Chiropractic Benefits and Services

Policy ID:	HHO-DE-RP-1120
Approved By:	Highmark Health Options – Market Leadership
Provider Notice Date:	08/18/2023
Original Effective Date:	09/18/2023
Annual Approval Date:	07/26/2023
Last Revision Date:	07/26/2023
Products:	Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1 of 7

Disclaimer

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

This policy provides information regarding the coverage of, as determined by applicable federal and/or state legislation.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and the Delaware Department of Health and Social Services (DHSS) and all applicable state and federal regulations.

PURPOSE

This policy outlines Highmark Health Options reimbursement for chiropractic services.

DEFINITIONS

Highmark Health Options (HHO) – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Health Options currently services Delaware Medicaid: Delaware Healthy Children Program (DHCP) and Diamond State Health Plan Plus members.

Adjunctive Procedures – Any therapeutic maneuver ancillary to the care needed short term to stabilize a patient, by which reduces the morbidity and mortality long term.

Chiropractic manipulative treatment (CMT) – A form of manual treatment to influence joint and neurophysiological function. This treatment may be accomplished using a variety of techniques.

Medical Necessity – Providing health care services or products that a prudent physician would provide to a patient for the purpose of diagnosing or treating illness, injury, disease, or its symptoms in a manner that is all of the following: in accordance with generally accepted standards of chiropractic practice, consistent with the symptoms or treatment of the condition, and not solely for anyone's convenience.

Chiropractic Supportive Care – Continuous, interval-based treatment that is medically necessary for patients diagnosed with chronic pain or disease, which maintains function or prevents or slows deterioration.

PROCEDURES

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 (26) spinal manipulations* within a calendar year. However, prior authorization and supporting clinical documentation is required for additional manipulations beyond the first twenty-six spinal manipulations (26).

- No prior authorization is required for evaluation and management services, nor x-rays.

Members under age 13:

- Members 0–12 require authorization for all chiropractic services and additionally require a primary care prescription with the clinical provider.

  Provider will obtain a prescription from the members PCP or servicing provider then contact HHO for prior authorization before rendering an evaluation and treatment.

PROVIDER REQUIREMENTS/QUALIFICATIONS

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

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.

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.

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.

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 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.

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.

NONCOVERED SERVICES

The following are items or services that are non-covered chiropractic services:

- 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 when provided to Medicaid recipients who do not suffer from chronic pain and/or dysfunction and continued therapy can be expected to result in some functional improvement or prevent deterioration of a chronic condition.
- Orthopedic devices prescribed by chiropractor.
- 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.

Post-payment Audit Statement

The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark Health Options at any time pursuant to the terms of your provider agreement.

Chiropractic claims must be billed on a CMS-1500 claim, or if billing electronically, the 837 professional claim using appropriate chiropractic CPT codes.

CODING REQUIREMENTS

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.

Spinal Manipulations

CPT 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.

Radiologic Examination Services

CPT 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.

Adjunctive Procedures

CPT code	Description
97010	Application of a modality to 1 or more areas; hot or cold packs.
97012	Application of a modality to 1 or more areas; traction, mechanical.
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended).
97016	Application of a modality to 1 or more areas; vasopneumatic devices.

97018	Application of a modality to 1 or more areas; paraffin bath.
97022	Application of a modality to 1 or more areas; whirlpool.
97024	Application of a modality to 1 or more areas; diathermy (e.g., microwave).
97026	Application of a modality to 1 or more areas; infrared.
97028	Application of a modality to 1 or more areas; ultraviolet.
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes.
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes.
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes.
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises.
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing).
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion).
97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes.
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes.
97810	Acupuncture**
97530	Therapeutic activities, direct (one on one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in the use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes.
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes.
97811	Acupuncture, 1 or more needles, without electrical stimulation; each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (list separately in addition to code for primary procedure).
97813	Acupuncture, 1 or more needles, with electrical stimulation; initial 15 minutes or personal one-on-one contact with the patient.

97814	Acupuncture, 1 or more needles, with electrical stimulation; each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (list separately in addition to code for primary procedure).

** 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.

REIMBURSEMENT

- Participating facilities will be reimbursed per their Highmark Health Options contract.
- Adjunctive services and spinal manipulations are limited to a daily reimbursement cap.

References

Highmark Health Options. (2023). Provider Manual. Retrieved from hho-2023-de-provider-manual_03012023.pdf

Delaware Health and Social Services Division of Medicaid & Medical Assistance. (2023). DMMA Practitioner Provider Specific Policy Manual. Retrieved from https://medicaidpublications.dhss.delaware.gov/docs/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=887&language=en-US&PortalId=0&TabId=94

State of Delaware. Title 24 Regulated Professions and Occupations Delaware Administrative Code, 700 Board of Chiropractic. Retrieved from https://regulations.delaware.gov/AdminCode/title24/700.pdf

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
07/26/2023	Approved in Governance