

## CHAPTER 5-000 CHIROPRACTIC SERVICES

### 5-001 Definitions

Initial Visit: History, examination, and manual manipulation for a client who has not received services from the chiropractor within the past three years.

### 5-002 Provider Requirements

5-002.01 General Provider Requirements: To participate in the Nebraska Medical Assistance Program (Medicaid), providers of chiropractic services shall comply with all applicable participation requirements codified in 471 NAC Chapters 2 and 3. In the event that provider participation requirements in 471 NAC Chapters 2 or 3 conflict with requirements outlined in this 471 NAC Chapter 5, the individual provider participation requirements in 471 NAC Chapter 5 shall govern.

5-002.02 Service Specific Provider Requirements: Chiropractors must be licensed by the Nebraska Department of Health and Human Services, and be eligible to participate in Medicare. If chiropractic services are provided outside of Nebraska, the chiropractor must be licensed in that state.

5-002.02A Provider Agreement: Chiropractors shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit the completed form to the Department for approval to participate in Medicaid.

### 5-003 Service Requirements

#### 5-003.01 General Requirements

5-003.01A Medical Necessity: Treatment that is reasonable and necessary. Documentation of a reasonable expectation of recovery or improvement from ongoing chiropractic treatment is required.

5-003.01B Services Provided for Clients Enrolled in the Nebraska Medicaid Managed Care Program: See 471 NAC 1-002.01.

5-003.01C HEALTH CHECK (EPSDT) Treatment Services: See 471 NAC Chapter 33.

5-003.02 Covered Services: Medicaid limits coverage of chiropractic services to treatment of the spine by manual manipulation and certain spinal x-rays (see 471 NAC 5-003.02B).

5-003.02A Manual Manipulation: Manual manipulation of the spine is covered only for the treatment of spinal subluxations for which treatment provides a direct therapeutic benefit.

1. For clients age 21 and older: Manual manipulation of the spine is limited to a maximum of 12 treatments per calendar year.
2. For clients age 20 and younger: Manual manipulation of the spine is limited to a maximum of 18 treatments in the initial 5 months from the date of the first visit for the reported diagnosis. After the 5<sup>th</sup> month a maximum of one treatment per month is covered until the age of 21.
3. No more than one treatment per client per day is covered.

5-003.02B Spinal X-Rays: Coverage of spinal x-rays is limited to one anteroposterior and one lateral view of the entire spine or each of the following: thoracic, cervical, and lumbosacral for a client in a 12 month period.

For spinal x-rays to be covered under Medicaid, at least one of the following criteria must be met:

1. Recent acute or violent trauma where there may be a question concerning avulsion, fracture, or subluxation;
2. Chronic or long-standing ailments that have been treated by other practitioners without success and, if x-rays were already taken, they are not available;
3. When there is a pathology or malignancy previously diagnosed, precautionary x-rays are covered when medically necessary;
4. If there is any indication of existing pathology in the evaluation of the client, the treatment of which may cause additional discomfort;
5. If the client has been under long-term treatment with no alleviation of symptoms; or
6. When specifically required by the Department's utilization review and for documentation of diagnosis and claims for services.

5-003.03 Non-Covered Services: Except for treatment of the spine by manual manipulation and spinal x-rays, Medicaid does not cover any other diagnostic or therapeutic service or supply provided by a chiropractor or on his/her order including, but not limited to:

1. Laboratory tests;
2. Orthopedic devices;
3. Physiotherapy (i.e., ultrasound, diathermy, etc.);
4. Nutritional supplements;
5. EKGs; and
6. Acupuncture.

## 5-004 Billing and Payment for Chiropractic Services

### 5-004.01 Billing

5-004.01A General Billing Requirements: Providers shall comply with all applicable billing requirements codified in 471 NAC Chapter 3. In the event that billing requirements in 471 NAC Chapter 3 conflict with billing requirements outlined in 471 NAC Chapter 5, the billing requirements in 471 NAC Chapter 5 shall govern.

### 5-004.01B Specific Billing Requirements

5-004.01B1 Billing Instructions: The provider shall bill Medicaid, using the appropriate claim form or electronic format (see Claim Submission Table at Appendix 471-000-49), in accordance with the billing instructions included in Appendix 471-000-54.

5-004.01B2 Usual and Customary Charge: The provider, or the provider's authorized agent, shall submit the provider's usual and customary charge for each procedure code listed on the claim. HCPCS/CPT procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-505).

5-004.01B3 Manual Manipulation: The chiropractor shall list the following information on the claim when billing Medicaid:

- a. The diagnosis which includes the level of subluxation;
- b. The symptom(s) that directly relates to the diagnosis (subluxation); and
- c. The initial date of treatment billed to Medicaid for the reported diagnosis.

### 5-004.02 Payment

5-004.02A General Payment Requirements: Nebraska Medicaid will reimburse the Provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC Chapter 3. In the event that payment regulations in 471 NAC Chapter 3 conflict with payment regulations outlined in this 471 NAC Chapter 5, the payment regulations in 471 NAC Chapter 5 shall govern.

### 5-004.02B Specific Payment Requirements

5-004.02B1 Reimbursement: Medicaid pays for covered chiropractic services in amount equal to the lesser of:

- a. The provider's submitted charge; and
- b. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for the date of service.

REV. MAY 22, 2018  
MANUAL LETTER #48-2018

NEBRASKA DEPARTMENT OF  
HEALTH AND HUMAN SERVICES

MEDICAID SERVICES  
471 NAC 5-004.02B2

5-004.02B2 Medicare/Medicaid Crossover Claims: For payment of Medicare/Medicaid crossover claims, see Appendix 471-000-70.

5-004.02B3 Copayment: For Medicaid copayment requirements, see 471 NAC 3-008.