



REIMBURSEMENT POLICY STATEMENT GEORGIA MARKETPLACE

Policy Name	Policy Number	Effective Date
Chiropractic Care – Spinal Manipulation	PY-1331	09/01/2021-10/31/2022
Policy Type		
Medical	Administrative	Pharmacy
		REIMBURSEMENT

Reimbursement Policy Statement: Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject
Chiropractic Care – Spinal Manipulation

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS/ICD-10 code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Chiropractic is a licensed healthcare profession where treatment typically involves manual therapy, often including spinal manipulation.

C. Definitions

NA

D. Policy

- I. A service performed must be medically necessary and related to the treatment of a specific medical complaint.
 - A. To determine medical necessity, CareSource requires all of the following:
 1. A primary diagnosis of subluxation
 - a. Examples include lumbar and sacral; and
 2. A secondary diagnosis that supports the treatment provided.
 - a. Examples include osteoarthritis and congenial musculoskeletal deformities of the spine.
 - B. The manual manipulation must have a direct therapeutic relationship to the member's condition as documented in the medical record. The lack of documentation specifying the relationship between the member's condition and treatment shall result in the service being ineligible for reimbursement.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.



F. Related Policies/Rules

Medical Necessity Determination Policy

CareSource Evidence of Coverage and Health Insurance Contract

G. Review/Revision History

DATE		ACTION
Date Issued	05/26/2021	
Date Revised		
Date Effective	09/01/2021	
Date Archived	10/31/2022	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. The Association of Chiropractic Colleges. (n.d.). Chiropractic Paradigm/Scope & Practice. Retrieved April 15, 2021 from www.chirocolleges.org

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.