Chiropractic Services

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This section contains information about chiropractic services and program coverage (*California Code of Regulations* [CCR], Title 22, Section 51308). For additional help, refer to the *Chiropractic Services Billing Example: CMS-1500* section of this manual.

Notice: Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009) excluded various optional benefits from coverage under the Medi-Cal program, including services rendered by a chiropractor. Refer to the Optional Benefits Exclusion subsection below for policy details, including information regarding exemptions to the excluded benefits. All codes listed in this section are affected by the optional benefits exclusion policy

Program Coverage

Medi-Cal chiropractic services are Medi-Cal benefits when rendered by chiropractor, subject to the following limitations:

- Services are limited to a maximum of two services per calendar month subject to Medi-Service limitations (CCR, Title 22, Section 51304[a]).
- Services are limited to treatment of the spine by means of manual manipulation (CCR, Title 22, Section 51308). No other diagnostic and/or therapeutic service furnished directly by a chiropractor, or pursuant to a chiropractor's order, is covered.
- Manual devices may be used by the chiropractor in performing manipulation of the spine. However, no additional payment is allowed for either the use of the device and/or the cost of the device itself.

  Note: "Manual devices" are defined as those devices that are hand held with the thrust of the force of the device being controlled manually.

Billing Codes

Only one chiropractic manipulative treatment code (98940 thru 98942) is reimbursable when billed by the same provider, for the same recipient and date of service.

Note: "Service" is defined as all care, treatment or procedures provided to a recipient by an individual practitioner on one occasion.

Eligibility Requirements

Providers should verify the recipient's Medi-Cal eligibility for the month of service.

Medi-Services

One Medi-Service must be reserved for each visit provided. Information about how to reserve a Medi-Service is contained in the following documents:

- If using the Automated Eligibility Verification System (AEVS), refer to the *AEVS: Transactions* section in the Part 1 manual.
- If using the Internet, refer to the *Medi-Cal Web Site Quick Start Guide*.

Note: "Visit" is defined as any covered chiropractic procedure or combination of procedures performed on the same day.

Prescription Requirements

No prescriptions are required for chiropractic services.

Authorization

Authorization is required for chiropractic services that exceed the two-visit per month limit.

In addition, a *Treatment Authorization Request* (TAR) is required for the following conditions. For pregnancy-related services and services for other conditions that might complicate the pregnancy. In this instance, the service(s) billed on the claim and requested on the TAR must include modifier TH. Modifier TH can be used for up to 60 days after termination of pregnancy.

For recipients with full-scope Medi-Cal who reach the age of 21 during the course of treatment to identify continuing care exemption. In this instance, the service(s) billed on the claim and requested on the TAR must include modifier GY for the treatment and resolution of an acute episode.

Claim Information

A diagnosis must be listed that shows anatomic cause of symptoms, for instance, sprain, strain, deformity, degeneration or malalignment.

- The spinal level must bear a direct causal relationship to the recipient's symptoms and the symptoms must be directly related to the level of the anatomic region that has been diagnosed.
- The recipient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment.
- The manual manipulative services rendered must have a direct therapeutic relationship to the recipient's condition.
- A statement and/or diagnosis of generalized or diffuse "pain" is not sufficient to establish medical necessity for the treatment.
- Maintenance therapy is not covered.

  Note: "Maintenance therapy" is defined as continued repetitive treatment without a clearly defined clinical end point.

Exceptions Not Requiring Medical Justification

The following exceptions for chiropractic services do not require medical justification to be documented in the *Remarks* field (Box 80) *Additional Claim Information* field (Box 19) or as an attachment to the claim.

- The service was provided to a recipient under 21 years of age.
- The service was rendered by a physician.

ICD-10-CM Diagnosis Codes Required

Providers may be reimbursed for chiropractic services when billed in conjunction with one of the following ICD-10-CM diagnosis codes.

ICD-10-CM Code	Description
M50.11 thru M50.13	Cervical disc disorder with radiculopathy
M51.14 thru M51.17	Intervertebral disc disorders with radiculopathy
M54.17	Radiculopathy, lumbosacral region
M54.31, M54.32	Sciatica
M54.41, M54.42	Lumbago with sciatica
M99.00 thru M99.05	Segmental and somatic dysfunction
S13.4XXA thru S13.4XXS	Sprain of ligaments of cervical spine
S16.1XXA thru S16.1XXS	Strain of muscle, fascia and tendon at neck level
S23.3XXA thru S23.3XXS	Sprain of ligaments of thoracic spine
S29.012A thru S29.012S	Strain of muscles and tendon of back wall of thorax
S33.5XXA thru S33.5XXS	Sprain of ligaments of lumbar spine
S33.6XXA thru S33.6XXS	Sprain of sacroiliac joint
S33.8XXA thru S33.8XXS	Sprain of other parts of lumbar spine and pelvis
S39.012A thru S39.012S	Strain of muscle, fascia and tendon of lower back

Optional Benefits Exclusion

Welfare and Institutions Code (W&I Code), Section 14131.10(b)(1)(C) excludes chiropractic services from coverage under the Medi-Cal program.

