Clinical Policy: Chiropractic Services

Reference Number: WNC.CP.275
Last Review Date: 11/22

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Note: When state Medicaid coverage provisions are less restrictive than the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

Chiropractic is 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)

Policy/Criteria[1]

I. It is the policy of **WellCare of North Carolina®** shall cover chiropractic manipulative treatment (CMT) services when health records substantiate that a beneficiary has met **ALL** the following criteria.

A. Member has a neuromusculoskeletal disorder; and
B. The medical necessity for treatment is clearly documented; and
C. Continued improvements based on current /CMT services are documented
D. Children ages 12 years and older are eligible for Chiropractic
E. WellCare of North Carolina covers unlimited chiropractic services as a value-added service, if medical necessity criteria in this policy are met, ONLY for members ages 21 and older.

Service Description	Documentation Requirement
Chiropractic manipulative treatment (CMT) involving one to two spinal regions	Medical record must document: 1. A complaint involving at least one spinal region; **and** 2. an examination of the corresponding spinal region(s); **and** 3. a diagnosis and manipulative treatment of a condition involving at least one spinal region.
Chiropractic manipulative treatment (CMT) involving one to three to four spinal regions	Medical record must document: 1. A complaint involving at least three spinal regions; **and** 2. an examination of the corresponding spinal region(s); **and** 3. a diagnosis and manipulative treatment of a condition involving at least three spinal regions.
Chiropractic manipulative treatment (CMT) involving one to five spinal regions	Medical record must document: 1. A complaint involving at least five spinal regions; **and** 2. an examination of the corresponding spinal region(s); **and**

	3. a diagnosis and manipulative treatment of a condition involving at least five spinal regions.

II. Chiropractic manipulative treatment (CMT) is covered when it is a component of a comprehensive, multi-modal treatment plan **AND** when symptoms significantly impact ability to perform job or activities of daily living.

A. A clear and appropriate treatment plan must document all of the following:
   1. the symptoms or diagnosis treated;
   2. diagnostic procedures and treatment modalities used;
   3. results of diagnostic procedures and treatments; and
   4. anticipated length of treatments.

B. Examples of covered conditions for CMT include:
   1. Back pain when ALL of the following are present:
      a. Absence of signs and symptoms that may be associated with serious neurologic conditions (e.g., bilateral leg weakness, bowel/bladder dysfunction, perineal anesthesia)
      b. Clinical situation is appropriate for spinal manipulation therapy, as indicated by 1 or more of the following:
         i. Acute or subacute low back pain (i.e., lasting 12 weeks or less)
         ii. Chronic low back pain (i.e., lasting more than 12 weeks) and recent worsening of symptoms in patient with previous chronic or stable condition
   2. Coccyx pain (coccydynia) and ALL of the following:
      a. Age 18 years and older
      b. Duration less than 1 year
      c. Stress x-rays show stable coccyx.
      d. Traumatic mechanism of injury
   3. Neck pain, when ALL of the following are present:
      a. Absence of signs and symptoms of cord compression or serious neurologic pathology (i.e., bowel/bladder dysfunction, gait disturbance, lower or upper extremity fine motor coordination difficulties, lower extremity weakness)
      b. Absence of signs and symptoms of impending vertebrobasilar artery stroke
      c. Absence of signs and symptoms of transient ischemic attack

III. Chiropractic Manipulative Therapy is **contraindicated** if any of the following are present:

A. evidence of acute fracture, dislocation, or ligament rupture
B. evidence of acute infection
C. evidence of multiple myeloma
D. evidence of psoriatic arthritis or rheumatoid arthritis
E. evidence of severe osteoporosis
F. evidence of tumor

IV. Discharge Criteria

A. If continued improvement is not documented during the initial 30 days of treatment, additional chiropractic treatment is considered not medically necessary unless the chiropractic treatment is modified.
B. If no improvement is documented within 30 days of modification of chiropractic treatment, continued chiropractic treatment is considered not medically necessary.
C. Once the maximum therapeutic benefit has been achieved, continuing chiropractic care is considered not medically necessary.
D. Chiropractic manipulation in asymptomatic persons or in persons without an identifiable clinical condition is considered not medically necessary.
E. Chiropractic care in persons, whose condition is neither regressing nor improving, is considered not medically necessary.

