

Chiropractic Services

Provider Manual



Department of
HUMAN SERVICES



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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. Chiropractors Eligible to Participate

All chiropractors licensed to practice in Iowa and certified eligible to participate in the Medicare program are eligible to participate in the Medicaid program. Chiropractors in other states are also eligible to participate, providing they are similarly qualified.

A record of past and current General Letters outlining the content changes to this chapter is available online at: http://dhs.iowa.gov/sites/default/files/Chiro_GL.pdf

B. Description

Generally speaking, payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (i.e., Medicare Part B). However, coverage under the Iowa Medicaid program is limited to provisions under 441 Iowa Administrative Code (IAC) Chapter 78.8(249A).

Chiropractic manipulative therapy (CMT) which is eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by x-ray. For the purpose of Medicaid, subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae. The chiropractic preferred definition of subluxation is the alteration of the normal dynamics, anatomical or physiological relationship of contiguous articular structures.

No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's order is covered under the Medicaid program.

Manual devices (those devices that are hand-held with the thrust of the force of the device being controlled manually) may be used by the chiropractor in performing manipulation of the spine. However, no additional payment is allowed for the use of the device or for the device itself.

C. Indications and Limitations of Coverage

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatments. The manual manipulative services rendered must have a direct therapeutic relationship to the patient's condition. The mere statement or diagnosis of "pain" is not sufficient to support medical necessity for the treatments.

Spinal axis aches, strains, sprains, nerve pains, and functional mechanical disabilities of the spine are considered to be reasonable and necessary therapeutic grounds for CMT. The level of spinal subluxation must bear a direct causal relationship to the patient's symptoms and the symptoms must be directly related to the level of the subluxation that has been diagnosed.

Symptoms are usually related directly to specific anatomic spine areas. Occasionally, symptoms are more generalized and associated with several adjacent anatomic sites of subluxation. In such cases, the symptoms involving body structures should relate to the areas of subluxation in the documentation.

Medicaid covers four categories of conditions:

- ◆ **Acute.** A patient's condition is considered to be acute when the patient is being treated for a new injury that is substantiated by x-ray date, first date of treatment and diagnosis that are reasonably proximate.

The result of chiropractic treatment is expected to be an improvement in, arrest or retardation of the patient's acute condition. This result should be obtained within a reasonable and generally predictable period of time.

Some patients with acute conditions may require several weeks of treatment, while others require a much shorter duration of treatment. Initially, services may be more frequent, but Medicaid would expect to see a decrease in frequency as a result of the improvement in the patient's condition.

- ◆ **Chronic.** A patient's condition is considered chronic when it is not expected to completely resolve but where continued therapy can be expected to result in some functional improvement. Once the functional status has remained stable (unchanged for four weeks) for a given condition, further manipulation treatment is considered maintenance therapy and is not covered.

- ◆ **Exacerbation.** An exacerbation is a temporary marked deterioration of the patient's pre-existing condition documented in the clinical record due to flare-up of the condition being treated. This must be documented in the patient's clinical record, including the date of occurrence, nature of the onset, or other pertinent factors that will support the reasonableness and necessity of treatments for this condition.
- ◆ **Recurrence.** A recurrence is a return of symptoms of a previously treated condition that has been quiescent for 30 or more days. This may require the reinstatement of therapy.

Medicaid limits the coverage of chiropractic services to the hands-on manual manipulation of the spine for symptomatology associated with spinal subluxation.

Maintenance therapy (such as therapy that is performed to stabilize a chronic condition or to prevent deterioration) is not a Medicaid benefit. Once the maximum therapeutic benefit has been achieved for a given condition, ongoing maintenance therapy is not considered to be reasonable and necessary under the Medicaid program.

Coverage will be denied if there is not a reasonable expectation that the continuation of treatment would result in improvement of the patient's condition. Continued repetitive treatment without a clearly defined clinical end point is considered maintenance therapy and is not covered.

Medicaid does not cover the use of chiropractic manipulative treatment to prevent disease, promote health, prolong and enhance the quality of life, or to treat most other spinal disease or other pathological disorders. Examples of these include, but are not limited to:

- ◆ Rheumatoid arthritis,
- ◆ Muscular dystrophy,
- ◆ Multiple sclerosis,
- ◆ Pneumonia, and
- ◆ Emphysema.

