



CHAPTER 504 – COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR CHIROPRACTIC SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 504.4.2	Prior Authorization Requirements for Outpatient Services	9/27/05	10/01/05

CHAPTER 504 – COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR CHIROPRACTIC SERVICES

SEPTEMBER 27, 2005

SECTION 504.4.2

Introduction: Implementing changes in policy for imaging procedures effective 10/01/05.

Change: Effective 10/01/05, prior authorization will be required on all outpatient radiological services that include Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Prior authorization requirements governing the provisions of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements, provider manual. Diagnostic services required during an emergency room episode will not require prior authorization. It is the responsibility of the ordering provider to obtain the prior authorization. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the service. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Directions: Replace pages.



CHAPTER 504—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR CHIROPRACTIC SERVICES

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CHAPTER 504—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR CHIROPRACTIC SERVICES

INTRODUCTION

The West Virginia (WV) Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

West Virginia Medicaid coverage of chiropractic services is limited to manual manipulation for subluxation of the spine and certain diagnostic radiological examinations related to chiropractic services.

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia.

This chapter sets forth the Bureau for Medical Services requirements for reimbursement of services provided by independently practicing and licensed chiropractors to eligible West Virginia Medicaid members.

504.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to Chapter 200, Definitions of the Provider Manual. In addition, the following definition also applies to the requirements for reimbursement of chiropractic services described in this chapter.

Manual manipulation – Coverage of chiropractic services specifically limited to treatment by means of manual manipulation, i.e. by use of hands. Additionally, manual devices may be used by chiropractors in performing manual manipulation of the spine, however, no additional payment is available for use of a device nor does Medicaid recognize an extra charge for devices.

Subluxation - For Medicaid coverage, subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae anatomically.

504.2 MEDICAL NECESSITY

All services must be medically necessary and appropriate to the member's needs in order to be eligible for reimbursement. The medical records of all members receiving chiropractic services must contain documentation that establishes the medical necessity of the service. Manipulation is deemed ineffective and not medically necessary when it is rendered for conditions other than subluxation of the spine.

IMPORTANT: The fact that a provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. Nor does it mean that the patient is eligible for Medicaid benefits. It is the provider's responsibility to verify Medicaid eligibility before services are provided.

504.3 PROVIDER PARTICIPATION



To participate in the West Virginia Medicaid Program and receive reimbursement from the Bureau for Medical Services, Chiropractors must:

- Meet and maintain all applicable licensing as required by the state in which the practice is located.
- Meet and maintain all BMS provider enrollment requirements (Outlined in Chapter 300).
- Have a valid signed provider enrollment application/agreement on file.

For provider enrollment application forms or additional information regarding provider participation requirements, please contact the Provider Enrollment Unit at 1-888-483-0793 or (304) 348-3360.

504.4 MEDICAID PROGRAM COVERAGE OF CHIROPRACTIC SERVICES

West Virginia Medicaid limits its coverage of chiropractic services to treatment by means of manual manipulation to correct a subluxation of the spine which is demonstrated by an x-ray. The x-ray requirement is waived for the initially covered services for pregnant women and children, but will be required for children if services above the initial twelve visits are requested.

The x-ray must be taken no more than three months prior to the date a course of treatment was initiated. In certain cases of an acute exacerbation of a chronic subluxation, an x-ray no older than a year may be accepted.

The manual manipulation must be directed to the spine to correct the subluxation. The precise level of the subluxation must be specified in the proposed treatment plan and the symptoms pertinent to the diagnosis must be described. The patient's symptoms must be related to the documented level of subluxation. For example, if pain is the symptom, the pain's location must be stated and an indication given as to whether the listed vertebrae can cause the pain in the identified area.

Attachment 1 lists the types of spinal manipulations (CPT 98940-CPT 98942) that West Virginia Medicaid covers and summarizes the services covered by these codes.

