Chiropractic Services

Chiropractic manipulative treatment may be covered for Medicaid beneficiaries up to 21 years of age when medically necessary and provided as a result of a medical referral from the beneficiary's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) medical screening primary care physician.

Billing Information

Only chiropractic manipulation of up to four spinal regions will be approved for reimbursement. Chiropractors are to bill for these services using the most current and appropriate *Current Procedural Terminology* (CPT) codes for the services provided. Healthcare Common Procedure Coding System (HCPCS) modifier "AT" may be used to designate acute treatment.

Claims for chiropractic services pend to Medical Review and must be submitted hardcopy. The claim is to be accompanied by a written, dated, and signed referral statement from the EPSDT medical screening primary care provider **and** documentation substantiating the medical necessity of the services. The documentation should include, but is not limited to, the following:

1. Diagnosis and chief complaint;
2. Relevant history;
3. Subjective and objective diagnostic examination findings;
4. Acuity and severity of the beneficiary's condition;
5. Results of x-ray, lab and other diagnostic tests;
6. Number of treatment sessions necessary to correct or alleviate the beneficiary's symptoms or problem;
7. The level of care (relief, therapeutic, rehabilitative, supportive) planned;
8. Procedures performed and results;
9. Response to therapy; and
10. Progress notes and beneficiary disposition.