

## Chiropractic Services

### PURPOSE

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ND Medicaid covers medically necessary chiropractic services provided by an enrolled Doctor of Chiropractic licensed under state law.

### APPLICABILITY

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#### ELIGIBLE PROVIDERS

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled on the date of service with ND Medicaid. Servicing providers acting as a locum tenens provider must enroll with ND Medicaid and be listed on the claim form. Please refer to [provider enrollment](#) for additional details on enrollment eligibility and supporting documentation requirements.

#### ELIGIBLE MEMBERS

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the [ND Medicaid MMIS Portal](#) or through the Automated Voice Response System (AVRS) by dialing 1.877.328.7098.

Refer to the [Member Eligibility manual](#) for additional information regarding eligibility, including information regarding limited coverage categories.

### COVERED SERVICES AND LIMITS

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#### GENERAL PROVIDER POLICIES

The [General Provider Policies](#) details basic coverage requirements for all services.

Basic coverage requirements include:

- The provider must be enrolled in ND Medicaid;
- Services must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

The [Procedure Code Look-up Tool](#) can be used to identify if a procedure code is covered by ND Medicaid, along with code-specific details such as Ordering, Referring, Prescribing requirements, Service Authorization requirements, and current rates.

## **MEDICAL NECESSITY FOR TREATMENT**

Chiropractic services are considered medically necessary when all the following criteria are met:

- The member has a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the member's condition and provide a reasonable expectation of recovery or improvement of function.
- The member has a subluxation of the spine as demonstrated by an X-ray or physical exam.
- The chiropractor specifies the precise level of the subluxation.
- Manual manipulation of one or more spinal regions is planned.

ND Medicaid chiropractic coverage includes 20 manual manipulations (including using an activator or similar instrument) of the spine to treat acute or chronic subluxations (incomplete or partial dislocation) demonstrated by x-rays or an exam. Limited Evaluation and Management (E/M) services and X-rays are also covered.

### Chiropractic Manipulative Treatment

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

### Evaluation and Management Services

New Patient Evaluation and Management (E/M) services (99202 or 99203) are covered in addition to chiropractic manipulative treatment (98940-98942) only when the patient has not received any professional (face-to-face) services from the chiropractor or another chiropractor of the same group practice within the past three years.

Established Patient Evaluation and Management (E/M) services (99211-99213) are covered on the same service date as a spinal manipulation only if the evaluation and management service is significant and separately identifiable from the procedure that is performed. Use modifier 25 to indicate that the patient's condition required a significant, separately identifiable E/M service beyond the usual pre- and post-procedure care associated with the service performed.

### X-rays

X-rays are not required to demonstrate subluxation. However, an X-ray may still be used to demonstrate subluxation. If the recipient indicates that another provider or facility performed X-rays, the provider should attempt to obtain them.

72020 - Radiologic examination, spine, single view, specify level

- There is a maximum limit of 4 single-view units (levels) for this code per date of service.

72040 - Radiologic examination, spine, cervical; 2 or 3 views

72050 - Radiologic examination, spine, cervical; 4 or 5 views

72052 - Radiologic examination, spine, cervical; 6 or more views

72070 - Radiologic examination, spine; thoracic, 2 views

72072 - Radiologic examination, spine; thoracic, 3 views

72074 - Radiologic examination, spine; thoracic, minimum of 4 views

72080 - Radiologic examination, spine; thoracolumbar junction, minimum of 2 views

72100 - Radiologic examination, spine, lumbosacral; 2 or 3 views

72110 - Radiologic examination, spine, lumbosacral; minimum of 4 views

72114 - Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views

72120 - Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views

72220 - Radiologic examination, sacrum and coccyx, minimum of 2 views

### LIMITS

Chiropractic Manipulative Treatment of the spine is limited to one manipulation per day and may not exceed 20 manipulations per calendar year without an approved service authorization.

Coverage of spinal X-rays is limited to two units per region of the spine (cervical, thoracic, lumbar) per calendar year.

Established patient E/M services (99211-99213) are limited to five per calendar year.