504.4.1 DIAGNOSTIC RADIOLOGY SERVICES

Medicaid reimburses chiropractors for the professional and technical components of covered diagnostic radiology services (CPT 72010-CPT 72120) if the chiropractor performs both parts of the procedure. Attachment 1 summarizes the radiological services reimbursed to Chiropractors.

To be reimbursable, x-rays must be taken on certified radiology equipment that complies with all applicable State and Federal requirements. It is the chiropractor's responsibility to furnish a copy of that certification and to keep that certification current with Medicaid's Provider Enrollment Unit.

Medicaid will provide reimbursement for only one interpretation of an x-ray and will not pay for a second confirmatory x-ray.

504.4.2 IMAGING PROCEDURE

Effective 10/01/05, prior authorization will be required on all outpatient radiological services that include Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic



Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Prior authorization requirements governing the provisions of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements, provider manual. Diagnostic services required during an emergency room episode will not require prior authorization. It is the responsibility of the ordering provider to obtain the prior authorization. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the service. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

504.5 LIMITATIONS AND CONDITIONS

Coverage of chiropractic services for subluxation of the spine is limited to one treatment per day for a Medicaid member and no more than twelve (12) treatments without prior authorization. A member may receive an additional twelve (12) treatments per calendar year if medically necessary and prior authorized. The maximum number of treatments that a member can have in any given year is 24 treatments.

Adjunctive therapies that a chiropractor may perform, such as diathermy, ultrasound, traction, laboratory tests, or other diagnostic procedures (excluding covered x-rays) are not covered services and will not be reimbursed. The chiropractic manipulative treatment codes include the pre-manipulation patient assessment and post-service work associated with the procedure.

Reimbursement is not available to chiropractors for any of the following radiology services:

- Mobile radiology services
- X-rays for soft tissue diagnosis
- Ultrasound or electrical stimulations.

504.6 PRIOR AUTHORIZATION

All chiropractic services beyond the initial twelve will require prior authorization. The provider is responsible for obtaining any required approvals. Any service rendered prior to obtaining authorization will not be reimbursed to providers, nor may the Medicaid member be held responsible for such charges unless the member did not inform the provider of the Medicaid coverage or signed an agreement to be treated as a private pay patient.

Attachment 2 contains the Chiropractic Information Form that must be completed in order to request prior authorization for chiropractic services. The completed form along with an x-ray report that is timely to the prior authorization request must be sent to:

West Virginia Medical Institute
3100 Chesterfield Ave SE
Charleston, West Virginia 25304

The West Virginia Medical Institute (WVMI) can be reached at 1-800-982-6334 or (304) 346-9167. The fax number is 304-346-8185.

Prior authorization for members who have Medicare and Medicaid benefits is unnecessary for services covered by the Medicare Program. Likewise, if a Medicaid member has private



health insurance, prior authorization is not required from Medicaid and the private insurance must be used before Medicaid.

Prior authorization does not guarantee payment for the approved services. Both providers and members must meet all applicable eligibility requirements, and services must be rendered within the Medicaid Program benefit limitations in effect as of the date of service.

All approved services must be performed within the authorized time frame. Medicaid payments will not be made for services provided outside the time frame.

504.7 GENERAL DOCUMENTATION REQUIREMENTS

Providers must maintain a specific record for all services provided for each West Virginia Medicaid eligible member including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, documentation of services provided, the dates, and times, plus the services which were provided, and the signature of the chiropractor who provided the service along with his/her credentials. Documentation must substantiate medical necessity of the service provided.

In addition to the documentation requirements in this Chapter 504, chiropractors must also comply with the documentation and maintenance of records requirements described in Chapter 100 – General Information, Chapter 300 – Provider Participation, and Chapter 800 – General Administration of the Provider Manual.

504.8 BILLING AND REIMBURSEMENT

Reimbursement for covered spinal manipulations and diagnostic radiological examinations is based on the Resource Based Relative Value Scale (RBRVS) fee schedule, subject to West Virginia Medicaid's coverage policies within the scope of services a chiropractor is legally authorized to perform by the State in which he or she practices. Payment equals the lower of the fee schedule amount or the amount the practitioner charges for the service.

