NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

June 29, 2020
10:00 A.M. Central Time
Nebraska State Office Building – Lower Level A
301 Centennial Mall South, Lincoln, Nebraska
Phone call information: 877-399-0501; Participant code: 3213662#

The purpose of this hearing is to receive comments on proposed changes to Title 471, Chapter 5 of the Nebraska Administrative Code (NAC) – *Chiropractic Services.* These regulations govern chiropractic services provided by enrolled providers to eligible clients under Nebraska's Medicaid program. The proposed changes: remove the specific number of annual visits; require chiropractic services to be subject to medical necessity; include new coverage guidelines to be more consistent with the licensure and scope of practice for chiropractors; and increase the scope of what can be billed by a chiropractor. Additionally, the Department removed duplicate statutory and inconsistent language in the regulations, restructured the regulatory chapter, and ensured compliance with the State Plan, other NAC chapters, federal law, and best practices.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7).

Due to the current public health crisis, the agency will enforce any Directed Health Measure Order on the size of gatherings that is in effect at the time of the hearing. In order to encourage participation in this public hearing, a phone conference line will be set up for any member of the public to call in and provide oral comments.

Interested persons may provide verbal comments by participating via phone conference line by calling 877-399-0501; Participant code: 3213662#.

Interested persons may provide written comments by mail, fax, or email, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 or dhhs.regulations@nebraska.gov, respectively.

A copy of the proposed changes is available online at http://www.sos.ne.gov, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

# FISCAL IMPACT STATEMENT

| | |
|---|---|
| Agency: **Department of Health and Human Services** | |
| Title: 471 | Prepared by: Dawn Kastens |
| Chapter: 5 | Date prepared: 10/29/19 |
| Subject: Chiropractic Services | Telephone: 402.471.9530 |

Type of Fiscal Impact:

| | State Agency | Political Sub. | Regulated Public |
|---|---|---|---|
| No Fiscal Impact | ( ☐ ) | ( ☒ ) | ( ☒ ) |
| Increased Costs | ( ☒ ) | ( ☐ ) | ( ☐ ) |
| Decreased Costs | ( ☐ ) | ( ☐ ) | ( ☐ ) |
| Increased Revenue | ( ☐ ) | ( ☐ ) | ( ☐ ) |
| Decreased Revenue | ( ☐ ) | ( ☐ ) | ( ☐ ) |
| Indeterminable | ( ☐ ) | ( ☐ ) | ( ☐ ) |

Provide an Estimated Cost & Description of Impact:

MLTC has been working with providers to address a request to remove the annual limit of 12 on adult chiropractic services, as well as increasing the scope of what a chiropractor can bill for, to be more consistent with their licensure scope of practice. This should result in all adult services being subject to medical necessity. This should also result in higher continuity of care for patients and an improved provider experience.

The total annual cost for capitation payments to be paid in rates to MCOs for covering beneficiary services and managing the benefit are as follows:

| Chiropractic Services | Total Fund Annual Cost Estimate |
|---|---|
| E&M codes | $1,450,000 |
| New therapy codes | $1,200,000 |
| 12 visit limit change | $500,000 |
| Total | $3,150,000 |

Due to the timing of the implementation of the changes, January 1, 2020, we anticipate the following impacts:

| FFY | Federal Fund | State Fund | Total Fund |
|---|---|---|---|
| 2020 | $ 1,301,378 | $ 1,076,872 | $ 2,378,250 |
| 2021 | $ 1,815,666 | $ 1,397,334 | $ 3,213,000 |

State Agency:  See above

Political Subdivision: n/a

Regulated Public:  n/a

If indeterminable, explain why:

TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 5 CHIROPRACTIC SERVICES

001. SCOPE AND AUTHORITY. These regulations govern services provided under the Medical Assistance Act, Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq.

002. PROVIDER REQUIREMENTS.

002.01 GENERAL PROVIDER REQUIREMENTS. Providers of chiropractic services must comply with all applicable provider participation requirements codified in 471 Nebraska Administrative Code (NAC) 2 and 3. In the event that provider participation requirements in 471 NAC 2 or 3 conflict with requirements outlined in this chapter, the individual provider participation requirements in this chapter will govern.

002.02 SERVICE SPECIFIC PROVIDER REQUIREMENTS. If chiropractic services are provided outside of Nebraska, the chiropractor must be licensed in the state in which the services are provided.

003. SERVICE REQUIREMENTS.

003.01 GENERAL REQUIREMENTS.

003.01(A) MEDICAL NECESSITY. Medicaid incorporates the definition of medical necessity from 471 NAC 1 as is fully rewritten herein. Services and supplies that do not meet the 471 NAC 1 definition of medical necessity are not covered.

003.01(B) SERVICES PROVIDED FOR CLIENTS ENROLLED IN NEBRASKA MEDICAID MANAGED CARE. See 471 NAC 1.

