

Clinical Policy: Chiropractic Services

Reference Number: WNC.CP.275

Last Review Date:

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Note: When state Medicaid coverage provisions are less restrictive than the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description¹

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)

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, member education, home exercises, and ergonomic postural modification as adjuncts to manual manipulation.

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Policy/Criteria¹

I. WellCare of North Carolina[®] shall cover chiropractic services when the member meets the following specific criteria:

- A. A spinal subluxation is confirmed by 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 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.

II. WellCare of North Carolina[®] **shall not** cover Chiropractic Services for the following:

- A. Non-musculoskeletal disorders, including but not limited to:
 - 1. A member aged 11 years and under;
 - 2. Maintenance, supportive and wellness care;
 - 3. Preventative care;
 - 4. Traction or acupuncture as part of the Chiropractic Plan of Care;
 - 5. As a replacement for immunizations or standard medical care for acute or chronic conditions; **examples of non-covered conditions are listed below:**
 - a) Respiratory conditions (e.g., asthma, pneumonia, emphysema)
 - b) Internal organs (e.g., intestinal)
 - c) Neurological (e.g., headaches, multiple sclerosis, epilepsy)
 - d) Muscular dystrophy
 - e) Rheumatoid arthritis
 - f) Ear, nose, and throat (e.g., otitis media, sinus infections)
 - g) Infectious diseases
 - h) Temporomandibular joint (TMJ) disorder
 - i) Idiopathic scoliosis or treatment of the curve progression in late adolescence or adulthood unless there is another indication for chiropractic manipulation.
 - j) Attention-deficit disorders.
 - k) Autism spectrum disorders.
 - l) Dysmenorrhea
 - m) Menopause-associated vasomotor symptoms
 - 6. Criteria not listed in Criteria I of this policy.

III. Visit Limits

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

Background¹

I. Requirements and Limitations on Coverage:

A. Documentation Requirements for the Initial Visit

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

1. Chief complaint and current symptoms causing the member to seek treatment;
2. Relevant family, medical, and surgical history;
3. Mechanism of trauma;
4. Location, onset, provoking or palliative factors, quality, duration, frequency, intensity and character of symptoms or problem;
5. Prior interventions, treatments, medications, secondary complaints;
6. Physical examination;
7. Diagnosis; **AND**
8. Affected vertebral level (s).

B. Treatment Plans:

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

1. The symptoms or diagnosis treated;
2. Diagnostic procedures and treatment modalities used;
3. Results of diagnostic procedures and treatments;
4. Specific treatment goals; **AND**
5. Anticipated length of treatments.

C. Continued Treatment:

1. 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.
2. If no improvement is documented after thirty (30) calendar days of modified chiropractic treatment, no additional treatment is allowed.
3. Once the maximum therapeutic benefit has been achieved, further chiropractic care is not allowed.
4. A copy of the treatment plan must be maintained in the beneficiary's chiropractic health record.

D. 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:

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

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Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
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

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	11/22	11/22
NCHC verbiage removed from NC Guidance Verbiage.	04/23	04/23
Annual Review. Removed verbiage from Services table with no effect on criteria.	11/23	11/23
Annual review. Added Definitions for Chiropractor, Maintenance Care, Supportive Care, Wellness Care. Criteria I. Added criteria for Chiropractic Services. Removed Criteria II.E.. “WellCare of North Carolina covers unlimited chiropractic services as a value-added service, if medical necessity criteria in this policy are met, ONLY for members ages 21 and older.” Criteria VI.B. & C. Deleted and became Criteria VI.A. 1-5. also added VI.A.20 “Criteria not listed in Criteria I. of this policy.” to ‘not covered’ services. Added Background I. Documentation requirements for the Initial Visit. Removed the ‘Medicaid and health choice’ verbiage from the References.	08/24	08/24
Criteria I.B. changed “if only” to “When.” Added Criteria III. Visit Limits. Deleted Criteria for (CMT), Service Table and Criteria IV Discharge. Background I.A.7. deleted “Treatment requires a primary diagnosis of subluxation, and documentation must include the level affected.” Background I.B. added “4. specific treatment goals” to list. Added Background I.C. Continued Treatment and I.D. X-Rays. Deleted text for CMT and Spinal manipulation. Deleted References for State of Florida, WellCare NC VAB, Noninvasive treatment..., Spinal Manipulation.		

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References

1. State of North Carolina Medicaid Clinical Coverage Policy No:1F Chiropractic Services. [Program Specific Clinical Coverage Policies | NC Medicaid \(ncdhs.gov\)](#). Published October 1, 2024. Accessed October 25, 2024.

North Carolina Guidance

Eligibility Requirements

- 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.

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

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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.

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.
2. **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/>

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.

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).

Claims-Related Information

Provider(s) shall comply with the NC Tracks 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 - as applicable to the service provided:
Professional (CMS-1500/837P transaction)
Institutional (UB-04/837I 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

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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.

- 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.

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 - Providers shall follow applicable modifier guidelines.
- e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
- f. Co-payments -
For Medicaid refer to Medicaid State Plan:
<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>
- g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering

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benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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