D. Interpreter Services

Interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for the agency. The services must facilitate access to Medicaid covered services.

In order for interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

- ◆ Provided by interpreters who provide only interpretive services
- ◆ Interpreters may be employed or contracted by the billing provider
- ◆ The interpretive services must facilitate access to Medicaid covered services

Providers may only bill for these services if offered in conjunction with an otherwise Medicaid covered service. Medical staff that are bilingual are not reimbursed for the interpretation but only for their medical services.

1. Documentation of the Service

The billing provider must document in the member's record the:

- ◆ Interpreter's name or company,
- ◆ Date and time of the interpretation,
- ◆ Service duration (time in and time out), and
- ◆ Cost of providing the service.

2. Qualifications

It is the responsibility of the billing provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to 645 IAC 361. Oral interpreters should be guided by the standards developed by the [National Council on Interpreting in Health Care](#).

Following is the instruction for billing interpretive services when that service is provided by an outside commercial translation service:

- ◆ Bill code T1013
 - For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at a per-minute unit.
 - The lack of the UC modifier will indicate that the charge is being made for the 15 minute face-to-face unit.

- ◆ Enter the number of minutes actually used for the provision of the service. The 15 minute unit should be rounded up if the service is provided for 8 minutes or more.

NOTE: Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is **NOT** used and the units exceed 24 will be paid at 24 units.

E. Documenting X-Ray

An x-ray must document the primary region of spinal subluxation. **EXCEPTION:** No x-ray is required for pregnant women and children aged 18 and under.

The documenting x-ray must be taken at a time reasonably near the initiation of treatment, i.e., no more than 12 months before or three months after the initiation of treatment.

In certain cases of chronic subluxation, an older x-ray may be accepted, provided the patient's health record indicates the condition has existed longer than 12 months and there are reasonable grounds for concluding that the condition is progressing. X-rays need not be repeated unless there is a new condition.

The x-ray films must be labeled with the patient's name and date the x-ray was taken, and must be marked right or left. The provider shall make the x-ray available to Medicaid when requested and have a written report, including interpretation and diagnosis, present in the patient's clinical record.

Medicaid has not approved use of magnetic resonance (MRI) or videofluoroscopy to determine the diagnosis of subluxation for chiropractic manipulations. Only diagnostic x-rays can be used to support the diagnosis.

Chiropractors are authorized to order a documenting x-ray whether or not the chiropractor owns or possesses x-ray equipment. Any x-rays so ordered are payable to the x-ray provider.

Chiropractors who provide x-rays are reimbursed at the physician fee schedule rate. Payable x-rays are limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. These codes are: 72020, 72040, 72050, 72052, 72070, 72080, 72100, 72170, and 72190.

Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for x-rays, as appropriate.

Payment for documenting x-rays is limited to one per condition. No payment will be made for subsequent x-rays, absent a new condition. A claim for a documenting x-ray related to the onset of a new condition is payable only if the x-ray is taken no more than 12 months before or three months after the initiation of treatment for the new condition.

F. Procedure Codes and Nomenclature

Medicaid recognizes Medicare's National Level II Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. However, all HCPCS and CPT codes are not covered. The specific CPT codes that are covered for chiropractors under Iowa Medicaid are listed in the following section. It is noted that Iowa Medicaid does not cover any HCPCS codes for chiropractors.

Click [here](#) to view the fee schedule for Chiropractic Services. Providers who do not have Internet access can obtain a copy of the provider-specific fee schedule upon request from the IME.

It is the provider's responsibility to select the procedure code that best describes the item of service that was dispensed. A claim submitted without a procedure code and a corresponding diagnosis code will be denied. Please use the applicable diagnosis code based upon the date of service. Below is a chart illustrating the ICD-9 and ICD-10 diagnostic codes based on region and category.

Covered CPT Codes

Covered procedures for chiropractic manipulative treatment are:

- 98940 Spinal, one or two regions
- 98941 Spinal, three or four regions
- 98942 Spinal, five regions

If services are provided as the result of a Care for Kids (EPSDT) examination, use modifier Z1.