Chapter 600 explains the RBRVS fee schedule.

504.9 MANAGED CARE

If the member belongs to the PAAS Program, the member's PCP must authorize and provide a referral for chiropractic services prior to services being rendered. Unless noted otherwise, services detailed in this manual are the responsibility of the HMO if the Medicaid member is a member of an HMO. Medicaid will not reimburse for services provided when HMO or PAAS requirements are not met for those members.

CHAPTER 504
CHIROPRACTIC SERVICES
OCTOBER 1, 2005

ATTACHMENT 1
COVERED PROCEDURES CODES
FOR SPINAL MANIPULATIONS AND
CHIROPRACTIC DIAGNOSTIC RADIOLOGY SERVICES
PAGE 1 OF 2

**Covered Procedures Codes
For Spinal Manipulations and
Chiropractic Diagnostic Radiology Services**

Spinal Manipulation Procedure Codes:

CPT Code	Description
98940	Chiropractor manipulation treatment: spinal, one to two regions
98941	Chiropractor manipulation treatment: spinal, three to four regions
98942	Chiropractor manipulation treatment: spinal, five regions

Diagnostic Radiology Services:

CPT Code	Description
72010	Radiological examination, spine, entire, survey study, anteroposterior and lateral
72020	Radiologic examination, spine, single view, specify level
72040	Radiologic examination, spine, cervical, two or three views
72050	Radiologic examination, spine, cervical, minimum of four views
72052	Radiologic examination, spine, cervical, complete, including oblique and flexion and/or extension studies
72069	Radiologic examination, spine, thoracolumbar, standing (scoliosis)
72070	Radiologic examination, spine, thoracic, two views
72072	Radiologic examination, spine, thoracic, three views
72074	Radiologic examination, spine, thoracic, minimum of four views
72080	Radiologic examination, spine, thoracolumbar, two views
72090	Radiologic examination, spine, scoliosis study, including supine and erect studies
72100	Radiologic examination, spine, lumbrosacral; two or three views
72110	Radiologic examination, spine, lumbrosacral; minimum of four views
72114	Radiologic examination, spine, lumbrosacral, complete, including bending views
72120	Radiologic examination, spine, lumbrosacral; bending views only, minimum of four views

**CHAPTER 504
CHIROPRACTIC SERVICES
OCTOBER 1, 2005**

**ATTACHMENT 2
THE CHIROPRACTIC INFORMATION FORM
(THESE PAGES MAY BE DUPLICATED)
PAGE 1 OF 3**

Chiropractic Information Form

This form must be completed by the treating chiropractor and submitted for authorization prior to services being rendered.

Patient Name: _____ Medicaid ID# _____

A. Diagnosis:

- 1. _____
- 2. _____

B. Specific Spine Subluxation:

- 1. Cervical _____
- 2. Thoracic _____
- 3. Lumbar _____
- 4. Other _____

C. Date and history of onset/date and history of exacerbation for this diagnosis:

D. Dates of service for the current calendar year:

List all dates patient was seen in provider's office for current calendar year only.

E. Subjective complaints:

- 1. _____
- 2. _____
- 3. _____
- 4. _____:

F. Objective Complaints

- 1. _____
- 2. _____

G. Description of spinal manipulation:

H. Short-term goals of treatment:

I. Long-term goals of treatment:

J. Co-Morbidities that could affect length of treatment:

K. Frequency of requested visits and schedule of declining frequency:

1. Date of first treatment for this authorization request: _____

2. Total number of treatments requested: _____

3. The request is for ____ additional treatments for the month of _____

4. This request is for ___ treatments over 30 60 90 days (circle the appropriate number)

Frequency of requested visits is:

_____ times per week for _____ weeks; and

_____ times per week for _____ weeks.

L. Emergency Request - Please give a brief explanation:

Provider name: _____ Provider ID# _____

Signature: _____ Date: _____