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15.01 **PURPOSE**

The Department’s purpose for this rule is to provide medically necessary chiropractic services to MaineCare members who are adults (age twenty-one (21) and over) with rehabilitation potential, and medically necessary chiropractic services to MaineCare members who are under age twenty‑one (21).

15.02 **DEFINITIONS**

15.02-1 **Chiropractic Services** are those services provided to a member by a licensed chiropractor.

15.02-2 **Chiropractor** is an individual who both is licensed by the state or province in which he/she provides chiropractic services and meets uniform minimum standards promulgated by the Secretary of Health and Human Services under 42 U.S.C. §1395x(r) and 42 C.F.R. 440.60.

15.02-3 **Rehabilitation Potential** is a documented expectation by the member’s primary care provider or prescribing provider (Medical Doctor (MD), Doctor of Osteopathic (DO), Physician Assistant (PA), or Advanced Practice Registered Nurse (APRN)), who is licensed and acting within the scope of his or her license, indicating that the member’s condition will improve significantly in a reasonable, predictable period of time as a result of the prescribed treatment plan.

15.02-4 **Prior Authorization** is the process of obtaining prior approval from the Department as to the medical necessity and eligibility for certain MaineCare services before they are delivered, as set forth herein and in Chapter I, Section 1 of the *MaineCare Benefits Manual* (MBM*)*.

* 1. **ELIGIBILITY FOR SERVICES**

A. Individuals must meet the financial, residency and eligibility criteria as set forth in the *MaineCare Eligibility Manual* in order to be eligible for chiropractic services under this Section. Some members may have restrictions on the type and amount of services they are eligible to receive. It is the responsibility of the primary care provider or prescribing provider (MD, DO, PA, or APRN) who is licensed and acting within the scope of his or her license to verify a member’s eligibility for MaineCare, as described in Chapter I, Section I of the “MBM”, prior to the provision of chiropractic services.

B. If the Centers for Medicare and Medicaid Services (CMS) approves, covered chiropractic services for members of all ages must be medically necessary for the diagnosis and treatment of a spinal condition, as determined in an initial evaluation by the chiropractor or his or her primary care provider or prescribing provider (MD, DO, PA, or APRN). The Department or its authorized agent has the right to perform eligibility determination and/or utilization review to determine if services provided were medically necessary.

C. A member age twenty-one (21) and over must obtain a referral by his or her primary care provider or prescribing provider (MD, DO, PA, or APRN), who is licensed and acting within the scope of his or her license that documents the member's rehabilitation potential. The provider’s documentation of rehabilitation potential must include the reasons used to support this expectation. New rehabilitation potential documentation must be re-authorized per episode of unrelated conditions.

This referral requirement does not apply to members with Medicare coverage or other third party health insurance while meeting a deductible. This referral requirement will also not apply to members with Medicare coverage or other third party health insurance until the coverage for chiropractic services by the other payer has been exhausted.

D. If for any reason a course of treatment is discontinued for a period longer than one (1) year, the primary care provider or prescribing provider (MD, DO, PA, APRN) must re-evaluate the member following the guidelines specified in Section 15.03.

15.04 **COVERED SERVICES**

If CMS approves, the Department shall make payment for covered services that are specifically included in the Department's MBM, Chapter III, Section 15, “Allowances for Chiropractic Services”. Covered services are limited to the following:

1. Evaluation or re-evaluation of spinal conditions to determine the rehabilitative effectiveness of chiropractic manipulation prescribed pursuant to Section 15.03(B).
2. Manual or mechanical manipulation of the spine that is medically necessary to treat spinal conditions.
3. X-ray services that are medically necessary for diagnosis and treatment of spinal conditions.

Medical necessity must be supported and documented in accordance with criteria defined in Section 15.07-3, “Member Records”. The Department reserves the right to request additional information to evaluate medical necessity.

15.05 **NON-COVERED SERVICES**

If CMS approves, MaineCare reimbursement shall cover only x-rays of the spine. X-rays ordered or performed by or for a chiropractor that are not of the spine are Non-Covered services. Any service not described and/or listed in Chapters II and III, Section 15, is considered a non-covered service.

15.06 **LIMITATIONS**

A. Unless otherwise indicated in this Section, reimbursement for chiropractic services for MaineCare members ages twenty-one (21) and over shall be limited to twelve (12) visits per calendar year and based upon medical necessity. For services beyond twelve (12) visits, all eligible MaineCare members twenty-one (21) and over require prior authorization as indicated in Section 15.07-2 (B).

B. Reimbursement and limitations on the number of x-rays will be based upon the criteria of medical necessity and documentation as specified in Section 15.07, Policies and Procedures.

C. When repeat x-ray examinations of the spine for the same condition are required because of technical or professional error in the original x-rays, such repeat x-rays are not a covered service and are not reimbursable by MaineCare.

