Clover

Clover Health Chiropractic Policy Policy # RP-026

Policy Title	Chiropractic Reimbursement Policy
Policy Department	Payment Strategy Operations
Effective Date	1/1/2022
Revision Date(s)	3/1/2022
Next Review Date	

Disclaimer:

Clover Health applies CMS criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Clover Policies, and MCG for determining medical necessity. Clover Policies are intended to provide a standard guideline but are not used to preempt providers' judgment in rendering services. Providers are expected to provide care based on best practices and use their medical judgment for appropriate care.

Description:

This policy outlines Clover Health's chiropractic service requirements for both contracted and non-contracted providers for all plans. Guidelines are based on national policy; however, Local Coverage Determinations will apply for specific regions.

Definitions:

- **Chiropractic**
  - A system of diagnosis and treatment based on the concept that the nervous system coordinates all of the body's functions, and that disease results from a lack of normal nerve function. Chiropractic employs manipulation and adjustment of body structures, such as the spinal column, so that pressure on nerves coming from the spinal cord due to displacement (subluxation) of a vertebral body may be relieved.
- **Subluxation**
  - Subluxation is defined as a motion segment in which alignment, movement integrity and/or physiological function of the spine are altered, although contact between joint surfaces remains intact.

Policy:

Clover Health follows Medicare coverage criteria for chiropractic services which does not impose caps or limits for covered chiropractic care. Coverage is limited to manual manipulation of the spine to correct subluxation. Manual manipulation includes manipulation by use of the hands or manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually). There is no additional reimbursement for the use of the manual device or the device itself.

Clover members must have a significant neuromuscular-skeletal condition requiring treatment. The primary diagnosis must be subluxation of the spine and the specific level of subluxation must show the necessity of manipulation of the spine. Providers must report the date of the initial visit or the date of exacerbation of the existing condition on each claim submission in item 14 of the CMS-1500 form or the electronic equivalent. If an x-ray is being used as documentation of the subluxation, the date of the x-ray (or existing MRI or CT scan) must be submitted in item 19 of the CMS-1500 form or the electronic equivalent and must have been taken at a time reasonably proximate to the beginning of the course of treatment.

Maintenance therapy
The AT modifier must not be placed on the claim when maintenance therapy has been provided. Claims without the AT modifier will be considered as maintenance therapy and denied.

Claim Codes (if applicable)	• 98940 - Chiropractic manipulative treatment (CMT); spinal, 1-2 regions • 98941 - Chiropractic manipulative treatment (CMT); spinal, 3-4 regions • 98942 - Chiropractic manipulative treatment (CMT); spinal, 5 regions • Modifier AT - (acute treatment) must be appended to the chiropractic manipulation code to indicate the manipulation was for medically necessary and reasonable treatment of an acute subluxation or chronic subluxation as defined in national policy and the LCD.

References
Medicare Claims Processing Manual, Chapter 12, Section 220
Medicare Coverage Database - NCD/LCD policies