## **SERVICE AUTHORIZATION REQUIREMENTS**

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Once a member's limits have been met, the [Service Limits Authorization Request form](#) must be used to request additional services. Services that exceed the member's limit and are not authorized by ND Medicaid will be denied as non-covered.

## **NON-COVERED SERVICES**

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### **GENERAL NON-COVERED SERVICES**

The Noncovered Services Policy contains a general list of services that are not covered by North Dakota Medicaid.

Non-covered chiropractic services:

- Maintenance therapy;
- Any joint manipulation outside of the spine;
- Continued chiropractic treatment after the initial two weeks if no improvement is documented, unless the chiropractic treatment is modified;
- Continued chiropractic treatment if no improvement is documented within 30 days, even with a modification of chiropractic treatment;
- Continued chiropractic treatment once the maximum therapeutic benefit has been achieved;
- Chiropractic manipulation of a member who is asymptomatic or is without an identifiable clinical condition;
- Chiropractic care of a member whose condition is neither regressing nor improving;
- Chiropractic manipulation for the treatment of idiopathic scoliosis or treatment of scoliosis beyond early adolescence, unless the member exhibits pain or spasm or some other medically necessary indications for chiropractic manipulation, are present; and
- Manipulation for non-neuromusculoskeletal conditions or symptom (e.g., attention-deficit hyperactivity disorder, breech or other malpresentation of fetus, scoliosis, dysmenorrhea, otitis media, asthma, epilepsy, etc.).

## **DOCUMENTATION REQUIREMENTS**

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### **GENERAL REQUIREMENTS**

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to ND Medicaid. Records must be retained for at least 7 years after the last date the claim was paid or denied. In addition to the documentation requirements in the Provider Requirements Policy, the following guidelines have been created specifically for chiropractic services.

#### Initial Chiropractic Visit

Document the following for the initial chiropractic visit:

- Date of initial treatment

- History, including the following:
  - Symptoms causing the patient to seek treatment
  - Family history, if relevant
  - Past health history (general health, prior illness, injuries or hospitalizations, medications, surgical history)
  - Mechanism of trauma
  - Quality and character of symptoms or problems
  - Onset, duration, intensity, frequency, location, and radiation of symptoms
  - Aggravating or relieving factor
  - Prior interventions, treatment, medications, secondary complaints
- Description of presenting conditions or complaints, including:
  - Mechanism of trauma
  - Quality and character of symptoms or problems
  - Onset, duration, intensity, frequency, location, and radiation of symptoms
  - Aggravating or relieving factors
  - Prior interventions, treatment, medications, secondary complaints
  - Symptoms causing the patient to seek treatment
- Evaluation of the musculoskeletal or nervous system through physical examination
- Diagnosis:
  - Subluxation must be the primary diagnosis
  - Secondary diagnosis must be the neuromusculoskeletal condition necessitating treatment
- Treatment plan which includes:
  - Recommended level of care
  - Specific treatment goals
  - Objective measures to evaluate the effectiveness of treatment

### Subsequent Visits

Document the following for subsequent visits:

- History
  - Review of chief complaint
  - Changes since last visit
  - System review, if relevant
- Physical exam
  - Examination of the area of the spine involved in diagnosis
  - Assessment of change in patient condition since last visit
  - Evaluation of treatment effectiveness
  - Documentation of treatment provided on day of visit

## **REIMBURSEMENT METHODOLOGY AND CLAIM INSTRUCTIONS**

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### **TIMELY FILING**

ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service. The time limit may be waived or extended by ND Medicaid in certain circumstances. The [Timely Filing Policy](#) contains additional information.

### **THIRD-PARTY LIABILITY**

Medicaid members may have one or more additional sources of coverage for health services. ND Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources. The [Third Party Liability Policy](#) contains additional information.

### **CLIENT SHARE (RECIPIENT LIABILITY)**

Client share (recipient liability) is the monthly amount a member must pay toward the cost of medical services before the Medicaid program will pay for services received. The [Client Share Policy](#) contains additional information.

### **REIMBURSEMENT**

A claim for services must be submitted with the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement.