15.07 **POLICIES AND PROCEDURES**

15.07-1 **Diagnosis**

A. If CMS approves, the chiropractor may use the evaluation and management codes 99201-99215 for the purposes of examining and diagnosing a spinal condition. Treatment of spinal conditions must be billed using the spinal manipulation treatment codes 98940-98942 listed in Chapter III of this policy.

B. The Chiropractor’s recent examination of the member must include, but is not limited to the examinations listed below:

1. Mensuration;

2. Biomechanical Evaluation;

3. Neurological Evaluation;

4. Kinesiological Evaluation; and

5. Orthopedic Evaluation.

C. For the purposes of this requirement, recent shall mean within thirty (30) days prior to the initiation of treatment.

D. MaineCare members who also qualify for Medicare shall meet the diagnostic requirements of the Medicare program.

15.07 **POLICIES AND PROCEDURES (cont.)**

15.07-2 **Treatment Exceeding Twelve (12) Visits per Calendar Year**

1. For all eligible MaineCare members requiring Covered Services herein beyond twelve (12) visits per calendar year, a primary care provider or prescribing provider (MD, DO, PA, or APRN), who is licensed and acting within the scope of his or her license, must provide a referral describing the medical necessity of Covered Services beyond twelve (12) visits per calendar year.
2. The Chiropractor must submit documentation to support the medical necessity of treatment exceeding twelve (12) visits per calendar year. This should include full clinical data, x-rays, progress notes, or other documentation to support the medical necessity for additional Covered Services.
3. In addition to the requirements of subpart (A), for all eligible members age twenty-one (21) and over, Prior Authorization is required before the delivery of any additional Covered Services beyond twelve (12) visits per calendar year.
4. X-ray services do not require Prior Authorization.

15.07-3 **Member Records**

The Department requires a specific record for each member that includes but is not limited to:

A. The member’s name, address, birthdate, and MaineCare I.D. number.

B. The member’s social and medical history, and diagnoses.

C. A personalized plan of service including (at a minimum):

1. Type of chiropractic services needed;

2. How the services can best be delivered, and the provider who will deliver the services;

3. Frequency of services and expected duration of services;

4. Long and short range goals;

5. Plans for coordination with other health service providers for the delivery of services and the transfer of x-rays, if needed; and

15.07 **POLICIES AND PROCEDURES (cont.)**

6. Documentation of x-ray findings or results of the examinations described in 15.007-1 (Diagnosis) supporting the medical necessity of the services to be delivered.

D. An adult member’s Rehabilitation Potential.

E. Progress notes must be maintained and include:

1. The name of the provider, a full description of the condition, and the date of each service provided;

2. Any progress toward the achievement of established long and short-range goals;

3. The signature of the servicing provider for each service; and

4. A full account of any unusual condition or unexpected event, including the date when it was observed.

 The Department requires entries to be made for each service billed. When the services delivered vary from the plan of care, entries in the member’s record must justify the changes.

15.08 **REIMBURSEMENT**

If CMS approves, the payment amount for services rendered shall be the lowest of the following:

1. The amount listed in the "Allowances for Chiropractic Services," Chapter III, Section 15, MBM; or
2. The lowest amount allowed by the Medicare Part B carrier; or
3. The provider's usual and customary charge; or
4. The amount, if any, by which the MaineCare rate of reimbursement for services billed exceeds the amount of the third-party payment as set in Chapter I of the MBM. MaineCare considers a claim paid in full if the third-party payment amount received exceeds the MaineCare rate of reimbursement.
5. Payment for x-ray services rendered medically necessary for diagnosis and treatment of a spinal condition shall be: the lowest of the amounts set forth in 15.08 (A)-(C); OR, the fee-for-service rate is set at seventy (70%) of the lowest level in the 2009 Medicaid fee

15.08 **REIMBURSEMENT (cont.)**

schedule for Maine area “99” for services under this policy, including adjustments for place of service and modifiers.

15.09 **COPAYMENT**

1. A copayment will be charged to each MaineCare member receiving services. The amount of the copayment shall not exceed $2.00 per day for services provided, according to the following schedule:

 **MaineCare Payment for Service Member Copayment**

$10.00 or less $ .50

$10.01 - 25.00 $1.00

$25.01 or more $2.00

B. The member shall be responsible for copayments up to $20.00 per month whether the copayment has been paid or not. After the $20.00 cap has been reached, the member will not be required to make additional copayments and the provider will receive full MaineCare reimbursement for covered services.

C. No provider may deny services to a member for failure to pay a copayment. Providers must rely upon the member’s representation that he or she does not have the resources available to pay the copayment. A member’s inability to pay a copayment does not, however, relieve him/her of liability for the copayment.

D. Providers are responsible for documenting the amount of copayments charged to each member regardless of whether the member has made payment.

15.10 **BILLING INSTRUCTIONS**

A. Providers must bill in accordance with the Department's current Billing Instructions.

B. All services provided on the same day shall be submitted on the same claim form for MaineCare reimbursement.