V. WellCare of North Carolina® **shall not** cover the following:

A. Non-musculoskeletal disorders, including but not limited to:
   1. Respiratory conditions (e.g., asthma, pneumonia, emphysema)
   2. Internal organs (e.g., intestinal)
   3. Neurological (e.g., headaches, multiple sclerosis, epilepsy)
   4. Muscular dystrophy
   5. Rheumatoid arthritis
   6. Ear, nose, and throat (e.g., otitis media, sinus infections)
   7. Infectious diseases
   8. Temporomandibular joint (TMJ) disorder
   9. Idiopathic scoliosis or treatment of the curve progression in late adolescence or adulthood unless there is another indication for chiropractic manipulation
   10. Attention-deficit disorders
   11. Autism spectrum disorders
   12. Dysmenorrhea
   13. Menopause-associated vasomotor symptoms
   14. As a substitute for childhood immunizations
B. Medicaid **shall not** cover Chiropractic services for beneficiaries under 12 years of age.
C. Maintenance programs, active corrective care, or supportive care, preventive care, or wellness care are not covered services:
   1. Maintenance care, 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 beneficiary has become symptomatically and objectively stable, to prevent a recurrence of the beneficiary'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, beneficiary 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.

4. Diagnostic procedures and tests, such as including but not limited to the following, are not covered when furnished or ordered by a chiropractor:
   a. Laboratory tests;
   b. X-rays, with the exception of the X-ray procedure codes listed in the NC Medicaid Chiropractic fee schedule;
   c. Video fluoroscopy;
   d. ECGs.
5. The following therapeutic modalities are not covered services when performed by a chiropractor:
   a. Physical or occupational therapy

      Note: Chiropractors may not seek reimbursement for physical or occupational therapy services performed under the supervision of an 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 Medicaid's website at https://medicaid.ncdhhs.gov/.)
   b. Traction (axial or longitudinal)
   c. Injections
   d. Acupuncture
   e. 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 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
   f. Nutritional supplements are not a covered service

Background[1]

Chiropractic manipulative therapy refers to chiropractic adjustment and spinal manipulation. Specifically, CMT refers to manipulation of the vertebrae that are not in the proper position or that are not functioning properly in an effort to protect the spinal cord and offer the body maximum structural integrity. CMT is often applied to members that are experiencing chronic pain in some part of their musculoskeletal system.

Spinal manipulation is one of several options—including exercise, massage, and physical therapy—that can provide mild-to-moderate relief from low-back pain. Spinal manipulation appears to work as well as conventional treatments such as applying heat and taking pain-relieving medications.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2021, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
	Chiropractic Services
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	11/22	11/22
NCHC verbiage removed from NC Guidance Verbiage.	04/23	04/23

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No:1F Chiropractic Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published July 1, 2022. Accessed November 15, 2022.
2. State of Florida Medicaid Sunshine Health Policy and Procedure FL.UM.59.00 Chiropractic Manipulative Therapy Expanded Benefit
3. WellCare of North Carolina Value Added Benefits list: https://www.wellcarenc.com/members/medicaid/benefits/additional-benefits.html. Accessed November 15, 2022
4. Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline from the American College of Physicians (2017)
5. Spinal Manipulation for Low-Back Pain. (2018, March 26). Retrieved from https://nccih.nih.gov/health/pain/spinemanipulation.htm

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

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.

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: https://medicaid.ncdhhs.gov/

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 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.

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 NC Medicaid'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).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, 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.
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.
   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 - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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