

Table of Contents

1.0	Description of the Procedure, Product, or Service.....	1
1.1	Definitions	1
1.1.1	Manipulation.....	1
1.1.2	Motion Segment.....	1
1.1.3	Subluxation.....	1
2.0	Eligible Beneficiaries.....	1
2.1	General Provisions.....	1
2.2	Medicaid for Pregnant Women.....	1
2.3	Special Provisions.....	1
2.3.1	EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age	1
3.0	When the Procedure, Product, or Service Is Covered.....	3
3.1	General Criteria Covered	3
3.2	Specific Criteria Covered.....	3
3.3	Subluxation.....	3
4.0	When the Procedure, Product, or Service Is Not Covered.....	3
4.1	General Criteria Not Covered	3
4.2	Specific Criteria Not Covered.....	4
4.3	Spinal Manipulation.....	5
5.0	Requirements for and Limitations on Coverage	5
5.1	Prior Approval for Beneficiaries with Medicaid for Pregnant Women Benefits.....	5
5.2	Treatment Plans	5
5.2.1	Continued Treatment	5
5.3	X-Rays	6
6.0	Provider(s) Eligible to Bill for the Procedure, Product, or Service	6
7.0	Additional Requirements	6
7.1	Compliance	6
8.0	Policy Implementation/Revision Information.....	7
Attachment A:	Claims-Related Information	8
A.	Claim Type	8
B.	International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10- CM) and Procedural Coding System (PCS).....	8
C.	Code(s).....	9
D.	Modifiers.....	9
E.	Billing Units.....	9
F.	Place of Service	9
G.	Co-payments	10
H.	Reimbursement	10

1.0 Description of the Procedure, Product, or Service

Chiropractic is defined to be the science of adjusting the cause of disease by realigning the spine, releasing pressure on nerves radiating from the spine to all parts of the body, and allowing the nerves to carry their full quota of health current (nerve energy) from the brain to all parts of the body. (G.S. 90-143)

1.1 Definitions

1.1.1 Manipulation

A manual procedure that involves a directed thrust to move a joint past the physiological range of motion, without exceeding the anatomical limit.

1.1.2 Motion Segment

A functional unit made up of the two adjacent articulating surfaces and the connecting tissues binding them to each other.

1.1.3 Subluxation

For the purpose of Medicaid claims, subluxation is defined as a motion segment in which alignment, movement integrity, and/or physiological function are altered although contact between joint surfaces remains intact.

2.0 Eligible Beneficiaries

2.1 General Provisions

Medicaid beneficiaries may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Medicaid for Pregnant Women

Pregnant women with Medicaid for Pregnant Women (MPW) benefits (pink MID card) are eligible for chiropractic services if the service is required for a pregnancy-related condition. Chiropractic services for these beneficiaries must be prior approved (see Section 5.1).

2.3 Special Provisions

2.3.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.3.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

Chiropractic services are limited to manual manipulation (use of hands) of the spine to correct a subluxation that has resulted in a musculoskeletal condition for which manipulation is appropriate [42 CFR 440.60(b); 10A NCAC 220.0106]. The service must relate to the diagnosis and treatment of a significant health problem in the form of a musculoskeletal condition necessitating manual manipulation.

Note: With the exception of X-rays (refer to **Section 5.3**), no other diagnostic or therapeutic service furnished by a chiropractor or under his or her order is a covered service.

3.3 Subluxation

Subluxation must be confirmed by physical examination and/or by one set of X-rays taken within 6 months of the initial date of service. To demonstrate a subluxation by physical examination, one or both of the following conditions must be documented:

- a. Asymmetry or misalignment on a segmental or sectional level, **or**
- b. Range of motion abnormality must be demonstrated.

If only one of these two conditions listed above is present, one of the following conditions must also be present:

- a. Pain and/or tenderness evaluated in terms of location, quality, and intensity
- b. Tissue or tone changes in the characteristics of contiguous or associated soft tissue including skin, fascia, muscle, and ligament.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.3.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;

- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

Chiropractic services are not covered in any of the following conditions:

- a. Maintenance programs, active corrective care, or supportive care, preventive care, or wellness care are not covered services:
 - 1. Maintenance programs, active corrective care and supportive care are therapies that are performed to treat a chronic, stable condition or to prevent deterioration. Once the maximum therapeutic benefit has been reached, chiropractic care is no longer considered necessary; therefore, maintenance and supportive care are not covered services.
 - 2. Active corrective care as ongoing treatment rendered after the patient has become symptomatically and objectively stable, to prevent a recurrence of the patient's condition, is not covered.
 - 3. Preventive care or wellness services such as nutritional supplements, hygienic modalities, environmental modalities, rehabilitation and physiotherapeutic modalities, massage therapy, counseling, patient education, home exercises, and ergonomic postural modification. Any program or treatment plan that is developed to prevent disease, promote health, prolong life, or enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a chronic condition, is not a covered service.
- b. Diagnostic procedures and tests, including but not limited to the following, are not covered when furnished or ordered by a chiropractor:
 - 1. Laboratory tests
 - 2. X-rays, with the exception of the CPT X-ray procedure codes listed in **Attachment A**
 - 3. Videofluoroscopy
 - 4. ECGs
- c. The following therapeutic modalities are not covered services when performed by a chiropractor:
 - 1. Physical and/or occupational therapy
Note: Chiropractors may not seek reimbursement for physical or occupational therapy services performed under the supervision of a medical/osteopathic physician or as an attending provider when the billing provider is a medical or osteopathic physician. (Refer to Clinical Coverage Policy #10A, *Outpatient Specialized Therapies*, on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>.)
 - 2. Traction (axial or longitudinal)
 - 3. Injections
 - 4. Acupuncture
 - 5. Mechanical or electrical equipment used for manipulations or other treatment modalities: mechanical or electrical equipment used for therapeutic manipulations or other treatment modalities that are not clearly related to