Optional Benefits Exclusion Exemptions

The following beneficiaries are not impacted by the optional benefits exclusion and may receive chiropractic services:

- Pregnant individuals for pregnancy-related services and services for other conditions that might complicate the pregnancy.
- Individuals eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to beneficiaries under 21 years of age.

  Note: Documentation retained in the patient medical record must support that the optional benefit service was medically necessary.
- Beneficiaries whose course of treatment continued after they turned 21. The continuing care exemption applies only to medical/surgical care required for the treatment of an acute episode. An acute episode is generally defined as an illness or condition of sudden onset, which is resolved after a short-term treatment.
- Beneficiaries residing in a skilled nursing facility (that is, Nursing Facility Level A [NF-A] and Level B [NF-B]), as defined in subdivisions (c) and (d) of Section 1250 of the *Health and Safety Code* (H&S Code) and licensed pursuant to subdivision (k) of Section 1250 of the *Health and Safety Code*. An adult subacute facility is considered an NF-B facility. The chiropractic service does not have to be provided in the facility to be reimbursable.
- Residents of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD), including Intermediate Care Facility for the Developmentally Disabled/Habilitative (ICF/DD-H) and Intermediate Care Facility for the Developmentally Disabled/Nursing (ICF/DD-N), are exempt from the optional benefits exclusion policy.
- Beneficiaries enrolled in the Program of All-Inclusive Care for the Elderly (PACE).

Additional Policies and Exemptions

In addition to those exemptions previously described in this section the optional benefits exclusion policy does not apply to the following:

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Beneficiaries receiving services in the following places of service:

- Medi-Cal acute inpatient hospitals; however, reimbursement is not permitted for ancillary services
- Out-of-state inpatient hospitals and other facilities when the service is included in the all-inclusive rate
- Hospital outpatient departments and hospital outpatient clinics (organized community hospital outpatient and county hospital outpatient only) as defined in CCR, Title 22, Section 51112
- Emergency rooms for acute inpatient hospitals, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs)

The following beneficiaries are affected by the optional benefits exclusion policy:

- Beneficiaries certified as developmentally disabled through the regional center and continue to reside in their home (non-institutionalized)
- Beneficiaries currently enrolled in one of the Department of Health Care Services' (DHCS) waivers.

Two-Visit Limit

In accordance with CCR, Title 22, Section 51304, outpatient chiropractic services are subject to a maximum of two services per month, or combination of two services per month from the following services: acupuncture, audiology, occupational therapy and speech therapy. Additional services may be provided based upon medical necessity through the TAR process. The two-visit limit does not apply to individuals eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to beneficiaries under 21 years of age (22 CCR 51340[h]).

Additional General Criteria Information

Additional general criteria information is as follows:

- Both Medi-Cal fee-for-service and Managed Care Plans (MCPs) are impacted by this policy.
- Most claims for chiropractic services billed by a physician or physician group are reimbursable. However, these claims will be denied if the rendering provider listed on the claim is not a physician, but a chiropractor and the service did not meet one of the exemption criteria stated in this section.
- Medicare/Medi-Cal crossover claims are exempt from this policy.

Billing for Nursing Facility Residents

When billing chiropractic services for Medi-Cal recipients residing in an ICF/DD, NF-A or NF-B, providers must include the following:

- On the *CMS-1500* claim form, the nursing facility's name must be entered in the Name of *Referring Provider or Other Source* field (Box 17) and the nursing facility's National Provider Identifier (NPI) entered in Box 17B.
- On the *UB-04* claim form, the NPI must be entered in Box 76.
- For electronic claims, the nursing facility's NPI must be included In Loop 2310A/2420F in the 837P v.5010 electronic format or in Loop 2310A for the 837I v.5010 electronic format. Providers should refer to the Technical Report – Type 3 (TR3) available on the Medi-Cal website (*www.medi-cal.ca.gov*) or with their third-party vendor to ensure this requirement is met.
- ‹‹For outpatient or medical claims, if the nursing facility is not a Medi-Cal provider, use modifier KX to indicate that the recipient's residency exemption has been verified. For inpatient hospital claims, document the residency exemption as an attachment to the claim. See "Services to Residents Receiving Long-Term Care In a Nursing Facility: Billing Modifier KX" in this section for additional information.››