### **CLAIM FORM**

Chiropractic services must be billed using the CMS-1500 claim form or the 837p HIPPA compliant X12 format. Detailed claim instructions are available on the ND Medicaid Provider Guidelines, Policies & Manual [webpage](#).

### **CLAIM REQUIREMENTS**

Two ICD-10-CM codes must be listed on the claim or service authorization to support the medical necessity of CMT:

- The level of subluxation must be specified and must be listed as the primary diagnosis (ABK qualifier) on the claim.
  - M99.00 - Segmental and somatic dysfunction of the head region
  - M99.01 - Segmental and somatic dysfunction of the cervical region
  - M99.02 - Segmental and somatic dysfunction of the thoracic region
  - M99.03 - Segmental and somatic dysfunction of the lumbar region

- M99.04 - Segmental and somatic dysfunction of the sacral region
- M99.05 - Segmental and somatic dysfunction of the pelvic region
- The associated neurological or musculoskeletal disease or symptom that is a direct result of the subluxation necessitating treatment must be listed as the secondary diagnosis (ABF qualifier).
- Modifier – AT must be appended to all CMT codes for active/corrective treatment to treat acute or chronic subluxation. CMT codes without a modifier -AT will be denied as non-covered.

X-rays require an Ordering/Referring/Prescribing provider to be listed at the line level of the X-ray. Please see the [Ordering/Referring/Prescribing Providers Policy](#) for further information. The treating chiropractor can order X-rays.

## DEFINITIONS

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*Acute subluxation* – a patient’s condition is considered acute when the patient is being treated for a new injury identified by x-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, or an arrest of, the patient’s condition.

*Chronic subluxation* – a patient’s condition is considered chronic when it is not expected to significantly improve or resolve with further treatment (as is the case with an acute condition), but where continued therapy can be expected to result in some functional improvement.

*Maintenance therapy* – Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life, or therapy performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

## REFERENCES

- [North Dakota Administrative Code](#)
- [North Dakota Century Code](#)
- [Code of Federal Regulations](#)

## RELATED POLICIES

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- Ordering/Referring/Prescribing Providers

## FREQUENTLY ASKED QUESTIONS

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- Q:** Can I bill ND Medicaid for maintenance therapy?
- A:** Yes, a claim for maintenance therapy can be submitted to ND Medicaid but will be denied as a non-covered service. To indicate a service is maintenance therapy, do not append modifier -AT to the CPT® code for the spinal manipulation.
- Q:** Can a chiropractor order X-rays?
- A:** Yes, ND Medicaid will reimburse X-rays of the spine when ordered by an enrolled Chiropractor.
- Q:** What are examples of neurological or musculoskeletal disease or symptoms that qualify as a secondary diagnosis?
- A:** Symptom codes such as M54.2 – neck pain for someone who has subluxation of the cervical spine, or M47.814 – Spondylosis without myelopathy or radiculopathy for a person with a subluxation of the thoracic spine.
- Q:** Can I bill a new patient E/M code 99202-99203 when the patient has seen another chiropractor in my clinic?
- A:** When the patient has not received any professional (face-to-face) services from the chiropractor or another chiropractor of the same group practice within the past three years.
- Q:** Do I use the -AT modifier on all codes for active treatment?
- A:** No, the -AT modifier is only required on the codes for spinal manipulation (CPT® 98940-98942). If the -AT modifier is billed on E/M services or X-rays, it will result in a denial for an invalid procedure to the modifier.

## CONTACT

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Medical Services  
600 East Boulevard Ave  
Bismarck, ND 58505-0250  
Phone: [\(701\) 328-2310](tel:(701)328-2310)  
Email: [dhsmedicalservices@nd.gov](mailto:dhsmedicalservices@nd.gov)

## POLICY UPDATES

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### January 2026

Section	Summary
	Updated format throughout policy to comply with ADA requirements.
Medical Necessity	Language added
X-rays	Cleaned up redundant language
Documentation Requirements	Added specific requirements for new and established chiropractic visits.
FAQs	Added several Q&As related to chiropractic services.