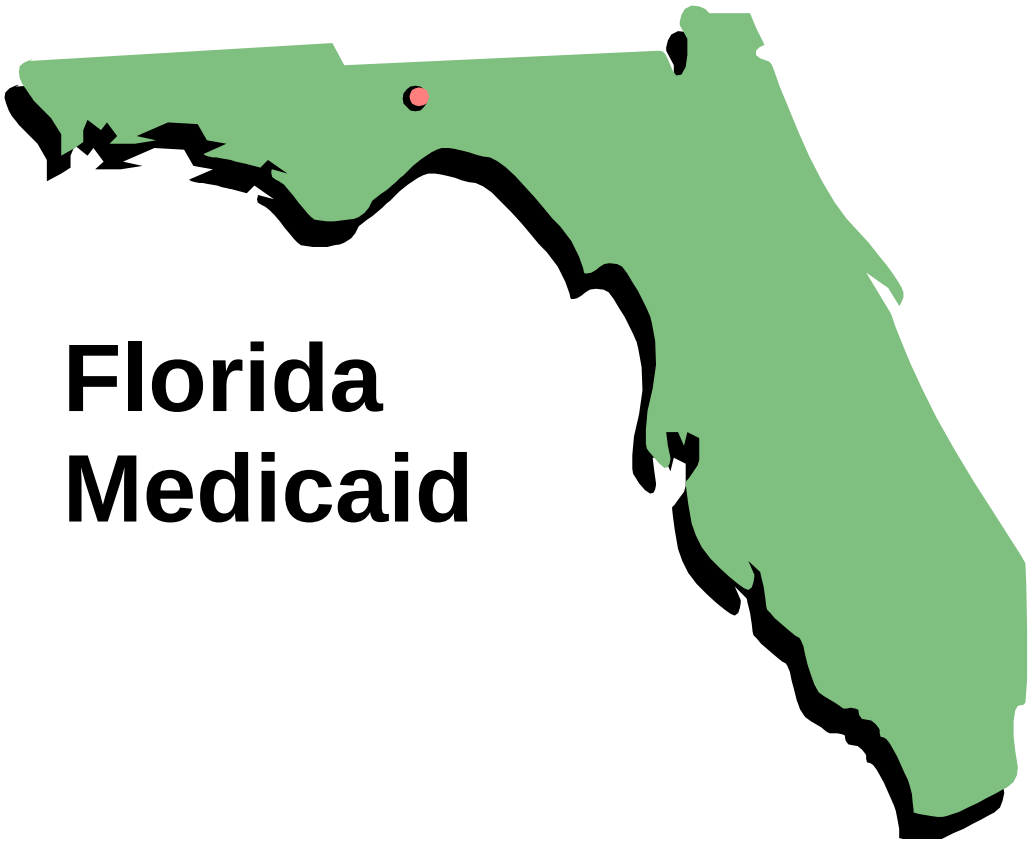

Florida Medicaid

Chiropractic Services Coverage Policy

Agency for Health Care Administration

August 2015

Table of Contents

1.0 Introduction

1.1 Description

Chiropractic services focuses on the diagnosis and manipulative treatment of misalignments of the joints, especially those of the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs.

1.1.1 Medicaid Policies

This policy is intended for use by chiropractic providers that render services to eligible Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider General Handbook, which describes requirements under the Florida Medicaid program that apply to all Medicaid providers. A provider who renders more than one type of Florida Medicaid service will have more than one coverage and limitations handbook or coverage policy with which they must comply.

Note: Policies are available on the Florida Medicaid fiscal agent's Web site at http://portal.flmmis.com/flpublic. All policies are incorporated by reference in Rule Division 59G, Florida Administrative Code (F.A.C.).

1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum requirements for all providers of chiropractic services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the coverage requirements outlined in this policy, unless otherwise specified in the Agency for Health Care Administration's (AHCA) contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Medicaid managed care plan must not be subject to more stringent coverage than specified in Florida Medicaid policies.

1.2 Legal Authority

Chiropractic services are authorized by the following:

- Title 42, Code of Federal Regulations (CFR), 440.60
- Section 409.906, Florida Statutes (F.S.)
- Rule 59G-4.040, F.A.C.

1.3 Definitions

1.3.1 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

1.3.2 Established Patient Visit

A visit to manually manipulate the spine.

1.3.3 Long-term Care Plan

A managed care plan that provides services in accordance with section 409.98, F.S., for the long-term care program of the Statewide Medicaid Managed Care program.

1.3.4 Managed Medical Assistance Plan

A managed care plan that provides services in accordance with section 409.973, F.S., for the medical assistance program of the Statewide Medicaid Managed Care program.

1.3.5 Medically Necessary/Medical Necessity

In accordance with Rule 59G-1.010, F.A.C., "[T]he medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider."

"(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service."

1.3.6 New Patient Visit
A visit which includes manual manipulation of the spine and screening.

1.3.7 Provider
The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.8 Provider General Handbook
A handbook with information that applies to all providers regarding the Florida Medicaid program, recipient eligibility, provider enrollment, fraud and abuse policy, and other important resources.

1.3.9 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

1.3.10 Reimbursement Handbook
A handbook that provides instructions on how to bill for services.

2.0 Eligible Recipient

2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary chiropractic services. Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance, Copayment, or Deductible
Recipients are responsible for a $1.00 copayment, unless the recipient is exempt from copayment requirements or the copayment is waived by the Medicaid managed care plan in which the recipient is enrolled.

Note: For more information regarding copay exemptions, see the Florida Medicaid Provider General Handbook.

3.0 Eligible Provider

3.1 General Criteria

To be reimbursed for services rendered to eligible recipients, providers must meet at least one of the following:

- Directly enrolled with Florida Medicaid if providing services through a fee-for-service delivery system
- Registered with Florida Medicaid if providing services through a managed care plan

3.2 Who Can Provide

Practitioners licensed within their scope of practice to perform this service.

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid reimburses services that:

- Are determined medically necessary.
- Do not duplicate another service.
- Meet the criteria as specified in this policy.

4.2 Specific Criteria

Florida Medicaid reimburses for the following:

- One new patient visit plus 23 established patient visits per year or 24 established patient visits per year
- X-rays

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when:

- The service does not meet the medical necessity criteria listed in section 1.0.
- The recipient does not meet the eligibility requirements listed in section 2.0.
- The service unnecessarily duplicates another provider's service.

5.2 Specific Non-Covered Criteria

There are no specific non-covered exclusion criteria for this service.

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to the Florida Medicaid Provider General Handbook.

6.2 Specific Criteria

There are no specific documentation criteria for this service.

7.0 Authorization

7.1 General Criteria

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of

21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary.

For recipients enrolled in a managed care plan, providers should request authorization through the recipient's managed care plan. For recipients receiving services through the fee-for-service delivery system, providers should request authorization through the process described in the Florida Medicaid Provider General Handbook.

7.2 Specific Criteria

There are no specific authorization criteria for this service.

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system, unless otherwise specified.

8.2 Claim Type

Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

8.4 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 Rate

For a schedule of rates, as incorporated by reference in Rule 59G-4.002, F.A.C., see http://portal.flmmis.com/flpublic.