Chiropractic Benefits and Services Policy

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Page Number(s):	1 of 6

Disclaimer

Highmark Health Options' medical claims payment and prior-authorization policy is a reference resource regarding payment and coverage for the services described. This policy does not constitute medical advice and is not intended to govern and/or otherwise influence medical necessity decisions.

POLICY SCOPE

This policy applies to claims submitted to Highmark Health Options under the Delaware Medical Assistance product and is intended clarify the chiropractic benefit for members and provide claim processing guidelines for related claims. This policy specifically applies to providers submitting claims under Chiropractic provisions outlined in DMMA documentation, regulators and internal HHO resources.

PROVIDER REQUIREMENTS/QUALIFICATIONS

Qualified chiropractors must be licensed per Delaware licensure requirements codified in the Delaware Administrative Code manual.

REIMBURSEMENT GUIDELINES

COVERED SERVICES

The practice of chiropractic includes, but is not limited to, the diagnosing and locating of misaligned or displaced vertebrae (subluxation complex), using x-rays and other diagnostic test procedures. Practice of chiropractic includes the treatment through manipulation/adjustment of the spine and other skeletal structures and the use of adjunctive procedures not otherwise prohibited by the applicable state license limitations.

Chiropractic services are furnished in accordance with state regulations and include only services that are provided by a State licensed chiropractor. Chiropractic claims must be billed on a CMS-1500 claim, or if billing electronically, the 837 Professional claim using appropriate chiropractic CPT codes. Chiropractic services involve manipulation associated with the treatment of neck, back, and pelvic/sacral. Allowable adjunctive therapy associated with the treatment of neck, back, pelvic/sacral, and extraspinal pain and/or dysfunction, that the chiropractor is legally authorized by the State to perform per state code. Chiropractic services are subject to prior authorization and/or medical review. Services consist of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform as follows:

- For Medicaid-eligible Individuals under age 13, as an EPSDT service, per state regulation, furnished upon meeting defined benefit criteria (through prior authorization approval); or

- For Medicaid-eligible individuals age 13 and over, furnished upon meeting defined benefit criteria (through prior authorization approval, after the first 20 visits).

MANIPULATIONS

Manipulations should be provided in accordance with an ongoing, written treatment plan and must be appropriate for the diagnosis reported. The treatment plan should be updated as the patient's condition changes and maintained in the medical records. Manipulations can be provided manually or with the assistance of various mechanical or computer operated devices. No additional payment is available for use of the device or for the device itself.

EVALUATION AND MANAGEMENT SERVICES

Manipulation includes a pre-manipulation assessment. Time-based physical medicine services also include the time required to perform all aspects of the service, including pre-, intra-, and post-service work. Therefore, a separate Evaluation and Management (E/M) service must be deemed medically necessary through prior authorization. A separate E/M service should not be routinely reported with manipulation or time-based physical medicine services.

A patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine diagnosis as demonstrated by x-ray or back pain necessitating treatment as demonstrated by physical examination.

X-ray may be used to diagnose spinal subluxation. If x-ray is used for this purpose, it must have been taken reasonably close to (within 12 months prior or 3 months following) the beginning of treatment. Coverage of spinal x-rays is limited to one set of spinal x-rays for a member in a rolling twelve-month period. A set is one anteroposterior and one lateral view of the entire spine or each of the following: cervical, thoracic, and lumbar sacral (maximum total of six).

Additional x-rays may be taken within the same calendar year in order to document a new condition or an exacerbation/re-injury. X-rays for new conditions, exacerbations or progress require a pre-authorization.

Physical exam to document spinal subluxation, back pain, or to determine progress; once in a twelve-month period, must meet two of the following four benefit plan criteria, one of which must be criteria number 2 (**DMAP Practitioner Provider Specific Policy Manual, 13.2**):

1. Pain/tenderness evaluated in terms of location, quality and intensity.
2. Asymmetry/misalignment identified on a sectional or segmental level.
3. Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility.
4. Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

ADJUNCTIVE PROCEDURES

Any therapeutic manuver ancillary to the care needed short term to stabilize a patient, but which reduces the morbidity and mortality long term.

NONCOVERED SERVICES

Examples of items or services that are non-covered chiropractic services include the following:

- Vitamins.
- Minerals.
- Supplements.
- Any other chiropractic service not defined in this benefit.
- Chiropractic maintenance therapy is not considered to be medically necessary and is not covered.
- Orthopedic devices prescribed by chiropractor.
- Treatment for any condition not related to a diagnosis of subluxation or back pain.
- X-rays other than those needed to support a diagnosis of subluxation.
- Any services outside of scope of state licensure.
- Room and Board fees are not covered.
- Hand-held and other devices may be used in treatment but are not eligible to be reimbursed.
- Experimental/Investigational (E/I) services are not covered regardless of place of service.
- Quantity level limits or quantity of supplies that exceed the frequency guidelines listed on the policy will be denied as noncovered.
- Services rendered prior to January 1, 2018, or prior to the provider's contractual effective date.

A network provider cannot balance bill the member for covered services.

