To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies
Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:
10A, *Outpatient Specialized Therapies*

1.0 Description of the Procedure, Product, or Service

Chiropractic Services 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)

1.1 Definitions

Chiropractor

A licensed healthcare professional trained to provide manual manipulation of the spine for a diagnosis of subluxation.

Maintenance Care

A traditional chiropractic approach, whereby active treatment is continued after optimum benefit is reached.

Manual Manipulation

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

Motion Segment

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

Subluxation

Subluxation is a motion segment in which alignment, movement integrity, or physiological function are altered although contact between joint surfaces remains intact.

Supportive Care

Periodic chiropractic treatments to maintain maximum therapeutic benefit.

Wellness Care

Includes nutritional supplements, hygienic modalities, environmental modalities, rehabilitation and physiotherapeutic modalities, massage therapy, counseling, beneficiary education, home exercises, and ergonomic postural modification as adjuncts to manual manipulation.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid policies*)

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.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. Medicaid
None Apply.

2.2 Special Provisions

2.2.1 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.

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/

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 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

3.2.1 Specific criteria covered by Medicaid

Medicaid shall cover chiropractic services when the beneficiary meets the following specific criteria:

a. A spinal subluxation is confirmed by a physical examination or by one (1) set of x-rays taken within six months prior to the initial date of service. One or both of the following must be present on the physical examination prior to initiation of therapy:
   1. asymmetry or misalignment on a segmental or sectional level; or
   2. range of motion abnormality.
b. When one of these two (2) conditions listed above is present, one (1) or both of the following must also be present:
   1. pain or tenderness at the area of subluxation; or
   2. tissue tone, texture, or temperature abnormalities.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

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

4.2.1 Specific Criteria Not Covered by Medicaid

Medicaid shall not cover Chiropractic Services for the following:

a. a beneficiary aged 11years and under;
b. maintenance, supportive and wellness care;
c. preventative care;
d. traction or acupuncture as part of the Chiropractic Plan of Care;
e. as a replacement for immunizations or standard medical care for acute or chronic conditions; or
f. criteria not listed in **Subsection 3.2.**

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid shall not require prior approval for Chiropractic Services.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Documentation Requirements for the Initial Visit

The following must be documented in the beneficiary's health record at the beneficiary's first visit:

a. chief complaint and current symptoms causing the beneficiary to seek treatment;
b. relevant family, medical, and surgical history;
c. mechanism of trauma;
d. location, onset, provoking or palliative factors, quality, duration, frequency, intensity and character of symptoms or problem;
e. prior interventions, treatments, medications, secondary complaints;
f. physical examination;
g. diagnosis; and
h. affected vertebral level(s).

Note: See **Attachment A: B** for acceptable primary diagnoses.

5.4 Treatment Plans

A clear and appropriate treatment plan must document all the following:

a. the symptoms or diagnosis treated;
b. diagnostic procedures and treatment modalities used;
c. results of diagnostic procedures and treatments;
d. specific treatment goals; and
e. anticipated length of treatments.

5.4 Continued Treatment

a. If no improvement is documented within the initial two (2) calendar weeks of chiropractic care, the treatment plan must be modified and documented in the beneficiary's health record.
b. If no improvement is documented after thirty (30) calendar days of modified chiropractic treatment, no additional treatment is allowed.
c. Once the maximum therapeutic benefit has been achieved, further chiropractic care is not allowed.
d. A copy of the treatment plan must be maintained in the beneficiary's chiropractic health record.

5.5 X-Rays

X-rays are allowed as part of the documentation associated with the definition of the musculoskeletal condition for which manual manipulation of the spine is appropriate as follows:

a. One (1) set of x-rays taken within six (6) calendar months of the date of service.
b. X-rays must be kept on file in the beneficiary's health record.

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

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

5.6 Visit Limits

Chiropractic visits, along with podiatry and optometry, are considered optional services. As per 42 CFR 440.225, combined optional services are limited to eight per beneficiary per State fiscal year (July 1 – June 30).

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 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.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Chiropractors shall comply with:

a. G.S, Chapter 90, Article 8;
b. 21 NCAC, Chapter 10; and
c. 42 CFR 440.60.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 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 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).