When determining recipient eligibility, providers are encouraged to access the California Department of Public Health (CDPH) Cal Health Find Database web page to verify that the facility where the recipient resides belongs in one of these categories and is licensed by the CDPH. To determine the NPI of the facility, providers should contact the facility directly or access the National Plan and Provider Enumeration System (NPPES) NPI Registry website

Modifiers

As described previously under “Optional Benefits Exclusion Exemptions,” pregnancy-related services and continuing care services are exempted from the optional benefits exclusion policy and are reimbursable with modifiers. The procedure code must be billed with the appropriate modifier on the claim to identify the exemption. The modifier requirements are described as follows:

Pregnancy-Related Exemption Billing Modifier TH

Modifier TH (obstetrical treatment/services, prenatal or postpartum) must be used to identify pregnancy-related exemptions. Medical justification for the service is not required for the claim but must be included in the medical record. Modifier TH can be used for up to 60 days after termination of pregnancy. When billing any medically necessary service during pregnancy or the postpartum period, include a pregnancy diagnosis code on all claims. Claims submitted without a pregnancy diagnosis code may be denied.

Modifier TH should not be used by FQHC, RHC, Indian Health Services – Memorandum of Agreement (IHS-MOA), 638, Clinics and inpatient hospital providers. Providers may refer to “FQHC, RHC and IHS-MOA Providers” in this provider manual section for medical justification and additional billing instructions.

Continuing Care Exemption Billing Modifier GY

Modifier GY (item or service statutorily excluded; does not meet the definition of any Medicare benefit or for non-Medicare insurers, is not a contract benefit) must be used to identify continuing care exemptions for full-scope Medi-Cal recipients who reach the age of 21 during a course of treatment. Medical justification for the service is not required for the claim but must be included in the medical record.

Modifier GY should not be used by FQHC, RHC, IHS-MOA and inpatient hospital providers. Providers may refer to “FQHC, RHC and IHS-MOA Providers” in this provider manual section for medical justification and additional billing instructions.

The use of modifier GY for the continuing care exemption applies only to medical/surgical care required for the treatment and the resolution of the acute episode.

Services to Residents Receiving Long-Term Care In a Nursing Facility: Billing Modifier KX

For outpatient or medical claims, if the nursing facility is not a Medi-Cal provider, use modifier KX to indicate that the recipient's residency exemption has been verified. The referring provider's NPI remains required on the claim. For inpatient hospital claims, document the residency exemption as an attachment to the claim. Providers may refer to "Billing for Nursing Facility Residents" in this section for additional billing information.

Note: Modifier KX should not be used by FQHC, RHC, IHS and inpatient hospital providers. Providers may refer to "FQHC, RHC and HIS-MOA Providers" in this provider manual section for medical justification and additional billing instructions.

Transportation Providers

Medi-Cal policy states that transportation will not be covered to obtain a service that is not a Medi-Cal benefit. This policy is consistent with CCR, Title 22, Section 51323(b)(2). Therefore, non-emergency medical transportation (NEMT) and nonmedical transportation are not reimbursable for transporting Medi-Cal recipients to obtain chiropractic services unless the visit meets an exemption criterion.

NEMT Exemptions and Authorization

The NEMT provider must appropriately document and submit supporting documentation with the approved TAR or SAR that the recipient meets the exemption criteria. Nonmedical transportation does not require prior authorization. In addition to this policy, medical justification and criteria for NEMT services remains the same. Providers should refer to the "Non-Emergency Coverage" topic in the *Medical Transportation – Ground* section of the Part 2 provider manual for more detailed information about the NEMT policy.

FQHC, RHC, and HIS-MOA Providers

In addition to the policy and exemptions mentioned above, the following applies to FQHCs, RHCs, and IHS-MOA providers, except as noted.

Impact of Appellate Court Decision on FQHCs and RHCs

Chiropractic services are covered and reimbursable by Medi-Cal when provided by FQHCs and RHCs, as mandated by *California Association of Rural Health Clinics, et al*. v. *Douglas*.

Chiropractic services are subject to a maximum of two services in any one calendar month, or any combination of two services per month per recipient, among acupuncture, audiology, occupational therapy and speech therapy, except as otherwise authorized for medical necessity.

FQHC, RHC, and IHS Modifiers

Modifiers are not required for FQHC, RHC, or IHS claims. However, exemption medical justification, such as for a resident of an NF-A, NF-B, ICF/DD, ICF/DD-H or ICF/DD-N facility is required to be documented in the *Remarks* field (Box 80*)*/*Additional Claim Information* field (Box 19), as an attachment to the claim, or in the NTE segment of the 837 Institutional 837I v.5010 electronic claim.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.