CHIROPRACTIC SERVICES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirements.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement.

Chiropractors licensed under South Dakota law or licensed by the state in which he or she practices are eligible to enroll with South Dakota Medicaid.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's online portal.

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to copays, coinsurance, and deductibles on Medicare A and B covered services.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.

Refer to the Recipient Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

COVERED SERVICES AND LIMITS

General Coverage Principles
Providers should refer to the General Coverage Principles manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

Covered Services
Chiropractic services are covered when medically necessary. Services are considered medically necessary when all the following criteria are met:

- The member has a neuromusculoskeletal condition and the manipulative services performed have a direct therapeutic relationship to the condition;
- The member has a subluxation of the spine as demonstrated by x-ray or physical examination; and
- The medical necessity for treatment is clearly documented.

Chiropractic maintenance therapy is not considered to be medically necessary.

Chiropractic services are limited to x-rays and manual manipulations of the spine to correct a subluxation. In addition, in performing manual manipulation of the spine, some chiropractors use manual devices that are hand-held with the thrust of the force of the device being controlled manually. While such manual manipulation may be covered, there is no separate payment permitted for use of this device. South Dakota Medicaid covers a maximum of 30 manual manipulations of the spine in a plan year, which starts July 1 and ends June 30. This limitation applies to any combination of CPT codes 98940, 98941, and 98942.

X-rays
South Dakota Medicaid covers the X-rays listed on the Chiropractic Services Fee Schedule when medical necessity is documented. An x-ray is not required to demonstrate subluxation. However, an x-ray still may be used to demonstrate the existence of the subluxation. If the recipient indicates that x-rays were performed by another provider or facility, the provider should attempt to obtain them. Coverage of spinal x-rays is limited to two units per region of the spine (cervical, thoracic, lumbar) per plan year. Providers may not bill multiple units of CPT code 72020, x-ray exam of spine 1 view, if a multiple-view procedure code is applicable. The number of units indicates the number of times a procedure is performed, not the number of views.

Evaluation and Management Services
Evaluation and management (EM) CPT Codes are only billable if coding requirements in the CPT codebook are met including the new patient requirements if billing a new patient code. The following conditions must be met for EM codes to be covered:

- A provider may only bill Medicaid an EM visit if it is the provider's customary practice to charge all patients for these services.

- An EM visit is not reimbursable on the same date of service as a manipulation unless the services are distinctly different.
- Only one EM visit is reimbursable in any 12-month period unless an additional EM code is being billed for a separate and distinct injury. The provider must maintain documentation that supports medical necessity. Documentation may be requested by South Dakota Medicaid.
- An annual claim for an EM visit must show continued medical necessity and progress towards improvement of the condition. Documentation may be requested.

Diagnosis Codes

Chiropractic providers must bill a diagnosis that includes the level of subluxation as the primary diagnosis code. Refer to the Diagnosis look-up tool for allowable ICD-10 codes. Symptoms that directly relate to the diagnosis (subluxation) may be listed as secondary diagnoses. Claims which are submitted with ICD-10 codes which are not allowed to be billed as a primary and/or secondary diagnosis code will deny. Providers may request South Dakota Medicaid review ICD-10 codes for potential coverage via the Online Portal. Instructions regarding submitting a request are available in the Reconsiderations, Appeals, and Grievances manual.

Pregnancy Coverage Limits

Effective July 1, 2023, most pregnant and postpartum women on Medicaid are in a full coverage group (aid categories 46 and 47) and qualify for chiropractic services if they meet the medical necessity coverage criteria above. Aid category 79 is a limited pregnancy coverage group. Chiropractic services are covered for women in Aid Category 79 after the first trimester if medically necessary due to the pregnancy causing a subluxation of the spine. The following secondary diagnosis codes may be used:

- Z34.82 Encounter for supervision of normal pregnancy, Second Trimester
- Z34.83 Encounter for supervision of normal pregnancy, Third Trimester

Refer to the Recipient Eligibility manual for additional information regarding full coverage and limited coverage aid categories.

NON-COVERED SERVICES

General Non-Covered Services

Providers should refer to ARSD 67:16:01:08 or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid.

Non-Covered Services

- Acupuncture;
- Any joint manipulation outside of the spine;
- Chiropractic maintenance therapy;
- Electrical stimulation;
- Custom orthotics provided by the chiropractor's office;
- Vitamins or nutritional supplements or counseling; and

- Ultrasound.

DOCUMENTATION REQUIREMENTS

General Requirements
Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

Pregnancy Coverage (Aid Category 79) Documentation
For recipients who are eligible via pregnancy related aid category (79), the provider must document how the service is medically necessary due to the pregnancy. Documentation may be requested.

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Timely Filing
South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability
Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

Reimbursement
A claim for chiropractic services must be submitted at the provider's usual and customary charge. Payment for chiropractic services is limited to the lesser of the provider's usual and customary charge or the fee contained on South Dakota Medicaid's Chiropractic Services fee schedule.

Claim Instructions
Claims for Chiropractic services must be submitted on the CMS 1500 claim form or on a 837P. Detailed CMS 1500 claim form instructions are available on the Medicaid Billing Manual website. Refer to the 837P instructions for electronic claims.

If an office visit is billed on the same date of service as a manipulation and it is a distinctly different service, modifier 25 should be appended to the office visit.

Medicare does not reimburse chiropractors for radiologic procedures. As such you do not need to submit your claim to Medicare prior to submitting the radiologic service to South Dakota Medicaid.

DEFINITIONS

1. "Chiropractic services," those diagnostic and treatment services provided by a chiropractor to detect and treat one or more subluxations of the spine;

2. “Chiropractic Maintenance Therapy,” a plan of care that seeks to prevent disease, promotes health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy;

3. "Chiropractor," a person licensed by the board of chiropractic examiners; a person who is licensed as a chiropractor in another state;

4. "Manual manipulation," a method used to successfully relocate a subluxated vertebra which consists of an assisted motion applied to the vertebra beyond the active and passive range of motion; and

5. "Subluxation," an incomplete or partial dislocation.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. **When does the annual limit for manual manipulations of the spine start over?**

   The annual limit is for the period of July 1 to June 30. An individual who has reached the maximum is eligible for services again on July 1.

2. **How can I determine if a recipient has exceeded their annual spinal manipulation limit?**

   South Dakota Medicaid recommends using the Online Portal to view the most current service limit status. The service limit status is not real-time. The only units which will appear are those that have been billed and paid as of the timeframe requested.

3. Can the annual limit be exceeded?

It can be exceeded for individuals under 21 with a prior authorization by South Dakota Medicaid. Please refer to the Prior Authorization manual for instructions on submitting an EPSDT prior authorization request. The limit cannot be exceeded for individuals 21 and over.

4. Are chiropractic services covered for pregnant women?

Effective July 1, 2023, most pregnant and postpartum women on Medicaid are in a full coverage group (aid categories 46 and 47) and qualify for chiropractic services if they meet the medical necessity coverage criteria above. Aid category 79 is a limited pregnancy coverage group. Chiropractic services are covered for women in Aid Category 79 after the first trimester if medically necessary due to the pregnancy causing a subluxation of the spine.