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.
07/01/2016	Attachment A	Correct ICD-10 code lists
03/01/2018	Attachment A: C	Removed CPT code 72010 and added CPT code 72082
03/01/2018	All Sections and Attachments	Placed policy in combined Medicaid and NCHC template format and updated policy template language
03/01/2018	Subsection 5.2.2	Prior approval is required for MPW. Referral is required for MPW.
3/01/2018	Attachment A	Correct ICD-10 code lists
03/01/2018	All Sections and Attachments	Provided coverage criteria for Medicaid beneficiaries 12 years of age and older.
03/01/2018	All Sections and Attachments	Provided coverage criteria for NCHC beneficiaries 12 to 18 years of age.
03/05/2018	All Sections and Attachments	Policy posted with an Amended Date of March 1, 2018.
05/23/2018	Attachment A: C	During 03/01/2018 amendment, code 72010 should have been removed (See note above). This update removes that code. No change to Amended Date.
03/15/2019	Table of Contents	Added, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.”
03/15/2019	All Sections and Attachments	Updated policy template language.
12/31/2019	Table of Contents	Updated policy template language, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.”
12/31/2019	Attachment A	Added, “Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines”.
07/01/2022	Throughout	Removed PA requirement for MPW beneficiaries based on NC Senate Bill 105 Session Law 2021-180 Section 9D.13 and the American Rescue Plan Act of 2021.
8/15/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program’s move to Medicaid. Policy

Date	Section Updated	Change
		posted 08/15/2023 with an effective date of 4/1/2023.
10/15/2024	Subsection 1.1	Added definitions for Chiropractor, Maintenance Care, Supportive Care, and Wellness Care. Clarified Manual Manipulation.
10/15/2024	Subsection 2.1.2	Deleted text and added None Apply.
10/15/2024	Subsection 3.2.1.1	Consolidated text previously under manual Manipulation of the Spine and Subluxation.
10/15/2024	Subsection 4.2.1	Combined and clarified text from 4.2.2 and 4.2.3.
10/15/2024	Subsection 4.2.2	Moved descriptive text to definitions in 1.0 and text to 4.2.1. Added None Apply.
10/15/2024	Subsection 4.2.3	Deleted text under "Spinal Manipulation."
10/15/2024	Subsection 5.3	Added Documentation Requirements for the Initial Visit
10/15/2024	Subsection 5.3	Removed "Treatment requires a primary diagnosis of subluxation, and documentation must include the level affected".
10/15/2024	Subsection 5.4.d.	Added text "specific treatment goals."
10/15/2024	Subsection 5.6	Added this section on Visit Limits.
10/15/2024	Attachment A, Letter B	Removed "Note: When billing for chiropractic services, both the applicable primary and secondary ICD- 10-ICD-10-CM code(s) must be reported on the claim" and replaced it with "Chiropractic claims must have a primary diagnosis of spinal subluxation found in the table below. Claims without a primary diagnosis of subluxation will be denied." The primary ICD-10-CM diagnosis codes M99.00, M99.01, M99.02, M99.03, M99.04, M99.05 and M99.08 were deleted and replaced with ICD-10-CM vertebral subluxation diagnosis codes M99.10, M99.11, M99.12, M99.13, M99.14 and M99.15. Removed the table of Secondary ICD-10-CD diagnosis codes.
10/15/2024	Attachment A, Letter C	Removed CPT 72069 which had been end-dated.
10/15/2024	Attachment A, Letter C	Removed CPT 72069 which had been end-dated.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks 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

Professional (CMS-1500/837P 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.

Note: Chiropractic claims must have a primary diagnosis of spinal subluxation found in the table below. Claims without a primary diagnosis of subluxation will be denied.

ICD-10-CM Code(s)	
Primary ICD-10-CD Code(s)	
M99.10 M99.11 M99.12	M99.13 M99.14 M99.15

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)		
Chiropractors may use the following CPT x -ray codes when documenting the musculoskeletal condition for which manual manipulation of the spine is appropriate.		
72020 72040 72050 72052 72070 72072 72074	72080 72081 72082 72083 72084 72100 72110	72114 72120 72170 72190 72200 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.

E. Place of Service

Office

F. Co-payments

For Medicaid refer to the Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

G. Reimbursement

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