003.01(C) HEALTH CHECK SERVICES. See 471 NAC 33.

003.02 COVERED SERVICES. Medicaid limits coverage of chiropractic services to:

(i) Certain spinal x-rays;
(ii) Manual manipulation of the spine;
(iii) Certain evaluation and management services;
(iv) Traction;
(v) Electrical stimulation;
(vi) Ultrasound; and

(vii) Certain therapeutic procedures, activities, and techniques designed and implemented to improve, develop, or maintain the function of the area treated.

003.02(A) CHIROPRACTIC TREATMENT. Covered services are only for the treatment of spinal subluxations for which treatment provides a direct therapeutic benefit, and is subject to the following limitations:

(i) For clients age 21 and older, chiropractic treatment is limited to those treatments deemed medically necessary;
(ii) For clients age 20 and younger, chiropractic treatment is limited to those treatments deemed medically necessary; and
(iii) No more than one treatment per client per day is covered.

003.02(B) SPINAL X-RAYS. Coverage of spinal x-rays is limited to one anteroposterior and one lateral view of the entire spine or one each of the following: thoracic, cervical, and lumbosacral for a client in a 12 month period. For spinal x-rays to be covered under Medicaid, at least one of the following criteria must be met:

(i) Recent acute or violent trauma where there may be a question concerning avulsion, fracture, or subluxation;
(ii) Chronic or long-standing ailments that have been treated by other practitioners without success and, if x-rays were already taken, they are not available;
(iii) When there is a pathology or malignancy previously diagnosed, precautionary x-rays are covered when medically necessary;
(iv) If there is any indication of existing pathology in the evaluation of the client, the treatment of which may cause additional discomfort;
(v) If the client has been under long-term treatment with no alleviation of symptoms; or
(vi) When specifically required by the Department's utilization review and for documentation of diagnosis and claims for services.

003.03 NON-COVERED SERVICES. Except for those services previously specified, Medicaid does not cover any other diagnostic or therapeutic service or supply provided by a chiropractor.

004. BILLING AND PAYMENT FOR CHIROPRACTIC SERVICES.

004.01 BILLING.

004.01(A) GENERAL BILLING REQUIREMENTS. Providers must comply with all applicable billing requirements codified in 471 NAC 3. In the event that individual billing requirements in 471 NAC 3 conflict with billing requirements outlined in this chapter, the individual billing requirements in this chapter will govern.

004.01(B) SPECIFIC BILLING REQUIREMENTS.

004.01(B)(i) BILLING INSTRUCTIONS. The provider must bill Medicaid, using the appropriate claim form or electronic format.

004.01(B)(ii) USUAL AND CUSTOMARY CHARGE. The provider, or the provider's authorized agent, must submit the provider's usual and customary charge for each procedure code listed on the claim. Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule.

004.01(B)(iii) CHIROPRACTIC TREATMENT. The chiropractor must list the following information on the claim when billing Medicaid:

(1) The diagnosis which includes the level of subluxation;
(2) The symptom(s) that directly relates to the diagnosis of subluxation; and
(3) The initial date of treatment billed to Medicaid for the reported diagnosis.

004.02 PAYMENT.

004.02(A) GENERAL PAYMENT REQUIREMENTS. Medicaid will reimburse the provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC 3. In the event that individual payment regulations in 471 NAC 3 conflict with payment regulations outlined in this chapter, the individual payment regulations in this chapter will govern.

004.02(B) SPECIFIC PAYMENT REQUIREMENTS.

004.02(B)(i) REIMBURSEMENT. Medicaid pays for covered chiropractic services in the amount equal to the lesser of:

(1) The provider's submitted charge; and
(2) The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for the date of service.

# CHAPTER 5-000 CHIROPRACTIC SERVICES

## 5-001 Definitions

Initial Visit: History, examination, and manual manipulation for a client who has not received services from the chiropractor within the past three years.

## 5-002 Provider Requirements

5-002.01 General Provider Requirements: To participate in the Nebraska Medical Assistance Program (Medicaid), providers of chiropractic services shall comply with all applicable participation requirements codified in 471 NAC Chapters 2 and 3. In the event that provider participation requirements in 471 NAC Chapters 2 or 3 conflict with requirements outlined in this 471 NAC Chapter 5, the individual provider participation requirements in 471 NAC Chapter 5 shall govern. Remains in section 002 as modified.

5-002.02 Service Specific Provider Requirements: Chiropractors must be licensed by the Nebraska Department of Health and Human Services, and be eligible to participate in Medicare. If chiropractic services are provided outside of Nebraska, the chiropractor must be licensed in that state. Remains in section 002 as modified.

5-002.02A Provider Agreement: Chiropractors shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit the completed form to the Department for approval to participate in Medicaid.

