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BY AAPC

# Chiropractic Coding & Compliance Alert

## Reader Question: Master the Medical Necessity Requirements

**Question:** A chiropractor provided manual manipulation of the spine in treating a condition which did not provide a primary diagnosis of subluxation. How should this be reimbursed?

Minnesota Subscriber

**Answer:** Medicare benefits policy manual, chapter 15, section 240.1.3, enlists the criteria necessary for chiropractic treatment. It states that:

"The patient must have 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 patient's condition and provide reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam, as described above."

Accordingly, the provider must demonstrate the presence of acute or chronic subluxation to prove medical necessity for a patient's care.

In this case, the most likely response you'll receive will be based on Medical Summary Notice (MSN) 15.4: "The information provided does not support the need for this service or item."

Also relevant is the Claims Adjustment Reason Code 50, "These are non-covered services because this is not deemed a 'medical necessity' by the payer."