

TITLE 471 - NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 5 - CHIROPRACTIC SERVICES

001. SCOPE AND AUTHORITY. These regulations govern services provided under the Medical Assistance Act, Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq.

002. PROVIDER REQUIREMENTS.

002.01 GENERAL PROVIDER REQUIREMENTS. Providers of chiropractic services must comply with all applicable provider participation requirements codified in 471 Nebraska Administrative Code (NAC) 2 and 3. In the event that provider participation requirements in 471 NAC 2 or 3 conflict with requirements outlined in this chapter, the individual provider participation requirements in this chapter will govern.

002.02 SERVICE SPECIFIC PROVIDER REQUIREMENTS. If chiropractic services are provided outside of Nebraska, the chiropractor must be licensed in the state in which the services are provided.

003. SERVICE REQUIREMENTS.

003.01 GENERAL REQUIREMENTS.

003.01(A) MEDICAL NECESSITY. Medicaid incorporates the definition of medical necessity from 471 NAC 1 as is fully rewritten herein. Services and supplies that do not meet the 471 NAC 1 definition of medical necessity are not covered.

003.01(B) SERVICES PROVIDED FOR CLIENTS ENROLLED IN NEBRASKA MEDICAID MANAGED CARE. See 471 NAC 1.

003.01(C) HEALTH CHECK SERVICES. See 471 NAC 33.

003.02 COVERED SERVICES. Medicaid limits coverage of chiropractic services to:

- (i) Certain spinal x-rays;
- (ii) Manual manipulation of the spine;
- (iii) Certain evaluation and management services;
- (iv) Traction;
- (v) Electrical stimulation;
- (vi) Ultrasound; and
- (vii) Certain therapeutic procedures, activities, and techniques designed and implemented to improve, develop, or maintain the function of the

area treated.

003.02(A) CHIROPRACTIC TREATMENT. Covered services are only for the treatment of spinal subluxations for which treatment provides a direct therapeutic benefit, and is subject to the following limitations:

- (i) For clients age 21 and older, chiropractic treatment is limited to those treatments deemed medically necessary;
- (ii) For clients age 20 and younger, chiropractic treatment is limited to those treatments deemed medically necessary; and
- (iii) No more than one treatment per client per day is covered.

003.02(B) SPINAL X-RAYS. Coverage of spinal x-rays is limited to one anteroposterior and one lateral view of the entire spine or one 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:

- (i) Recent acute or violent trauma where there may be a question concerning avulsion, fracture, or subluxation;
- (ii) 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;
- (iii) When there is a pathology or malignancy previously diagnosed, precautionary x-rays are covered when medically necessary;
- (iv) If there is any indication of existing pathology in the evaluation of the client, the treatment of which may cause additional discomfort;
- (v) If the client has been under long-term treatment with no alleviation of symptoms; or
- (vi) When specifically required by the Department's utilization review and for documentation of diagnosis and claims for services.

003.03 NON-COVERED SERVICES. Except for those services previously specified, Medicaid does not cover any other diagnostic or therapeutic service or supply provided by a chiropractor.

004. BILLING AND PAYMENT FOR CHIROPRACTIC SERVICES.

004.01 BILLING.

004.01(A) GENERAL BILLING REQUIREMENTS. Providers must comply with all applicable billing requirements codified in 471 NAC 3. In the event that individual billing requirements in 471 NAC 3 conflict with billing requirements outlined in this chapter, the individual billing

requirements in this chapter will govern.

004.01(B) SPECIFIC BILLING REQUIREMENTS.

004.01(B)(i) BILLING INSTRUCTIONS. The provider must bill Medicaid, using the appropriate claim form or electronic format.

004.01(B)(ii) USUAL AND CUSTOMARY CHARGE. The provider, or the provider's authorized agent, must submit the provider's usual and customary charge for each procedure code listed on the claim. Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule.

004.01(B)(iii) CHIROPRACTIC TREATMENT. The chiropractor must list the following information on the claim when billing Medicaid:

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

004.02 PAYMENT.

004.02(A) GENERAL PAYMENT REQUIREMENTS. Medicaid will reimburse the provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC 3. In the event that individual payment regulations in 471 NAC 3 conflict with payment regulations outlined in this chapter, the individual payment regulations in this chapter will govern.

004.02(B) SPECIFIC PAYMENT REQUIREMENTS.

004.02(B)(i) REIMBURSEMENT. Medicaid pays for covered chiropractic services in the amount equal to the lesser of:

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