symptoms and/or diagnostic X-rays, or that are not likely to result in long-term improvement of a beneficiary's symptoms or conditions, or that do not have a clearly defined and achievable end point

- d. Nutritional supplements are not a covered service.

4.3 Spinal Manipulation

Spinal manipulation, also called manual manipulation of the spine, is not considered necessary for the following musculoskeletal conditions, including but not limited to

- a. Rheumatoid arthritis
- b. Muscular dystrophy
- c. Multiple sclerosis
- d. Idiopathic scoliosis or treatment of the curve progression in late adolescence or adulthood, unless there is another indication for chiropractic manipulation.

Spinal manipulation is not covered for non-musculoskeletal conditions, including but not limited to

- a. Pneumonia
- b. Emphysema
- c. Sinus problems
- d. Suppurative otitis media
- e. Infectious diseases
- f. As a substitute for childhood immunizations

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.3.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval for Beneficiaries with Medicaid for Pregnant Women Benefits

Prior approval is required for chiropractic services for beneficiaries with Medicaid for Pregnant Women (MPW) benefits. Prior approval must be obtained before a chiropractic service is rendered. A referral from the obstetrical provider must be submitted with the request for prior approval.

Refer to NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html> for additional information on prior approval.

5.2 Treatment Plans

A clear and appropriate treatment plan must document the symptoms or diagnosis treated, diagnostic procedures and treatment modalities used, results of diagnostic procedures and treatments, and anticipated length of treatments.

5.2.1 Continued Treatment

- a. If no improvement is documented within the initial two weeks of chiropractic care, the treatment plan must be modified and documented in the beneficiary's medical record.

- b. If no improvement is documented after 30 days of modified chiropractic treatment, no additional treatment will be covered.
- c. Once the maximum therapeutic benefit has been achieved, further chiropractic care is not covered.
- d. A copy of the treatment plan must be maintained in the beneficiary's chiropractic record.

5.3 X-Rays

Medicaid covers X-rays as part of the documentation associated with the definition of the musculoskeletal condition for which manual manipulation of the spine is appropriate.

- a. Medicaid covers one set of X-rays taken within six months of the date of service.
- b. X-rays must be kept on file in the beneficiary's records for a period of 5 years.

Note: These records are subject to post-payment review.

Refer to **Attachment A** for the list of X-ray procedure codes that are covered.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

Note: Refer to Subsection 2.3.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 1996

Revision Information:

Date	Section Updated	Change
11/1/07	Section 3.3	Revised requirement to document necessity by X-ray to include physical examination
11/1/07	Attachment A, Item F	Corrected place of service
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

ICD-10-CM Code(s)			
Primary ICD-10-CD Code(s)			
M99.00	M99.02	M99.04	
M99.01	M99.03	M99.05	

ICD-10-CM Code(s)			
Secondary ICD-10-CD Code(s)			
G24.3	G43.701	G43.909	S13.180S
G43.001	G43.709	G43.911	S23.100S
G43.009	G43.711	G43.919	S23.110S
G43.011	G43.719	G44.209	S23.120S
G43.019	G43.A0	G54.1	S23.122S
G43.101	G43.A1	G54.2	S23.130S
G43.109	G43.B0	G54.3	S23.132S
G43.111	G43.B1	G54.4	S23.140S
G43.119	G43.C0	G54.5	S23.142S
G43.401	G43.C1	G54.6	S23.150S
G43.409	G43.D0	G54.7	S23.152S
G43.411	G43.D1	G54.8	S23.160S
G43.419	G43.801	G54.9	S23.162S
G43.501	G43.809	S13.100S	S23.170S
G43.509	G43.811	S13.110S	S33.100S
G43.511	G43.819	S13.120S	S33.110S
G43.519	G43.821	S13.130S	S33.120S
G43.601	G43.829	S13.140S	S33.130S
G43.609	G43.831	S13.150S	S33.140S
G43.611	G43.839	S13.160S	
G43.619	G43.901	S13.170S	

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

CPT Code(s)		
Chiropractic Services		
98940	98941	98942

CPT Code(s)		
X-rays		
Chiropractors may use the following CPT X-ray codes to document the musculoskeletal condition for which manual manipulation of the spine is appropriate.		
72010	72070	72114
72020	72072	72120
72040	72074	72170
72050	72080	72190
72052	72100	72200
72069	72110	72202
		72220

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Manipulation of the spine may be billed only once per date of service.

F. Place of Service

Office

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <http://www.ncdhhs.gov/dma/plan/sp.pdf>.

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <http://www.ncdhhs.gov/dma/fee/>