue to be limited to manual manipulation of the spine. Implementation of this recommendation will have to be determined.

## Health Services Advisory Committee Recommendation

The Health Service Advisory Committee discussed the contents of this report and the options offered at their February 14, 2008 meeting. After careful consideration, the committee unanimously approved Dr. Richard Branson, D.C.'s recommendations – refer to Addendum on page 17.

- Expansion of chiropractic coverage to include:
  - One new patient evaluation and management office visit*
  - One progress exam per patient every 12 months
  - All additional exams (initial and progress) needed beyond those in the coverage expansion require authorization.

* The American Medical Association Current Procedural Coding (CPT) defines evaluation and management (E & M) office visits for new patients as follows: "Have not received care from the physician or any other physician in the same practice within the same specialty in the previous three years (99201 – 99205)." [7]

[7] 2008 Ingenix CPT Expert, Copyright © 2007 Ingenix

**Appendix A**

**Minnesota Rule, 9505.0245 CHIROPRACTIC SERVICES.**

Subpart 1. **Definitions.** The following terms used in this part have the meanings given them.

A. "Chiropractic service" means a medically necessary health service provided by a chiropractor.

B. "Chiropractor" means a person licensed under Minnesota Statutes, sections 148.01 to 148.101.

Subp. 2. **Payment limitations.** Medical assistance payment for chiropractic service is limited to medically necessary manual manipulation of the spine for treatment of incomplete or partial dislocations and the x-rays that are needed to support a diagnosis of subluxation.

A. Payment for manual manipulations of the spine of a recipient is limited to six manipulations per month and 24 manipulations per year unless prior authorization of a greater number of manipulations is obtained.

B. Payment for x-rays is limited to radiological examinations of the full spine; the cervical, thoracic, lumbar, and lumbosacral areas of the spine; the pelvis; and the sacroiliac joints.

Subp. 3. **Excluded services.** The following chiropractic services are not eligible for payment under the medical assistance program:

A. laboratory service;

B. diathermy;

C. vitamins;

D. ultrasound treatment;

E. treatment for a neurogenic or congenital condition that is not related to a diagnosis of subluxation;

F. medical supplies or equipment supplied or prescribed by a chiropractor; and

G. x-rays not listed in subpart 2.

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HIST: 12 SR 624
*Current as of 10/11/07*

Appendix B

| State | Medicaid Policy for Chiropractic Services |
|---|---|
| **Alabama** | Chiropractic services are only covered for QMB recipient or for recipients referred directly as a result of an EPSDT screening. |
| **Alaska** | Over age 21 and on Medicare, reimbursement is limited to co-insurance and deductible. If over 21 and not on Medicare, no coverage.<br>Children under 21: coverage is limited to 12 spinal manipulations and one x-ray per calendar year. |
| **Arizona** | Only available to recipients under age 21 and QMB eligible members. |
| **Arkansas** | Manipulation of the spine for the treatment of subluxation is the only covered chiropractic service. Benefits are not limited for beneficiaries under age 21 in the EPSDT program. Services for beneficiaries over age 21 are limited to 12 visits per fiscal year. Two chiropractic x-rays per fiscal year are covered, however; chiropractic x-rays count against the $500 laboratory and x-ray benefit limit. |
| **California** | Limited to a maximum of 2 treatments per month by means of manual manipulation of the spine. Prior authorization is not available for additional units of service. |
| **Colorado** | No coverage |
| **Connecticut** | Medically necessary manual manipulation of the spine. Prior authorization required for manipulation of the spine in excess of five per month. Non-covered services include x-rays furnished by a chiropractor, lab work, initial visit for exam and diagnosis, etc. |
| **Delaware** | No coverage |
| **Florida** | 24 manipulations of the spine per year and spinal x-rays, or 23 manual manipulations of the spine and one new patient visit which consists of a screening and any required manipulation of the spine. A new patient is one who has not received any professional services from the provider or provider group within the past three years. |
| **Georgia** | No coverage |
| **Hawaii** | No coverage |
| **Idaho** | 24 manual manipulations of the spine during any calendar year to correct a subluxation condition. No other chiropractic services are reimbursable. |
| **Illinois** | Manual manipulations of the spine. Screenings are not covered. |
| **Indiana** | 50 units of service annually including manual manipulation of the spine, up to five office visits, or physical medicine treatments. |
| **Iowa** | Manual manipulation of the spine for the purpose of correcting a subluxation demonstrated by x-ray. No more than 28 manipulations per 12-month period. |
| **Kansas** | Cross-over claims from Medicare are the only chiropractic service covered. |
| **Kentucky** | Covered services include chiropractic manipulative treatment, diagnostic x-rays, an evaluation and management service, and specific physical modalities identified in Kentucky statutes |
| **Louisiana** | Eligible recipients: ages 0 – 20. Services: Medically necessary manual manipulations of the spine when the service is provided as a result of a referral from a KIDMED medical screening provider or Primary Care Provider (PCP). |
| **Maine** | Manual manipulation of the spine and x-rays for the diagnosis and treatment of subluxation. Treatment beyond six months requires justification in the form of a recent examination or x-ray documenting a clinical manifestation of subluxation and every 12 months thereafter. |
| **Maryland** | Available only through the EPSTD program for recipients age 0 – 20; referral must be made by EPSTD screening provider every six (6) month; a quarterly progress report must be submitted to the recipient's primary care provider. |
| **Massachusetts** | Chiropractic services require a written referral from the recipient's primary-care provider prior to the delivery of services. Services are limited to medically necessary treatments related to a neuromusculoskeletal condition. Providers may not receive payment for office visit and chiropractic manipulation treatments provided on the |

