CHIROPRACTIC SERVICES

ND Medicaid covers chiropractic services provided by an enrolled Doctor of Chiropractic licensed under state law.

COVERED SERVICES

ND Medicaid chiropractic coverage includes 20 manual manipulations (including using an activator or similar instrument) of the spine to treat subluxations (incomplete or partial dislocation) demonstrated by x-rays or an exam. Limited Evaluation and Management (E/M) services and X-rays are also covered.

COVERAGE LIMITATIONS

Manual manipulation of the spine is limited to one manipulation per day and may not exceed 20 manipulations per calendar year without an approved service authorization.

Spinal Manipulations

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

Evaluation and Management Services

New Patient Evaluation and Management (E/M) services (99202 or 99203) are covered in addition to chiropractic manipulative treatment (98940-98942) only when the patient has not received any professional (face-to-face) services from the chiropractor or another chiropractor of the same group practice within the past three years.

«Established Patient Evaluation and Management (E/M) services (99211-99213) are covered on the same service date as a spinal manipulation only if the evaluation and management service is significant and separately identifiable from the procedure that is performed. Use modifier 25 to indicate that the patient's condition required a significant, separately identifiable E/M service beyond the usual pre- and post-procedure care associated with the service performed. Established patient E/M services are limited to five per calendar year. »

X-rays

X-rays may not exceed two (2) per year per region. Full spine X-rays will count as 1 of the two (2) allowed X-rays per region.

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, spine; thoracic, 2 views
72072 - Radiologic examination, spine; thoracic, 3 views
72074 - Radiologic examination, spine; thoracic, minimum of 4 views
72080 - Radiologic examination, spine; thoracolumbar junction, minimum of 2 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
72220 - Radiologic examination, sacrum and coccyx, minimum of 2 views

NONCOVERED SERVICES

- Chiropractic maintenance therapy is not covered. Maintenance therapy is defined as a plan of care that seeks to prevent disease, promote health, and prolong and enhance the quality of life, or therapy to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective, the treatment is considered maintenance therapy.
- Any joint manipulation outside of the spine.

MEDICAL NECESSITY FOR TREATMENT

Chiropractic services are considered medically necessary when all the following criteria are met:

- The member has a neurological or musculoskeletal condition, and the manipulative services performed have a direct therapeutic relationship to the condition; and
- The member has a subluxation of the spine as demonstrated by X-ray or physical exam.

SERVICES THAT ARE NOT MEDICALLY NECESSARY

- Continued chiropractic treatment after the initial two weeks if no improvement is documented unless the chiropractic treatment is modified.
- Continued chiropractic treatment if no improvement is documented within 30 days, even with a modification of chiropractic treatment.

- Continued chiropractic treatment once the maximum therapeutic benefit has been achieved.
- Chiropractic manipulation of a member who is asymptomatic or is without an identifiable clinical condition.
- Chiropractic care of a member whose condition is neither regressing nor improving.
- Chiropractic manipulation for the treatment of idiopathic scoliosis or treatment of scoliosis beyond early adolescence, unless the member exhibits pain or spasm or some other medically necessary indications for chiropractic manipulation, are present.
- Manipulation for non-neurological or musculoskeletal conditions (e.g., attention-deficit hyperactivity disorder, breech or other malpresentation, scoliosis, dysmenorrhea, otitis media, asthma, epilepsy, etc.).

BILLING GUIDELINES

Two diagnostic codes must be listed on the service authorization and claim to support medical necessity:

- The level of subluxation must be specified and must be listed as the primary diagnosis.
    - M99.00 - Segmental and somatic dysfunction of head region
    - M99.01 - Segmental and somatic dysfunction of the cervical region
    - M99.02 - Segmental and somatic dysfunction of the thoracic region
    - M99.03 - Segmental and somatic dysfunction of the lumbar region
    - M99.04 - Segmental and somatic dysfunction of the sacral region
    - M99.05 - Segmental and somatic dysfunction of the pelvic region
- The associated neurological or musculoskeletal condition necessitating treatment must be listed as the secondary diagnosis**.**
- Chiropractic services must be submitted via an 837P transaction or a CMS 1500 professional claim.

SERVICE AUTHORIZATION

Once a member's limits have been met, the Service Limits Authorization Request form must be used to request additional services. Services in excess of the member’s limit and not authorized by ND Medicaid will not be covered.