DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

PROPOSED

PUBLIC NOTICE

Chiropractic Services

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code), 42 CFR §447.205, and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to amend Title XIX Medicaid State Plan and the DMMA Provider Policy Specific Manual regarding chiropractic services, specifically, to remove annual numerical limitations placed on chiropractic care visits for the purpose of treating back pain.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to, Planning, Policy and Quality Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906, by email to Nicole.M.Cunningham@state.de.us, or by fax to 302-255-4413 by 4:30 p.m. on January 31, 2019. Please identify in the subject line: Chiropractic Services.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSAL

The purpose of this notice is to advise the public that Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) is proposing to amend Title XIX Medicaid State Plan and the DMMA Provider Policy Specific Manual regarding chiropractic services, specifically, *to remove annual numerical limitations placed on chiropractic care visits for the purpose of treating back pain*.

Statutory Authority

- Senate Bill 225

Background

Senate Bill 225, an Act to Amend Title 16, Title 24, Title 29, and Title 31 of the Delaware Code Relating to Insurance Coverage for the Treatment of Back Pain, was enacted by the General Assembly of the State of Delaware, and signed into law on September 10, 2018, with an effective date of March 9, 2019. This Act encourages prescribers and patients to use proven non-opioid methods of treating back pain by prohibiting numerical limits on physical therapy and chiropractic care, which might deter prescribers or patients from using those treatments rather than opioids. As a result, DMMA is proposing to amend policy by removing annual limits associated with chiropractic treatment services.

Summary of Proposal

Purpose

The purpose of this proposed regulation is to remove annual numerical limitations placed on chiropractic care visits for the purpose of treating back pain.

Summary of Proposed Changes

Effective for services provided on and after January 11, 2019 Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DHSS/DMMA) proposes to amend Attachment 3.1-A Page 3 Addendum of Title XIX Medicaid State Plan and the Practitioner Provider Specific Manual, of the DMMA Provider Policy Specific Manuals sections 13.2.2 - 13.2.3.2 regarding chiropractic services.

Public Notice

In accordance with the *federal* public notice requirements established at Section 1902(a)(13)(A) of the Social Security Act and 42 CFR 447.205 and the state public notice requirements of Title 29, Chapter 101 of the Delaware Code, Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) gives public notice and provides an open comment period for thirty (30) days to allow all stakeholders an opportunity to provide input on the proposed regulation. Comments must be received by 4:30 p.m. on January 31, 2019.

Centers for Medicare and Medicaid Services Review and Approval

The provisions of this state plan amendment (SPA) are subject to approval by the Centers for Medicare and Medicaid Services (CMS). The draft SPA page(s) may undergo further revisions before and after submittal to CMS based upon public comment and/or CMS feedback. The final version may be subject to significant change.

Provider Manuals and Communications Update

Also, there may be additional provider manuals that may require updates as a result of these changes. The applicable Delaware Medical Assistance Program (DMAP) Provider Policy Specific Manuals and/or Delaware Medical Assistance Portal will be updated. Manual updates, revised pages or additions to the provider manual are issued, as required, for new policy, policy clarification, and/or revisions to the DMAP program. Provider billing guidelines or instructions to incorporate any new requirement may also be issued. A newsletter system is utilized to distribute new or revised manual material and to provide any other pertinent information regarding DMAP updates. DMAP updates are available on the Delaware Medical Assistance Portal website: https://medicaid.dhss.delaware.gov/provider

Fiscal Impact

The following fiscal impact is projected:

	Federal Fiscal Year 2019	Federal Fiscal Year 2020
General (State) Funds	212,250	215,968
Federal Funds	287,750	296,533

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: **DELAWARE**

LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

6. Medical Care and other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law (continued).

6.b. Optometrists' Services

These services are reimbursed:

1. For Medicaid-eligible Individuals under age 21, as an EPSDT service (routine eye exams including refraction and provision of eyeglasses); or
2. For Medicaid-eligible individuals over age 21, medically necessary diagnostic and treatment services provided under the scope of optometric practice in State law for symptomatic Medicaid recipients (i.e. disease, injury, illness, or other medical disorder of the eyes), excluding routine eye exams or refractions related to the provision of eyeglasses and excluding coverage of eyeglasses.

