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| **Division of Medical Assistance** | **Policy No.: NCHC2009.11** |
| **Chiropractic Services** | **Original Effective Date: July 1, 2010** |
| | **Revised Date:** |
| | **Date of Termination: February 28, 2018** |

# This policy is superseded by clinical coverage policy 1F, Chiropractic Services

## ~~Table of Contents~~

| | |
|---|---|
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## 1.0 Description of the Procedure, Product, or Service

Chiropractic service 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.

## 2.0 Eligible Recipients

### 2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

## 3.0 When the Procedure, Product, or Service Is Covered

### 3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are 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 recipient'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; **AND**
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

### 3.2 Specific Criteria

Chiropractic services are limited to the alignment of the spine, the release of pressure by manipulation, and x-rays.

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

### 4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

a. the recipient does not meet the eligibility requirements listed in **Section 2.0;**
b. the recipient does not meet the medical necessity criteria listed in **Section 3.0;**
c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; **OR**
d. the procedure, product, or service is experimental or investigational.

### 4.2 Specific Criteria

a. Acupuncture, or any other invasion of the skin when performed by a chiropractor, is not covered.

b. Chiropractors are not licensed to prescribe or administer any medications or drugs, nor practice osteopathy, nor perform surgery.

c. When chiropractic services are performed by a chiropractor, coverage is limited to those services listed in **Subsection 3.2**.

## 5.0 Requirements for and Limitations on Coverage

### 5.1 Prior Approval

Prior approval is not required.

### 5.2 Limitation

The maximum benefits allowed are $2,000 per fiscal year.

## 6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

a. meet NCHC qualifications for participation;

b. be currently enrolled with NCHC; **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

### 7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

## ~~8.0 Policy Implementation/Revision Information~~

~~**Original Effective Date:** July 1, 2010~~

~~**Revision Information:**~~

| ~~Date~~ | ~~Section Revised~~ | ~~Change~~ |
|---|---|---|
| ~~**July 1, 2010**~~ | | ~~Policy Conversion: Implementation of Session Law 2009-451,~~ ~~**Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY**~~ |
| 02/28/2018 | Throughout | Policy Termination |
| | | |

# Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines.

## A. Claim Type

Professional (CMS-1500/837P transaction)

## B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

## C. Procedure Code(s)

| CPT Codes | | | | |
|---|---|---|---|---|
| **Office services** | | | | |
| 97001<br>97002<br>99201-99205<br>99211-99215<br>Only one code under office services is allowed within a 30 day period for the same chiropractor<br>99050 must be billed with an office visit code | | | | |
| **Modalities and therapeutic procedures** | | | | |
| 97010<br>97012<br>97014<br>97016 will deny as incidental to a primary service, even if it's the only service filed | | | | |
| 97018 | 97022 | 97024 | 97026 | 97028 |
| 97032 | 97034 | 97035 | 97039 | 97110 |
| 97112 | 97116 | 97124 | 97139 | 97140 |
| 97530 | 98940 | 98941 | 98942 | 98943 |
| **Radiology** | | | | |
| 72010 | | 72020 | 72040 | 72050 |
| 72052 | 72070 | 72072 | 72074 | 72080 |
| 72090 | 72100 | 72110 | 72114 | 72120 |
| 72170 | 72220 | 76140 | | |

## D. Modifiers

Providers are required to follow applicable modifier guidelines.

## E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

## F. Place of Service

Office

### ~~G. Co-payments~~

~~Co-payment(s) may apply to covered prescription drugs and services.~~

### ~~H. Reimbursement~~

~~Providers must bill their usual and customary charges.~~