

907 KAR 3:125. Chiropractic services and reimbursement.

RELATES TO: KRS 312.015, 312.017, 42 C.F.R. 440.230, 441 Subpart B

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560, Pub.L. 109-171

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the provisions relating to chiropractic services for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and the medically needy.

Section 1. Definitions. (1) "Chiropractic service" means the diagnosis and the therapeutic adjustment or manipulation of the subluxations of the articulations of the human spine and its adjacent tissues performed by, and within the scope of licensure of, a licensed chiropractor in accordance with KRS 312.015 and 312.017.

(2) "Chiropractor" is defined in KRS 312.015(3).

(3) "Current procedural terminology code" or "CPT code" means the code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.

(4) "Department" means the Department for Medicaid Services or its designee.

(5) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(6) "Usual and customary charge" means the uniform amount that a medical provider charges to a private-pay patient or third-party payor in the majority of cases for a specific medical procedure or service.

Section 2. Covered Services. (1) A covered chiropractic service shall include the following:

- (a) An evaluation and management service;
- (b) Chiropractic manipulative treatment;
- (c) Diagnostic X-rays;
- (d) Application of a hot or cold pack to one (1) or more areas;
- (e) Application of mechanical traction to one (1) or more areas;
- (f) Application of electrical stimulation to one (1) or more areas; or
- (g) Application of ultrasound to one (1) or more areas.

(2) A chiropractic service shall be covered to the extent that the same service is covered by the department for a physician and with the same reimbursement limits.

(3) A chiropractic service shall be reported using:

- (a) An evaluation and management CPT code;
- (b) A chiropractic manipulative treatment CPT code;
- (c) A diagnostic X-ray CPT code; or
- (d) Physical modality application CPT codes for the following:
 - 1. Application of a hot or cold pack to one (1) or more areas;
 - 2. Application of mechanical traction to one (1) or more areas;
 - 3. Application of electrical stimulation to one (1) or more areas; or
 - 4. Application of ultrasound to one (1) or more areas.

(4) Coverage of chiropractic services shall:

- (a) Be based on medical necessity;

(b) Be limited to twenty-six (26) visits per recipient per twelve (12) month period.

Section 3. Reimbursement for Covered Services. (1) A charge for a chiropractic service submitted to the department for payment shall not exceed the usual and customary charge to a private-pay patient or third-party payor for an identical procedure or service.

(2) For reimbursement of a covered service, a chiropractor shall be paid the lessor of the chiropractor's usual and customary actual billed charge or an amount determined in accordance with the Medicaid Physician Fee Schedule established in 907 KAR 3:010.

Section 4. Conditions for Provider Participation. A participating chiropractor shall:

(1) Be licensed as a chiropractor in Kentucky or in the geographic location in which chiropractic services are provided;

(2) Have an active Medicare provider number; and

(3) Meet the requirements for provider participation in the Kentucky Medicaid Program in accordance with 907 KAR 1:671, 907 KAR 1:672, and 907 KAR 1:673.

Section 5. Appeal Rights. (1) An appeal of a negative action taken by the department regarding a Medicaid recipient shall be in accordance with 907 KAR 1:563.

(2) An appeal of a negative action taken by the department regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) An appeal of a negative action taken by the department regarding a Medicaid provider shall be in accordance with 907 KAR 1:671. (27 Ky.R. 2015; 2487; eff. 3-6-2001; 33 Ky.R. 624; 1409; 1588; eff. 1-5-2007; Crt eff. 7-23-2018.)