| | |
|---|---|
| | same day. Payment is limited to a total of 20 office visits or chiropractic manipulative treatments, or a combination of 20 office visits and chiropractic manipulative treatments per member per calendar year. |
| **Michigan** | Manual manipulation of the spine to correct a subluxation; x-ray must demonstrate a subluxation exists. Services are limited to 18 visits per year. Evaluation and management (E&M) visits are not covered. |
| **Mississippi** | Manual manipulation of the spine to correct a subluxation, if x-ray demonstrates a subluxation exists. Reimbursement is limited to $700.00 per fiscal year. |
| **Missouri** | No Coverage |
| **Montana** | Limited to recipients age 20 and under to evaluation and management (E&M) office visits, manual manipulation of the spine and x-rays to support diagnosis of subluxation of the spine. |
| **Nebraska** | Covers chiropractic services provided in the office or the client's home. Covered services are limited to x-rays and manual manipulation of the spine. For clients age 21 and older: manual manipulation of the spine is limited to 20 treatments per calendar year. For clients under age 20 and younger: treatments are limited to 18 during the initial five-month period from the date of initial treatment for the reported diagnosis. No more than one treatment per client per day is covered. |
| **Nevada** | No Coverage |
| **New Hampshire** | Six visits per year |
| **New Jersey** | Six visits per year |
| **New Mexico** | No Coverage |
| **New York** | Medicare co-insurance and deductible are the only chiropractic related covered services. |
| **North Carolina** | Limited to manual manipulation of the spine to correct a subluxation. With the exception of x-rays, no other diagnostic or therapeutic service furnished by a chiropractor or under his or her order is a covered service. Services are limited to pregnant women and recipients of EPSDT services under the age of 21. |
| **North Dakota** | Twelve (12) medically necessary manual manipulations of the spine for treatment of subluxation per calendar year, and x-rays, not to exceed two (2) per year, that are needed to support a diagnosis of subluxation. E/M services (99201 -- 99203) may be billed in addition only when the recipient has not received any professional face-to-face services from a chiropractor within the past three (3) years. |
| **Ohio** | Medically necessary manual manipulation of the spine for subluxation, diagnostic x-rays, limited to 30 visits in a 12 month period for patients under 21, and 15 visits for patients 21 years old and older. E & M services are not covered. |
| **Oklahoma** | No Coverage |
| **Oregon** | Limited coverage |
| **Pennsylvania** | Evaluation by means of examination of the patient, treatment by means of manual manipulation of the spine to adjust misaligned or displace vertebrae, and diagnostic x-rays. |
| **Rhode Island** | No Coverage |
| **South Carolina** | Medically necessary manual manipulation of the spine for the purpose of correcting a subluxation demonstrated on x-ray, limited to 12 chiropractic visits per years, commencing on July 1, of each year. X-rays are limited to two per state fiscal year. |
| **South Dakota** | Manual manipulation of the spine, limited to 30 treatments in each 12 month period, any combination of 98940, 98941, or 98942, and diagnostic x-rays. If the provider routinely charges the general public for new patient and established patient visit, the provider may also bill Medicaid these services once in three years. |
| **Tennessee** | Medically necessary chiropractic services are covered for recipients age 21 and younger. |
| **Texas** | Manual manipulation of the spine for treatment of subluxation of the spine. Services are limited to 12 treatments per 12 consecutive months. Coverage does not reimburse chiropractors for x-ray services, office visits, injections, supplies, appliances, lab services, physical therapy or other adjunctive services furnished by a |

