Connecticut interChange MMIS

Provider Manual

Chapter 7 - Chiropractic
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CONNECTICUT MEDICAL ASSISTANCE PROGRAMS
Chiropractic Services Policy/Regulation
Chapter 7

Medical Services Policy 7.1

This section of the Provider Manual contains the Medical Services policy sections that pertain to chiropractic providers.

Policy updates, additions, and revisions are approved in accordance with the Connecticut Uniform Administrative Procedure Act. Should this occur, providers are notified through the Provider Bulletin process and sent policy update pages to place in Chapter 7 of their manuals.

Chiropractic Services

Requirements for Payment of Chiropractic Services (Regulations of Connecticut State Agencies)

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Requirements for Payment of Chiropractic Services

Sec. 17b-262-535 Scope

Sections 17b-262-535 through 17b-262-545 inclusive set forth the Department of Social Services requirements for payment of chiropractic services, performed by licensed practitioners of chiropractic in private or group practices, for clients who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

Sec. 17b-262-536 Definitions

For the purposes of sections 17b-262-535 through 17b-262-545 the following definitions shall apply:

(1) **"Acute"** means having rapid onset, severe symptoms, and a short course.

(2) **"Chiropractic"** means the services described in Title 42 of the Code of Federal Regulations (CFR), Part 440, section 440.60, and subsection (1) of section 20-24 of the Connecticut General Statutes.

(3) **"Client"** means a person eligible for goods or services under the department's Medical Assistance Program.

(4) **"Commissioner"** means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(5) **"Department"** means the Department of Social Services or its agent.

(6) **"Emergency"** means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(7) **"HealthTrack Services"** means the services described in subsection (r) of section 1905 of the Social Security Act.

(8) **"HealthTrack Special Services"** means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(9) **"Interperiodic Encounter"** means any medically necessary visit to a Connecticut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(10) **"Licensed Practitioner of the Healing Arts"** means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(11) **"Medical Appropriateness or Medically Appropriate"** means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.
(12) **"Medical Assistance Program"** means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes (CGS) and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.
(13) **"Medical Necessity or Medically Necessary"** means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring.
(14) **"Medical Record"** means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is also the Public Health Code.
(15) **"Prior Authorization"** means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.
(16) **"Provider"** means one who is licensed to practice chiropractic.
(17) **"Provider Agreement"** means the signed, written, contractual agreement between the department and the provider of services or goods.
(18) **"State Plan"** means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).
(19) **"Subluxation"** means an incomplete dislocation, off centering, misalignment fixation of a joint or abnormal spacing of a vertebra as used by the practitioner of chiropractic.

Sec. 17b-262-537 Provider Participation
In order to enroll in the Medical Assistance Program and receive payment from the department, providers shall:
(a) meet and maintain all applicable licensing, accreditation, and certification requirements;
(b) meet and maintain all departmental enrollment requirements; and
(c) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

Sec. 17b-262-538 Eligibility
Payment for chiropractic services shall be available on behalf of all persons eligible for the Medical Assistance Program subject to the conditions and limitations which apply to these services.

Sec. 17b-262-539 Services Covered and Limitations

(a) Except for the limitations and exclusions listed below, the department shall pay for the following:

(1) the manual manipulation of the spine, but not for any procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history;

(2) services provided in the provider's office, client's home, hospital, nursing facility, rest home, home for the aged, boarding home, or intermediate care facility for the mentally retarded (ICF/MR); and

(3) HealthTrack Services and HealthTrack Special Services.

(b) Limitations on covered services shall be as follows:

(1) those services listed in the department's fee schedule and within the scope of the provider's practice;

(2) the department shall pay for no more than one visit per day per client per provider; and

(3) the department shall pay for a maximum of four exams or treatments in a single visit to a home, hospital, nursing facility, rest home, home for the aged, boarding home, or intermediate care facility for the mentally retarded (ICF/MR).

Sec. 17b-262-540 Services Not Covered

The department shall not pay for the following chiropractic services which are not covered under the Medical Assistance Program:

(a) chiropractic practice does not include the prescription or administration of any medicine or drug or the performance of any surgery;

(b) x-rays furnished by a practitioner of chiropractic;

(c) an initial visit for exam and diagnosis;

(d) manipulation of other parts of the body such as: the shoulder, arm, knee--even when for subluxation of the spine;

(e) lab work ordered by a practitioner of chiropractic;

(f) for information or services provided to a client over the telephone; and

(g) for cancelled office visits or appointments not kept.

Sec. 17b-262-541 Need for Service

The department shall pay for medically necessary and medically appropriate treatment only when:

(a) provided by a licensed practitioner of chiropractic and the services are within the scope of practice of the practitioner, and

(b) the services are made part of the client's medical record.

Sec. 17b-262-542 Prior Authorization

(a) Prior authorization, on forms and in a manner as specified by the department, is required for:

(1) manipulation of the spine in excess of five per client per provider per month; and

(2) HealthTrack Special Services. HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis. The request for HealthTrack Special Services shall include:

(A) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or service required;

(B) a description of the outcomes of any alternative measures tried; and

(C) if applicable and requested by the department, any other documentation required in order to render a decision.

(b) The procedure or course of treatment authorized shall be initiated within six months of the date of authorization.

(c) The initial authorization period shall be up to three months.

(d) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered up to six months per request.

(e) For services requiring prior authorization, a provider shall be required to provide pertinent medical or social information adequate for evaluating the client's medical need for services. Except in emergency situations, or when authorization is being requested for more than one visit in the same day, approval shall be received before services are rendered.

(f) In an emergency situation which occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided. This applies only to those services which normally require prior authorization.

(g) In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

Sec. 17b-262-543 Billing Procedures

(a) The amount billed to the department shall represent the practitioner of chiropractic's usual and customary charge for the services delivered.

(b) Claims from practitioners of chiropractic shall be submitted on a hard copy invoice or electronically transmitted to the department's fiscal agent, in a form and manner as specified by the department, and shall include all information required by the department to process the claim.

Sec. 17b-262-544 Payment

(a) Payment shall be made at the lowest of:

(1) the provider's usual and customary charge to the general public;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(b) Payment Rate

(1) The commissioner establishes the fees contained in the practitioner of chiropractic's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(2) Payment rates, as established by the commissioner, are the same for in- and out-of-state providers.

(c) Payment Limitations

The fee paid by the department for visits to a home, hospital, nursing facility, rest home, home for the aged, boarding home, or intermediate care facility for the mentally retarded (ICF/MR) shall include payment for travel and all such incidental expenses.

Sec. 17b-262-545 Documentation

(a) Practitioners of chiropractic shall maintain a specific record for all services received for each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, a current treatment plan signed by the provider, documentation of services provided, and the dates the services were provided.

(b) All required documentation shall be maintained for at least five years in the practitioner of chiropractic's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for which the required documentation is not maintained or provided to the department upon request.