6.c. Chiropractors' Services

Chiropractic services are furnished in accordance with 42 CFR 440.60(b) and include only services that are provided by a chiropractor who is licensed by the State, and consists of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform. Services may be subject to prior authorization and/or medical review, and include:

1. Evaluation and management services;
2. Diagnostic x-rays; and
3. Chiropractic manipulative treatment.

~~Services are provided as follows:~~

~~1. For Medicaid-eligible Individuals under age 21, as an EPSDT service, per 42 CFR §441 Subpart B, furnished upon medical necessity; or~~
~~2. For Medicaid-eligible individuals over age 21, furnished upon medical necessity and following the service utilization criteria below:~~
   ~~a. One (1) office visit per year;~~
   ~~b. One (1) set of X-rays per year, and~~
   ~~c. Twenty (20) manipulations per year.~~

Provider Qualifications: Qualified chiropractors must be licensed per Delaware licensure requirements codified in Chapter 7, Title 24 of the Delaware Administrative Code, Professions and Occupations.

6.d. Other Practitioners' Services

1. Licensed Midwife services are services permitted under scope of practice authorized by state law for the licensed midwife.
2. Licensed Behavioral Health Practitioner: A licensed behavioral health practitioner (LBHP) is a professional who is licensed in the State of Delaware to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license. A LBHP includes professionals licensed to practice independently:
   - Licensed Psychologists
   - Licensed Clinical Social Workers (LCSWs)
   - Licensed Professional Counselors of Mental Health (LPCMHs)
   - Licensed Marriage and Family Therapists (LMFTs)

TN No. SPA #	Approval Date _____
Supersedes TN No. SPA #17-001	Effective Date March 11, 2019

13.0 Specific Criteria for Chiropractic Services

13.1 Member Eligibility

13.1.1 Providers must verify member eligibility by logging into the Delaware Medical Assistance Portal for Providers at https://Medicaid.dhss.delaware.gov/ or by using the Voice Response System (VRS) by calling 1-800-999-3371.

13.1.2 The DMAP will not cover eligible members for chiropractic services prior to October 1, 2014.

13.1.3 Effective January 1, 2018 chiropractic services was added as a Managed Care Organization (MCO) covered benefit.

13.2 Covered Services

13.2.1 Covered Services & Limitations

13.2.2 ~~"Manual" manipulation of spine for treatment of spinal subluxation-one manipulation per member per day and a maximum of twenty (20) manipulations during a rolling twelve month period.~~

Chiropractic services are furnished in accordance with 42 CFR 440.60(b) and include only services that are provided by a chiropractor who is licensed by the State, and consists of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform.

13.2.2.1 Manipulation associated with the treatment of neck, back, and pelvic/sacral pain.

13.2.3 Necessity for Treatment

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine as demonstrated by x-ray or back pain necessitating treatment as demonstrated by physical examination, as described below.

13.2.3.1 ~~X-ray of complete spine only to document medical necessity for spinal subluxation; the x-ray must be taken within twelve (12) months of the date of service~~

X-ray may be used to diagnose spinal subluxation. If x-ray is used for this purpose, it must have been taken reasonably close to (within 12 months prior or 3 months following) the beginning of treatment. Coverage of spinal x-rays is limited to one set of spinal x-rays for a member in a rolling twelve-month period.

Additional X-rays may be taken within the same calendar year in order to document a new condition or an exacerbation/re-injury.

X-rays used to determine progress are limited to one study per calendar year. Progress X-ray studies, beyond the first in a calendar year, may be pre-authorized.

13.2.3.2 Physical exam to document spinal subluxation, back pain, or to determine progress; ~~once in a rolling twelve-month period;~~ evaluation must be demonstrated by meeting two of the following four criteria, one of which must be "13.2.3.4" below;

13.2.3.3 Pain/tenderness evaluated in terms of location, quality and intensity;

13.2.3.4 Asymmetry/misalignment identified on a sectional or segmental level;

13.2.3.5 Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility);

13.2.3.6 Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

13.3 Non-Covered Services

13.3.1 Non-covered chiropractic services include the following:

- Acupuncture;
- Vitamins;
- Minerals;
- Supplements;
- Or any other chiropractic service not defined in this benefit.
- Chiropractic maintenance therapy is not considered to be medically necessary and is not covered.
- Orthopedic devices prescribed by chiropractor.
- Physiotherapy modalities including diathermy and ultrasound provided by chiropractor.
- Treatment for any condition not related to a diagnosis of subluxation or ~~low~~ back pain.
- X-rays other than those needed to support a diagnosis of subluxation.
- Any services outside of scope of state licensure.
- Room and Ward fees are not covered.
- Hand-held and other devices may be used in treatment but are not eligible to be reimbursed.

22 DE Reg. 566 (01/01/19) (Prop.)