| | |
|---|---|
| | chiropractor or under their orders. |
| **Utah** | Initial evaluation and examination, payable only once per episode of illness, x-rays for diagnostic purposes only, and manipulative treatments. All chiropractic services require prior authorization. |
| **Vermont** | Ten visits per calendar year available only to recipients under 21 years of age. Additional medically necessary visits available for children under 12 with authorization. |
| **Virginia** | No coverage |
| **Washington** | Available only to recipients under 21 years of age, and referred by a screening provider under the Health Kids/Early and Periodic Screening Diagnostic, and Treatment (EPSDT) program. Unlimited chiropractic manipulative treatment of the spine. X-rays are limited to a single view. |
| **West Virginia** | Twelve (12) manual manipulations of the spine per year, to correct a subluxation which has been demonstrated by an x-ray. The x-ray must be taken no more than three months prior to the date a course of treatment has been initiated. All chiropractor services beyond the initial twelve require authorization. |
| **Wisconsin** | Twenty (20) manual manipulations of the spine to treat a spinal subluxation. Initial visit and 20 manipulations per spell of illness do not require prior authorization. Prior authorization is required for more than 20 manipulations. X-rays are covered when performed on the same date as an initial office visit. A diagnostic urinalysis is covered only when performed on the same date as the initial office visit and must be related to the diagnosis of a spinal subluxation. |
| **Wyoming** | No Coverage |

## Appendix C

### Chiropractic Manipulative Treatment[8]

Chiropractic manipulative treatment (CMT), reported with codes 98940-98943, is a form of manual treatment performed to influence joint and neurophysical function. CMT codes include a premanipulation patient assessment. Evaluation and management services should not be report separately unless the patient's condition requires a separate identifiable E/M service beyond the usual pre-and post-service work normally associated with the procedure.

CMT codes are reported by region. The five spinal regions are cervical (includes atlanto-occipital joint); thoracic (includes costovertebral and costotransverse joints); lumbar sacral; and pelvic (includes sacroiliac joint). The five extraspinal regions are defined as follows: head (including tempormandibular joint); lower extremities; upper extremities; rib cage, and abdomen.

Consult the appropriate Evaluation and Management CPT code and append modifier 25 (or 09925) in addition to the code for CMT when separately identifiable Evaluation and Management services, above and beyond any pre or post service work associated with CMT, are provided.

Consult the glossary for terms and definitions and the front matter of this chapter for additional information.

| CMT Code | Description | Rate |
|---|---|---|
| **98940** | Chiropractic manipulative treatment (CMT); spinal, one to two regions | $16.48 |
| **98941** | spinal, three to four regions | $20.86 |
| **98942** | spinal, fine regions | $25.70 |
| **98943** | extraspinal, one or more regions | not covered |

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## Appendix D

### Ingenix CPT Expert[9]

| Procedure Code | Description | MHCP MD Rate* |
|---|---|---|
| **99201** | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:<br>• a problem focused history;<br>• a problem focuses examination;<br>• straight forward medical decision making.<br>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family. | $27.19 |
| **99202** | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:<br>• an expanded problem focused history;<br>• an expanded problem focused examination;<br>• straight forward medical decision making.<br>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family. | $30.48 |
| **99203** | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:<br>• a detailed history;<br>• a detailed examination;<br>• medical decision making of low complexity.<br>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and /or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family. | $36.25 |
| **99211** | Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services | $12.36 |
| **99212** | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:<br>• a problem focused history;<br>• a problem focused examination;<br>• straight forward medical decision making.<br>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family. | $20.60 |
| **99213** | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:<br>• an expanded problem focused history;<br>• an expanded problem focused examination;<br>• medical decision making of low complexity.<br>Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family. | $24.72 |

* Rates are reduced when paid to some non-MD providers.

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## Addendum

**Response to the Health Services Advisory Council Regarding the Draft DHS Legislative Report on Chiropractic Coverage of Initial and Progress Exams**
**Prepared and Submitted by: Dr. Richard Branson, D.C.**

This report concludes expanded coverage by DHS for payment of initial and progress exams is not cost effective based on its review of materials reviewed and information obtained and compiled.

