

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 tenen 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 requirement.

South Dakota Medicaid has a streamlined enrollment process for ordering, referring, and attending physicians 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 co-payments and deductibles on Medicare A and B covered services.
Medicaid – Pregnancy Related Coverage Only (77)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.
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.

Procedure Codes

Covered chiropractic services are limited to the procedures listed on the department's [Chiropractic Services](#) fee schedule.

The following restrictions apply:

- South Dakota Medicaid pays for 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.
- A provider 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.
- A provider may not submit a claim for CPT code 99211, office/outpatient visit established patient, in conjunction with procedure code 99201, office/outpatient visit new patient.
- A provider may not submit a claim for CPT code 99211, office/outpatient visit established patient, more than once in any 12-month period.
 - Annual claims for procedure code 99211 must show continued medical necessity and progress towards improvement of the condition. Documentation may be requested.
 - An additional claim for procedure code 99211 may be submitted within the 12-month period for a separate and distinct injury with supporting documentation of medical necessity. Documentation may be requested.
- A provider may not submit a claim for procedure code 99201, office/outpatient visit new patient, or 99211, office/outpatient visit established patient, unless it is the provider's customary practice to charge all patients for these services.
- An office visit is not reimbursable on the same date of service as a manipulation unless the services are distinctly different.

Diagnosis Codes

Chiropractic services are only reimbursable if the diagnosis is for subluxation of the spine. Only the following diagnosis codes are covered:

M99.00 to M99.05, inclusive;
M99.10 to M99.14; inclusive;

S13.0XXA	S13.131A	S13.180A	S23.110A	S23.133A	S23.153A	S23.29XA	S33.130A
S13.100A	S13.140A	S13.181A	S23.120A	S23.140A	S23.160A	S33.0XXA	S33.131A
S13.101A	S13.141A	S13.20XA	S23.121A	S23.141A	S23.161A	S33.100Z	S33.140A
S13.110A	S13.150A	S13.29XA	S23.122A	S23.142A	S23.162A	S33.101A	S33.141A
S13.111A	S13.151A	S.230XXA	S23.123A	S23.143A	S23.163A	S33.110A	S33.2XXA
S13.120A	S13.160A	S23.100A	S23.130A	S23.150A	S23.170A	S33.111A	
S13.121A	S13.170A	S23.101A	S23.131A	S23.151A	S23.171A	S33.120A	
S13.130A	S13.171A	S23.101A	S23.132A	S23.152A	S23.20XA	S33.121A	

Pregnancy Related Services Limits

Chiropractic services are covered for women in Aid Category 77 or 79 if medically necessary due to the pregnancy. Chiropractic service are not covered in the first trimester and are only covered in the second and third trimester if the pregnancy causes back pain that results in chiropractic services being medically necessary. The following diagnosis codes may be used for pregnant women:

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

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.

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 Documentation

For recipients who are eligible via pregnancy related aid category (77 or 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, meaning Medicaid only pays for a service if there are no other liable third-party payers. 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 in the [Professional Services Billing Manual](#). Refer to the [837P](#) instructions for electronic claims.

If an office 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. "Chiropractor," a person licensed by the board of chiropractic examiners; a person who is licensed as a chiropractor in another state;
3. "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
4. "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 limit?

The chiropractor is responsible for tracking the number of manipulations.

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 women with pregnancy only coverage?

Yes, in the second and third trimester when medically necessary due to the pregnancy.

5. Can I bill Medicaid for services other than manual manipulations of the spine?

No, federal regulation limits coverage of chiropractic services to manual manipulations of the spine.