PRIOR AUTHORIZATION

Prior authorization is required for all Chiropractic services as follows:

Members age 13 and over

- No prior authorization is needed for the first twenty (20) qualifying visits* within a calendar year. However, prior authorization and supporting clinical documentation is required for additional manipulations beyond the first twenty visits (20).
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Members under age 13

- Members 0—12 require authorization for all chiropractic services and additionally require a primary care script with the clinical provider

*Providers will only be reimbursed for one qualifying visit per day. A qualifying visit is defined as a spinal manipulation, extraspinal manipulation, or adjunctive procedure, or any combination of the three. Evaluation and Management procedures and X-ray are not considered a qualifying visit.

Appendix

CHIROPRACTIC BILLING CODES

Chiropractors are limited to billing the following codes:

CHIROPRACTIC SERVICES

Code	Description
98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions.
98941	Chiropractic manipulative treatment (CMT); spinal, three to four regions.
98942	Chiropractic manipulative treatment (CMT); spinal, five regions.
98943	Extraspinal - one or more regions.

EVALUATION AND MANAGEMENT SERVICES

Code	Description
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

RADIOLOGIC EXAMINATION SERVICES

Code	Description
72020	Radiologic Examination, spine, single view, specify level.
72040	Radiologic Examination, spine, cervical; 2 or 3 views.
72050	Radiologic Examination, spine, cervical; 4 or 5 views.
72052	Radiologic Examination, spine, cervical; 6 or more views.
72070	Radiologic Examination, spinel thoracic, 2 views.
72072	Radiologic Examination, spine; thoracic, 3 views.
72074	Radiologic Examination, spine; thoracic, minimum of 4 views.

72080	Radiologic Examination, spine; thoracolumbar, minimum of 2 views.
72081	Radiologic Examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis evaluation); 1 view.
72082	Radiologic Examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis evaluation); 2 or 3 views.
72083	Radiologic Examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis evaluation); 4 or 5 views.
72084	Radiologic Examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis evaluation); minimum of 6 views.
72100	Radiologic Examination, spine; lumbosacral; 2 or 3 views.
72110	Radiologic Examination, spine, lumbosacral; minimum of 4 views.
72114	Radiologic Examination, spine, lumbosacral; complete, including bending views, minimum of 6 views.
72120	Radiologic Examination, spine, lumbosacral; bending views only, 2 or 3 views.
72170	Radiologic Examination, pelvis; 1 or 2 views.
72190	Radiologic Examination, pelvis; complete, minimum of 3 views.
72200	Radiologic Examination, sacroiliac joints; less than 3 views.
72202	Radiologic Examination, sacroiliac joints; 3 or more views.
72220	Radiologic Examination, sacrum and coccyx, minimum of 2 views.

PER DE STATUTORY REQUIREMENTS AND SCOPE OF PRACTICE LAWS

Effective for services provided on and after January 1, 2022, Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) proposes to amend chiropractors' services, specifically, to allow coverage guidelines for treatment more consistent with the licensure scope of practice for chiropractors. An adjunctive procedure not otherwise prohibited by Chapter 7 which aids and or assists the chiropractor in providing chiropractic care and includes by way of example and is not limited to: Acupuncture Procedures Physiological Therapeutics Diet and Nutritional Programs Rehabilitation/Exercise Programs

ADJUNCTIVE PROCEDURES

Code	Description
97010	Cold/Hot Packs
97012	Mechanical Traction
97014	Electric Stim (unattended)
97016	Vaso pneumatic Device Therapy
97018	Paraffin Bath Therapy
97022	Whirlpool
97024	Diathermy
97026	Infrared
97028	Ultraviolet Therapy
97032	Electric Stim (attended)
97035	Ultrasound
97036	Hydrotherapy
97110	Therapeutic Procedure
97112	Neuromuscular Re-ed
97113	Aquatic Therapy
97116	Gait Training
97124	Massage Therapy
97140	Joint Mobil/Myofascial Release
97810	Acupuncture**

97802	Medical Nutrition Assessment and Intervention
97803	Medical Nutrition Re-Assessment and Intervention

** An acupuncturist who obtains licensure pursuant to this section may go on to become a licensed acupuncture and eastern medicine practitioner by achieving a Diplomate in Oriental Medicine from the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) or its equivalent as recognized by the Council and approved by the Board, or an organization that is recognized as equivalent to the NCCAOM by the Acupuncture Advisory Council and approved by the Board Medical Licensure and Discipline. Additionally, acupuncture can only be performed by a chiropractor with the appropriate licensure. It is the providers responsibility to maintain said license. Providers will be subject to post payment

References

Highmark Health Options Provider Manual, 2022.

Delaware Health and Social Services Division of Medicaid & Medical Assistance. (2020). DMMA Practitioner Provider Specific Policy Manual. Sections 13.0-13.3, 32.0.

Title 24 Regulated Professions And Occupations Delaware Administrative Code, 700 Board of Chiropractic.

Department Of Health and Social Services Division of Medicaid And Medical Assistance Statutory Authority: 31 Delaware Code, Section 512 (31 Del.C. §512).

Delaware Code | Chapter 17 - MEDICAL PRACTICE ACT | Casetext.

POLICY UPDATE HISTORY

03.01.2022	Approved in Governance Meeting