The department made four possible recommendations based on this review:

1. No change to the current policy
2. Make no recommendation or changes to the policy until the results of the Medicare Demonstration Project are available
3. Require authorization for all E&M services delivered by Chiropractors
4. Expand chiropractic services to include a limited number of initial and progress exams

It is my recommendation that DHS expand coverage to include a minimum of one new patient evaluation (99201-99203) initial and one progress exam (99211-99213) every 12 months with prior authorization required for additional examinations within a 12 month period. This recommendation is based on the following rationale:

1. The main issue is patient safety and quality of care. In the absence of a patient assessment the potential for unsafe and improper chiropractic treatment may occur.
2. All health care providers take a history and provide an examination that lead to medical decision making. The profession of chiropractic is no different, being held to the same standards of care as other diagnosis-rendering health care providers, e.g. MDs, DOs, DDSs, etc. DHS includes coverage for these services for all other healthcare providers as part of their standard operating procedures. No issue of cost effective outcomes related to patient examination is raised with these other health care providers.
3. The Minnesota Board of Chiropractic Examiners require doctors of chiropractic to perform examinations "to determine a preliminary diagnosis" and reexaminations "to evaluate significant changes in a patients condition". See rule 2500.5000.
4. The patient is currently paying for this service. Since an evaluation is required under statute and recommended by all current treatment guidelines, the provider must charge the patient for this service as Medicaid currently does not reimburse evaluations. This low-income population often finds the cost of such an evaluation beyond their means.
5. All published randomized clinical trials (approximately 50) related to the profession of chiropractic have included a patient initial and reevaluation. Without this information inclusion and exclusion criteria (a working diagnosis) cannot be determined.
6. Published guidelines recommend patient assessment before treatment. This principle is consistent with evidence-based medicine.

**References**

MINNESOTA BOARD OF CHIROPRACTIC EXAMINERS
ADMINISTRATIVE RULES
(Revised July, 2007)
RECORDKEEPING
2500.5000 RECORDKEEPING.

All items in this part should be contained in the patient record. However, a record to justify patient care must contain items A , B, C, E, G, and I.

A. A description of past conditions and trauma, past treatment received, current treatment being received from other health care providers, and a description of the patient's current Condition, including onset and description of trauma if trauma occurred.
B. **Examinations performed to determine a preliminary diagnosis based on indicated diagnostic tests, with an indication of all findings of each test performed.**
C. A diagnosis supported by documented subjective and objective findings or clearly qualified as an opinion.
D. A treatment plan that describes the procedures and treatment used for the conditions identified, including approximate frequency of care.
E. Daily notes documenting current subjective complaints as described by the patient, any change in objective findings if noted during that visit, a listing of all procedures provided during that visit, and all information that is exchanged and will affect the patient's treatment.
F. A description by the chiropractor or written by the patient each time an incident occurs that results in an aggravation of the patient's condition or a new developing condition.
**G. Results of reexaminations that are performed to evaluate significant changes in a patient's condition, including tests that were positive or deviated from results used to indicate normal findings.**
H. When symbols or abbreviations are used, a key that explains their meanings must accompany each file when requested in writing by the patient or a third p arty.
I. Documentation that family history has been evaluated.

**Treatment Guidelines**


1. Airaksinen O, Brox JI, Cerderlund CG, Hildebrandt J, Klaber-Moffett J, Kovacs F, et al. European guidelines for the management of chronic non-specific low back pain. European commission, research directorate general, 2004. (Amended June 2005) www.backpaineurope.org
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3. Bigos S, Bowyer O, Braen G et al: Acute low back problems in adults: Assessment and treatment. Clinical Practice Guideline Number 14. US department of health and human services, public health service, agency for health care policy and research, Rockville, MD, 1994.
4. Coulter ID, Hurwitz EL, Adams AH, et al: The appropriateness of manipulation and mobilization of the cervical spine. Santa Monica, CA, Rand, 1996.

5. Institute for Clinical Systems Improvement. Health Care Guidelines. Adult Low Back Pain. Last Update September 2005. Retrieved February 13th, 2008 from www. Icsi.org.
6. Mercy Center Consensus Conference, Chapman-Smith, D. (Ed.), Petersen, D. M. (Ed.), & Haldeman, S. (Ed.). (1992). Guidelines for quality assurance and practice parameters, proceedings of the Mercy Center Consensus Conference. Gaithersburg, MD: Aspen Publications.