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1. Section Modifications

Version	Section	Update	Publish Date	SME
15.0	All	Published version	1/10/19	TQD
14.1	2.3 Covered Services and Limitations	Defined active care, acute and chronic services. Added EPSDT coverage information.	1/10/19	W Deseron E Garibovic
14.0	All	Published version	08/27/18	TQD
13.5	2.5. References	Formatting of references	08/27/18	E Garibovic D Baker
13.4	2.4. Reimbursement	Information about encounter rates	08/27/18	E Garibovic D Baker
13.3	2.2. Eligible Participants	Information about checking eligibility and language clean-up	08/27/18	E Garibovic D Baker
13.2	2.1. Provider Qualifications	Removed redundant language	08/27/18	E Garibovic D Baker
13.1	2. Chiropractor	Direction to required handbooks	08/27/18	E Garibovic D Baker
13.0	All	Published version	05/18/18	TQD
12.2	Appendix A: Diagnosis Codes Covered for Chiropractic Services	Added additional diagnosis references	05/18/18	W Deseron E Garibovic C Loveless
12.1	2.4 Reimbursement	Added additional billing references	05/18/18	W Deseron E Garibovic C Loveless
12.0	All	Published version	05/09/18	TQD
11.1	2.3.2 Prior Authorization (PA)	Clarification on IDAPA requirements and PA requirements.	05/09/18	K Eidemiller W Deseron E Garibovic D Baker
11.0	All	Published version	04/26/18	TQD
10.1	All	Document restructured and updated throughout	04/26/18	W Deseron D Baker E Garibovic C Loveless
10.0	All	Published version	08/24/17	TQD
9.1	2.2.5 Prior Authorization (PA)	Removed x-ray requirement; updated additional visit qualifications	08/24/17	K Eidemiller E Garibovic
9.0	All	Published version	08/15/17	TQD
8.1	2.2.5 Prior Authorization (PA)	Changed September date to October	08/15/17	K Eidemiller D Baker E Garibovic
8.0	All	Published version	06/27/17	TQD

Version	Section	Update	Publish Date	SME
7.2	2.2.5 Prior Authorization (PA)	Updated x-ray information and added information regarding documentation	06/27/17	K Eidemiller D Baker E Garibovic
7.1	2.2.3 Covered Services and Limitations	Added information about spinal manipulation and maintenance therapy	06/27/17	K Eidemiller D Baker E Garibovic
7.0	All	Published version	07/01/16	TQD
6.1	2.2.5 Prior Authorization (PA)	Updated form name and link	07/01/16	J Siroky D Baker
6.0	All	Published version	07/01/14	TQD
5.1	2.2.5 PA	Updated name of PA form	07/01/14	A Coppinger C Taylor
5.0	All	Published version	02/06/14	TQD
4.1	2.2.5 PA	Updated PA information	02/06/14	J Siroky
4.0	All	Published version	11/23/11	TQD
3.1	2.2.4 Co-payment	Added link to General Billing Instructions for information about co-payment	11/23/11	TQD
3.0	All	Published version	10/20/11	TQD
2.2	All	Updated links	10/20/11	TQD
2.1	2.2.8	Added POS Codes	10/20/11	K Mcneal
2.0	All	Published version	08/27/10	TQD
1.3	2.2.2	Updated to reflect policy	08/27/10	J Siroky
1.2	2.2.2	Updated to read: PA is not required	08/27/10	D Baker
1.1	All	Updated all sections to accommodate Section Modifications	08/27/10	TQD
1.0	All	Initial document – Published version	05/7/10	TQD

2. Chiropractor

This section covers all Medicaid services provided by health care providers of chiropractic services as deemed appropriate by the Department of Health and Welfare (DHW).

Sections of the Idaho Medicaid Provider Handbook applicable in specific situations are listed throughout the handbook for provider convenience. Additional handbook sections that always apply to this provider type include the following.

- *General Billing Instructions*
- *General Provider and Participant Information*

2.1. Provider Qualifications

Chiropractors in any state are eligible to participate in the Idaho Medicaid Program. They must be licensed in the state where the services are performed, and enroll as an Idaho Medicaid provider prior to submitting claims for services. Providers must follow the Idaho Medicaid Provider Handbook and all applicable state, and federal, rules and regulations.

See *General Provider and Participant Information*, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

2.2. Eligible Participants

Participants with Medicaid Basic and Enhanced Plans are eligible to receive chiropractic services. When billing for participants enrolled in other benefit plans, refer to *General Provider and Participant Information*, Idaho Medicaid Provider Handbook for coverage. Providers must check participant eligibility prior to delivery of the service by calling MACS at 1 (866) 686-4272; or through the trading partner account on the Idaho Molina Medicaid website.