Generally, Medicaid limits chiropractic manipulative treatment to one code per day per patient. You are not required to bill excluded services.

Any treatments beyond the utilization guidelines listed must be submitted with documentation to support the medical necessity. If documentation is not submitted, the claim will be denied for lack of information. The claim may be resubmitted with documentation for reconsideration:

- ◆ Category I diagnoses generally require short term treatment (12 manipulations per 12-month period).
- ◆ Category II diagnoses generally require moderate term treatment (18 manipulations per 12-month period).
- ◆ Category III diagnoses generally require longer term treatment (24 manipulations per 12-month period).
- ◆ The utilization guideline for diagnostic combinations between categories is 28 manipulations per 12-month period.

A list of the ICD-10-CM diagnosis codes associated with each category is available on the DHS website under the [Covered Services, Rates, and Payments section](#).

G. Billing Policies and Claim Form Instructions

Claims for Chiropractic Services are billed on federal form CMS-1500, *Health Insurance Claim Form*.

- ◆ Click [here](#) to view a sample of the CMS-1500.
- ◆ Click [here](#) to view billing instructions for the CMS-1500.

Refer to [Chapter IV. Billing Iowa Medicaid](#) for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:
<https://dhs.iowa.gov/sites/default/files/All-IV.pdf>.

1. Claim/Fiscal Record

All information reported on the CMS-1500 must be supported by the documentation in the clinical record.

Chiropractic claims require two diagnoses for each subluxation, a subluxation diagnosis and a secondary diagnosis from one of the three categories, this diagnosis being the cause of the subluxation.

The chiropractor may bill for manipulations of up to five separate regions (a subluxation in each region); this diagnostic requirement may lead to five different subluxation diagnoses and five different neuromusculoskeletal diagnoses. Select up to two subluxation diagnoses and two corresponding Category I, II or III diagnoses codes.

When billing for CMT for more than one region, the chiropractor may have more than one x-ray. The x-ray date and initiation of treatment date that corresponds with the claim form must be entered.

Even though the claim form will only contain the diagnoses, x-ray date or initiation date for one or two regions treated, if CMT for more than two regions is being billed, the clinical record MUST document the reasons for treating the other regions.

2. Documentation Requirements

Generally speaking, chiropractors must follow all applicable provisions regarding maintenance of records by providers of service, as found under 441 IAC 79.3(249A).

The following information must be documented in the patient's clinical record on the initial visit:

- ◆ History. Describe the chief complaint, including the symptoms present that caused the patient to seek chiropractic treatment.
- ◆ Present illness. This may include any of the following as appropriate:
 - Mechanism of trauma
 - Quality and character of problem or symptoms
 - Intensity of symptoms
 - Frequency of symptoms occurring
 - Location and radiation of symptoms
 - Onset of symptoms
 - Duration of symptoms
 - Aggravating or relieving factors of symptoms
 - Prior interventions, treatments, including medications
 - Secondary complaints
- ◆ Family history, if pertinent.
- ◆ Past health history. This may include any of the following as appropriate:
 - General health statement
 - Prior illnesses
 - Surgical history
 - Prior injuries or traumas

- Past hospitalizations as appropriate
- Medications
- ◆ Physical examination. Musculoskeletal, neurologic or other findings documenting the diagnosis must be present.
- ◆ Diagnosis. This may include any of the following as appropriate:
 - The spinal region of subluxation, and
 - Either a Category I, II or III diagnosis
 - Treatment plan. Include the following:
 - ◇ Therapeutic modalities to effect cure or relief (patient education and exercise training)
 - ◇ The level of care that is recommended (the duration and frequency of visits)
 - ◇ Specific goals that are to be achieved with treatment
 - ◇ The quantitative measures that will be used to evaluate the effectiveness of treatment
- ◆ Initial treatment date. The following information must be documented on subsequent visits.
 - A subjective record of the patient's complaint
 - Physical findings to support manipulation in a region or segment being treated
 - Assessment of change in patient condition as appropriate
 - Record of specific regions manipulated

Failure to document that the chiropractic spinal manipulation is reasonable and necessary may result in claim denials. Documentation must be legible and made available to Medicaid upon request. Failure to do so may result in claim denials.