/

Payment Policy | Chiropractic Services

EFFECTIVE DATE:07|21|2009
POLICY LAST REVIEWED: 05|1|2024

OVERVIEW

Chiropractic is a healthcare profession that focus on disorders of the musculoskeletal and nervous system, and the effects of these disorders on functions of the body and general health. Chiropractic care is used most often to treat neuromusculoskeletal complaints, especially of the spine. Treatment may be of the lower back, thoracic, and cervical areas of the spine. Chiropractors use the recuperative powers of the body to restore and maintain health without drugs or surgery.

MEDICAL CRITERIA

Not applicable.

PRIOR AUTHORIZATION

Prior authorization review is not required.

POLICY STATEMENT

Medicare Advantage Plans

Medicare Advantage Plans have coverage limits to spinal manual manipulation only; all other services performed or ordered by a chiropractor are non-covered.

Subluxation is defined in this instance as an incomplete dislocation, off centering; misalignment, fixation, or abnormal spacing of the vertebrae anatomically and usually falls into one of three categories:

- Acute, such as strains and sprains; or
- Chronic, such as loss of joint mobility; or
- Nerve root problems, such as a pinched nerve.

Medicare Advantage Plans do not allow chiropractic providers to order, perform or interpret X-rays and/or diagnostic tests.

An Advance Beneficiary Notice (ABN) is not used for items or services provided under the Medicare Advantage Plans. If a provider believes a service will not be covered by the plan, the provider is expected to request a pre-service organization determination from the plan. If the provider does not request a pre-service organization determination prior to rendering the services, the provider will be liable for the cost of the services. Medicare Advantage Plan members will be held harmless.

Commercial Products

Chiropractic services are covered based on the benefit limit of the applicable members benefit plan.

Daily maximum rates apply to Blue Cross & Blue Shield of Rhode Island (BSBSRI) participating providers for all Commercial products only.

The following services are included in the daily maximum rates:

- Evaluation and Management (E/M) Services (CPT codes 99202-99205, 99211-99215)
- Chiropractic Manipulation Services (CPT codes 98940-98943)
- Physical Medicine and Rehabilitation Modality Codes (CPT codes 97012-97036)

- Physical Medicine and Rehabilitation Therapeutic Procedure Codes (CPT codes 97110-97530)
- Physical Medicine and Rehabilitation Test and Measurement Codes (CPT codes 97750-97755)
- Physical Medicine and Rehabilitation Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes (CPT codes 97760, 97761, 97763)

NOTE: Daily maximum E/M service reimbursement rates vary between new and established patients.

Laboratory procedures and radiological examinations can be performed and ordered by chiropractic physicians for all Commercial products and reimbursed according to the applicable benefit for the service rendered.

- Codes listed below for laboratory procedures, radiological examinations and durable medical equipment are not part of the daily maximum reimbursement rate and are the only codes that may be separately reimbursed.
- All chiropractic services performed on the same date of service will count as one visit towards the member's benefit limit.

Place of Service
Chiropractic services are limited to office settings and are not covered when performed in the home, nursing, residential, domiciliary, or custodial facility for all BCBSRI products including Medicare Advantage Plans.

COVERAGE

Benefits may vary between groups/contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage or Subscriber Agreement for applicable chiropractic services, diagnostic imaging, laboratory and machine tests coverage/benefits.

The number of Chiropractic visits allowed per year may vary according to the member's specific benefit.

BACKGROUND

Every state has licensing or certification laws that clearly define the services a chiropractor may provide.

According to Rhode Island General Laws (RIGL) § 5-30-1

> *"Chiropractic medicine" defined. – For the purpose of this chapter, the practice of "chiropractic medicine" is defined as the science and art of mechanical and material healing as follows: the employment of a system of palpating and adjusting the articulations of the human spinal column and its appendages, by hand and electromechanical appliances, and the employment of corrective orthopedics and dietetics for the elimination of the cause of disease; provided, that chiropractic physicians may not write prescriptions for drugs for internal medication nor practice major surgery as defined in chapter 37 of this title.*

Chiropractic manipulative therapy (CMT) primarily focuses on the adjustment and manipulation of a joint articulation and adjacent tissues of the body, particularly of the spinal column. CMT is used to restore normal mobility and range of motion (ROM) in a joint due to subluxation. The effects of manipulation can be categorized as either mechanical or neurological.

Subluxation/biomechanical dysfunction of a joint is defined as a reduction/lack of motion, i.e., hypo mobility, aberrant motion of an articular joint or a fixation of the joint. The neurological mechanism issue, with its classic theory of a "pinched nerve" offers a model that includes both direct and indirect effects on the function of the peripheral and central nervous system resulting from spinal dysfunction. Pain, swelling, muscle spasm, nerve irritation with radiating pain and spasm, damage to joint cartilage, and loss of normal ROM may result from the physiological changes caused by mechanical or neurological effects of subluxation.