2.2.1. Healthy Connections (HC)

Medicaid participants enrolled in HC, Idaho's Medicaid primary care case management (PCCM) model of managed care, may obtain services without a referral when those services or procedures are performed in the chiropractor's office.

2.3. Covered Services and Limitations

Idaho Medicaid pays for chiropractic services only when active care is medically necessary to treat a subluxation condition of the spine. Active care is treatment which has a direct, therapeutic relationship to the patient's condition and a reasonable expectation of functional improvement. Only acute and chronic spinal manipulation services are considered active care and reimbursable. Acute services are used for treatment of new injuries identified by x-ray or physical examination, when treatment is expected to improve or arrest the progression of the acute condition. Chronic services treat conditions that are not expected to significantly improve or resolve without intervention and continued treatment can be expected to provide functional improvement. A total of six (6) visits during any calendar year for remedial chiropractic care are covered without a prior authorization.

Maintenance therapy is not considered medically reasonable and necessary, and is not covered by Idaho Medicaid. Maintenance therapy is defined (per Chapter 15, Section 30.5B. of the "Medicare Benefit Policy Manual") as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, the treatment is then considered maintenance therapy.

Medicaid does not reimburse for any other chiropractic services including x-rays and diagnostic tests for demonstrating the existence of a subluxation of the spine.

Chiropractic services for participants under the age of twenty-one (21) are available with a prior authorization under the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) guidelines when necessary to correct or ameliorate defects, physical illness, and conditions discovered by screening services as defined in Section 1905(r) of the Social Security Act. The prior authorization process for EPSDT is separate from traditional chiropractic services. Services must be considered safe, effective, and meet acceptable standards of medical practice. See the *General Provider and Participant Information*, Idaho Medicaid Provider Handbook for more information including how to request a prior authorization under EPSDT.

2.3.1. Establishing Medical Necessity

A subluxation of the spine may be demonstrated by an x-ray or a physical examination within twelve (12) months prior of initiating treatment. These services are not reimbursable if rendered by a chiropractor, but may be used as proof of medical necessity.

Physical examinations must show one of the following:

- An asymmetry/misalignment identified on sectional or segmental level; or
- A range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or decrease of sectional or segmental mobility).

And, one of:

- Pain/tenderness evaluated in terms of location, quality, and intensity; or
- Tissue, tone changes in characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

2.3.2. Prior Authorization (PA)

Providers must submit a PA request for additional chiropractic services after the initial six (6) visits. An additional twelve (12) visits may be approved through the prior authorization process if medical necessity to correct a subluxation is clearly demonstrated. PAs are valid for the dates indicated on the authorization. Providers cannot bill Medicaid participants for covered services.

Professionally-recognized standards of care have not established medical necessity for over 18 visits per year. Requests for more than 18 visits will be denied as other interventions may be more appropriate.

The following documentation is needed to determine the need for additional visits:

- Completed Chiropractic Request Form
- Chiropractic evaluation completed within the past year
- Current plan of care (POC) signed and dated by the chiropractor, physician or mid-level

Documentation must specify:

- Diagnosis
- Anticipated short and long-term goals that are outcome-based with measurable objectives
- Frequency of treatment
- Expected duration of treatment
- Discharge plan
- Reports of current status

- Communication and coordination with other providers. Documentation may include dates of communication, person contacted, summary of services provided by other providers, and the unique and specific contribution of each provider
- Copies of the daily entries completed within the last 30 days
- Number of visits being requested
- Date range of requested services
- Current progress notes

Please fax all complete and valid PA requests to 1 (877) 314-8779. Failure to provide all required documentation at time of submission will result in denial of the prior authorization request.

2.4. Reimbursement

Chiropractors are paid on a fee-for-service basis except for services provided in Rural Health Clinics (RHC), Federally Qualified Health Clinic (FQHC), or Indian Health Services (IHS). Usual and customary fees are paid up to the Medicaid maximum allowance. See the *Ambulatory Health Care Facility*, Idaho Medicaid Provider Handbook for information on encounter fees for services provided in an RHC, FQHC or IHS.

The following CPT® codes are reimbursable for chiropractic services. Only one code and one unit is available per day. The use of manual devices, and services provided by assistants or aides, are included in the payment.