## 5-003 Service Requirements

### 5-003.01 General Requirements

5-003.01A Medical Necessity: Treatment that is reasonable and necessary. Documentation of a reasonable expectation of recovery or improvement from ongoing chiropractic treatment is required. Remains in section 003 as modified.

5-003.01B Services Provided for Clients Enrolled in the Nebraska Medicaid Managed Care Program: See 471 NAC 1 002.01. Remains in section 003 as modified.

5-003.01C HEALTH CHECK (EPSDT) Treatment Services: See 471 NAC Chapter 33. Remains in section 003 as modified.

5-003.02 Covered Services: Medicaid limits coverage of chiropractic services to treatment of the spine by manual manipulation and certain spinal x-rays (see 471 NAC 5-003.02B). Remains in section 003 as modified.

5-003.02A Manual Manipulation: Manual manipulation of the spine is covered only for the treatment of spinal subluxations for which treatment provides a direct therapeutic benefit.

(i) For clients age 21 and older: Manual manipulation of the spine is limited to a maximum of 12 treatments per calendar year.

(ii) For clients age 20 and younger: Manual manipulation of the spine is limited to a maximum of 18 treatments in the initial 5 months from the date of the first visit for the reported diagnosis. After the 5th month a maximum of one treatment per month is covered until the age of 21.

(iii) No more than one treatment per client per day is covered. Remains in section 003 as modified.

5-003.02B Spinal X-Rays: Coverage of spinal x-rays is limited to one anteroposterior and one lateral view of the entire spine or each of the following: thoracic, cervical, and lumbosacral for a client in a 12 month period.

For spinal x-rays to be covered under Medicaid, at least one of the following criteria must be met:

1. Recent acute or violent trauma where there may be a question concerning avulsion, fracture, or subluxation;
2. Chronic or long-standing ailments that have been treated by other practitioners without success and, if x-rays were already taken, they are not available;
3. When there is a pathology or malignancy previously diagnosed, precautionary x-rays are covered when medically necessary;
4. If there is any indication of existing pathology in the evaluation of the client, the treatment of which may cause additional discomfort;
5. If the client has been under long-term treatment with no alleviation of symptoms; or
6. When specifically required by the Department's utilization review and for documentation of diagnosis and claims for services. Remains in section 003 as modified.

5-003.03 Non-Covered Services: Except for treatment of the spine by manual manipulation and spinal x-rays, Medicaid does not cover any other diagnostic or therapeutic service or supply provided by a chiropractor or on his/her order including, but not limited to:

1. Laboratory tests;
2. Orthopedic devices;
3. Physiotherapy (i.e., ultrasound, diathermy, etc.);
4. Nutritional supplements;
5. EKGs; and
6. Acupuncture. Remains in section 003 as modified.

## 5-004 Billing and Payment for Chiropractic Services

### 5-004.01 Billing

5-004.01A General Billing Requirements: Providers shall comply with all applicable billing requirements codified in 471 NAC Chapter 3. In the event that billing requirements in 471 NAC Chapter 3 conflict with billing requirements outlined in 471 NAC Chapter 5, the billing requirements in 471 NAC Chapter 5 shall govern. Remains in section 004 as modified.

#### 5-004.01B Specific Billing Requirements

5-004.01B1 Billing Instructions: The provider shall bill Medicaid, using the appropriate claim form or electronic format (see Claim Submission Table at Appendix 471-000-49), in accordance with the billing instructions included in Appendix 471-000-54. Remains in section 004 as modified.

5-004.01B2 Usual and Customary Charge: The provider, or the provider's authorized agent, shall submit the provider's usual and customary charge for each procedure code listed on the claim. HCPCS/CPT procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-505). Remains in section 004 as modified.

5-004.01B3 Manual Manipulation: The chiropractor shall list the following information on the claim when billing Medicaid:

(1) The diagnosis which includes the level of subluxation;
(2) The symptom(s) that directly relates to the diagnosis (subluxation); and
(3) The initial date of treatment billed to Medicaid for the reported diagnosis.

Remains in section 004 as modified.

### 5-004.02 Payment

5-004.02A General Payment Requirements: Nebraska Medicaid will reimburse the Provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC Chapter 3. In the event that payment regulations in 471 NAC Chapter 3 conflict with payment regulations outlined in this 471 NAC Chapter 5, the payment regulations in 471 NAC Chapter 5 shall govern. Remains in section 004 as modified.

#### 5-004.02B Specific Payment Requirements

5-004.02B1 Reimbursement: Medicaid pays for covered chiropractic services in amount equal to the lesser of:

a. The provider's submitted charge; and
b. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for the date of service.

Remains in section 004 as modified.

5-004.02B2 Medicare/Medicaid Crossover Claims: For payment of Medicare/Medicaid crossover claims, see Appendix 471-000-70.

5-004.02B3 Copayment: For Medicaid copayment requirements, see 471 NAC 3-008.