CHIROPRACTOR

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Chiropractors.

1.1 MEDICAL NECESSITY

Determination of medical necessity and appropriateness of service is the responsibility of chiropractors within the scope of accepted medical practice and Medicaid limitations. Chiropractors are held responsible if excessive or unnecessary services are ordered, regardless of who actually renders these services (e.g., x-rays), or if reimbursement is received for the service. Chiropractors are subject to any corrective action related to these services, including recovery of funds.

1.2 BENEFICIARY COPAYMENT

A copayment for each Medicaid reimbursable chiropractic visit may be required for beneficiaries age 21 years and older. (Refer to the General Information for Providers Chapter for information about copayments.) Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

When more than one reimbursable service is provided during one visit (e.g., spinal manipulation and x-ray on the same date of service [DOS]), only a single copayment may be charged to the beneficiary.

When billing Medicaid for the service, chiropractors should bill their usual and customary (U&C) charge (i.e., without any adjustment for the copayment). Upon approval of the service, Michigan Department of Health and Human Services (MDHHS) automatically deducts the copayment. If the chiropractor deducts the copayment from the charge billed, an underpayment may result.

Refer to the Billing Beneficiaries Section of the General Information for Providers Chapter of this manual for additional information regarding copayment requirements. Beneficiaries may not be denied care or services based on inability to pay a copayment, except as outlined in that section.

1.3 OTHER INSURANCE AND MEDICARE SERVICES

It is the chiropractor's responsibility to question the beneficiary regarding Medicare and other insurance coverage prior to providing the service. Medicaid is the payer of last resort. Payment must be sought from other third party payers before submitting claims to MDHHS. (Refer to the Coordination of Benefits Chapter of this manual for additional information.)

1.4 NURSING FACILITY

Chiropractors may render manual spinal manipulations to beneficiaries in a NF as an ancillary service. The attending physician (MD or DO) must order all ancillary services, including chiropractic services. The chiropractor must keep and make available complete records of the services provided.

SECTION 2 – COVERED SERVICES

2.1 MANUAL SPINAL MANIPULATION

Medicaid covers medically necessary chiropractic services rendered by a chiropractor for the treatment of a diagnosed condition of subluxation of the spine. The subluxation must be demonstrable on x-rays.

Spinal manipulation is the only covered chiropractic procedure. (Refer to the Codes Section of this chapter for additional information.) Only one of the spinal manipulation procedure codes is billable per day, per beneficiary. Clinical signs and symptoms must be consistent with the level of subluxation.

If documentation other than x-rays supports the medical necessity of spinal manipulation for children, the x-ray requirement may be waived. Medicaid reserves the right to request x-ray documentation if deemed necessary.

Medicaid reimburses up to 18 chiropractic visits per calendar year.

2.2 PRIOR AUTHORIZATION INSTRUCTIONS

If additional visits during the calendar year are medically necessary, providers must submit a prior authorization (PA) request before performing manipulations that exceed the 18-visit limit. Submit a written request to the MDHHS Program Review Division. (Refer to the Directory Appendix for contact information.)

The letter requesting PA must:

- Provide beneficiary name and Medicaid identification (ID) number;
- Specify height;
- Specify weight;
- Provide the date of onset of current complaint and the frequency of visits to date, including a brief history of complaint, initial symptoms and significant symptom characteristics;
- Indicate level of subluxation and associated diagnosis, including complications or predisposing conditions, if present;
- Specify physical and objective findings;
- Specify radiographic findings, including significant findings in support of diagnosis;
- Indicate the patient's response to current treatment (improvement to date, if any);
- Provide an estimate of continued treatment necessary for current complaint;
- Provide expected and anticipated benefit of continued treatment; and
- Include any additional details, comments, etc. that may be of assistance in the evaluation.

The PA request is reviewed and a notice is returned to the provider stating the approval or denial of the request. If approved, the provider is notified of the number of additional visits granted. Providers are also given a PA number that must be placed in the PA field on the claim form when billing for the additional services. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for claim completion instructions.)

2.3 X-Ray Services

A chiropractor may order, and be reimbursed for, no more than one set of spinal x-rays per beneficiary, per year. If more than two procedures are provided for the beneficiary on the same date of service, the services must be combined and billed as one inclusive procedure code, such as the entire radiologic examination of the spine with survey study, anteroposterior and lateral.