CPT® Code	Description
98940	Chiropractic manipulative treatment; spinal, 1 - 2 regions.
98941	Chiropractic manipulative treatment; spinal, 3 - 4 regions.
98942	Chiropractic manipulative treatment; spinal, 5 regions.

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding policy on billing, co-pays, prior authorization, and requirements for billing all other third party resources before submitting claims to Medicaid.

See the *General Provider and Participant Information*, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable.

2.4.1. CMS-1500 Claim Form: Supplemental

Enter POS code 11 (office) when billing for chiropractic services.

Any claim with an injury-related diagnosis code must include the cause of the injury, and when and where the injury occurred. Enter this information in field 19 of the paper CMS-1500 claim form or attach injury-related documentation when billing electronically.

2.5. References

2.5.1. CMS Billing Guidance

Billing and Coding Guidelines: CHIRO-001-Chiropractic Services. Centers for Medicare & Medicaid Services, https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/34585_19/L34585_CHIRO001_BCG.pdf.

"Chapter 15 – Covered Medical and Other Health Services." *Medicare Benefit Policy Manual*, Centers for Medicare & Medicaid Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

Fact Sheet L37254: Chiropractic Services. CGS Administrators, LLC, https://www.cgsmedicare.com/partb/mr/pdf/chiropractic.pdf.

2.5.2. Idaho Medicaid Publications

Basic Alternative Benefit Plan. Division of Medicaid, Department of Health and Welfare, State of Idaho, http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/BasicBenchmark.pdf.

House Bill 260 Budget Reductions – Chiropractic Services, Information Release MA11-10 (5/24/2011). Division of Medicaid, Department of Health and Welfare, State of Idaho, http://www.healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA11-10.pdf.

2.5.3. Regulations

"Chiropractic Services." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 530 – 534. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Definitions." Social Security Act, Sec. 1905(g) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

Definitions – Medical or Other Remedial Care Provided by Licensed Practitioners, 42 C.F.R. Sec. 440.60(b) (2012). Government Printing Office, https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=5f3c1217461d97825091955cda925f93&mc=true&r=SECTION&n=se42.4.440_160.

"Definitions of Services, Institutions, Etc." Social Security Act, Sec. 1861(r) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title18/1861.htm.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2006). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255/.

Appendix A: Diagnosis Codes Covered for Chiropractic Services

For dates of service on or after October 1, 2015:

ICD-10 CM - Diagnosis Codes	ICD-10 CM - Diagnosis Description
M99.00 – M99.05	Segmental and somatic dysfunction
M99.10 – M99.15	Subluxation complex (vertebral)
S13.110A – S13.110S	Subluxation of C0/C1 cervical vertebrae
S13.120A – S13.120S	Subluxation of C1/C2 cervical vertebrae
S13.130A – S13.130S	Subluxation of C2/C3 cervical vertebrae
S13.140A – S13.140S	Subluxation of C3/C4 cervical vertebrae
S13.150A – S13.150S	Subluxation of C4/C5 cervical vertebrae

S13.160A – S13.160S	Subluxation of C5/C6 cervical vertebrae
S13.170A – S13.170S	Subluxation of C6/C7 cervical vertebrae
S13.180A – S13.180S	Subluxation of C7/T1 cervical vertebrae
S23.110A – S23.110S	Subluxation of T1/T2 thoracic vertebra
S23.120A – S23.120S	Subluxation of T2/T3 thoracic vertebra
S23.122A – S23.122S	Subluxation of T3/T4 thoracic vertebra
S23.130A – S23.130S	Subluxation of T4/T5 thoracic vertebra
S23.132A – S23.132S	Subluxation of T5/T6 thoracic vertebra
S23.140A – S23.140S	Subluxation of T6/T7 thoracic vertebra
S23.142A – S23.142S	Subluxation of T7/T8 thoracic vertebra
S23.150A – S23.150S	Subluxation of T8/T9 thoracic vertebra
S23.152A – S23.152S	Subluxation of T9/T10 thoracic vertebra
S23.160A – S23.160S	Subluxation of T10/T11 thoracic vertebra
S23.162A – S23.162S	Subluxation of T11/T12 thoracic vertebra
S23.170A – S23.170S	Subluxation of T12/L1 thoracic vertebra
S33.110A – S33.110S	Subluxation of L1/L2 lumbar vertebra
S33.120A – S33.120S	Subluxation of L2/L3 lumbar vertebra
S33.130A – S33.130S	Subluxation of L3/L4 lumbar vertebra
S33.140A – S33.140S	Subluxation of L4/L5 lumbar vertebra