Adjunctive physical medicine/physical therapy modalities are used to prepare and enhance the manipulation by the chiropractor. A chiropractor typically uses manipulation, adjustment, physiotherapy, and support devices in clinical practice.

Osteopathic Manipulative Treatment
Osteopathic Manipulative Treatment codes 98925-98929 should not be confused with Chiropractic Manipulative Treatment codes 98940-98943. Osteopathic treatment method is administered by a Doctor of Osteopathic Medicine, or a D.O., who is licensed to prescribe medication and can practice in all specialty areas as well as perform surgery, while a chiropractic physician's scope of practice is limited.

CODING

Medicare Advantage Plans
Chiropractic services are covered when filed with one of the following CPT codes and a covered diagnosis:

CPT Chiropractic Manipulation Treatment:
98940 Chiropractic manipulative treatment (CMT); spinal, one to two regions
98941 Chiropractic manipulative treatment (CMT); spinal, three to four regions
98942 Chiropractic manipulative treatment (CMT); spinal, five regions

Medicare only pays for active/corrective treatment to correct acute or chronic subluxation.
Medicare does not pay for maintenance therapy.

- Active Treatment submit HCPCS modifier AT
- Supporting documentation is required in the patient's medical record (do not submit additional documentation with your claims, submit supporting documentation only if requested.)

Effective July 1, 2024, Modifier: AT***** is required.

- The AT modifier should be used when reporting service 98940, 98941, 98942
- The AT modifier should not be used when providing *maintenance* therapy

*** Active Treatment**:
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. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section240.1.3).

Covered diagnosis codes:
M99.00 Segmental and somatic dysfunction of head region
M99.01 Segmental and somatic dysfunction of cervical region
M99.02 Segmental and somatic dysfunction of thoracic region
M99.03 Segmental and somatic dysfunction of lumbar region
M99.04 Segmental and somatic dysfunction of sacral region
M99.05 Segmental and somatic dysfunction of pelvic region

Daily maximum rates do not apply to Medicare Advantage Plans.

Commercial Products
The following CPT codes are covered for all Commercial products and are included in the daily maximum reimbursement rate:
Chiropractic Manipulation Treatment:
98940 Chiropractic manipulative treatment (CMT); spinal, one to two regions
98941 Chiropractic manipulative treatment (CMT); spinal, three to four regions
98942 Chiropractic manipulative treatment (CMT); spinal, five regions
98943 Chiropractic manipulative treatment (CMT); extra-spinal, one or more regions (non-covered for

Evaluation and Management Services:

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate straightforward medical decision making. When using time for code selection, 15- minutes of total time must be met or exceeded on the date of the encounter.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate low level of medical decision making. When using time for code selection, 30-minutes of total time must be met or exceeded on the date of the encounter.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate moderate level of medical decision making. When using time for code selection, 45- minutes of total time must be met or exceeded on the date of the encounter.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate high level of medical decision making. When using time for code selection, 60- minutes of total time must be met or exceeded on the date of the encounter.

99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional (Revised text 1/01/2022)

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate straightforward medical decision making. When using time for code selection, 10- minutes of total time must be met or exceeded on the date of the encounter.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate low level of medical decision making. When using time for code selection, 20- minutes of total time must be met or exceeded on the date of the encounter.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate moderate level of medical decision making. When using time for code selection, 30 minutes of total time must be met or exceeded on the date of the encounter.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate high level of medical decision making. When using time for code selection, 40minutes of total time must be met or exceeded on the date of the encounter.

Note: When any of the CPT codes below are filed**,** one of the following modifiers must be appended to the CPT code to distinguish the discipline under which the service is delivered. Claims filed without the required modifier will deny:

- **GO** - Services delivered under an outpatient OT plan of care
- **GP** - Services delivered under an outpatient PT plan of care

97012 Application of a modality to one or more areas; traction, mechanical
97014 Application of a modality to one or more areas; electrical stimulation (unattended)
97016 Application of a modality to one or more areas; vasopneumatic devices
97018 Application of a modality to one or more areas; paraffin bath
97022 Application of a modality to one or more areas; whirlpool
97024 Application of a modality to one or more areas; diathermy (eg, microwave)
97026 Application of a modality to one or more areas; infrared
97028 Application of a modality to one or more areas; ultraviolet
97032 Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes

97033 Application of a modality to one or more areas; iontophoresis, each 15 minutes
97034 Application of a modality to one or more areas; contrast baths, each 15minutes
97035 Application of a modality to one or more areas; ultrasound, each 15 minutes
97036 Application of a modality to one or more areas; Hubbard tank, each 15minutes
97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97112 Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113 Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116 Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
97124 Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)
97140 Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150 Therapeutic procedure(s), group (2 or more individuals)
97530 Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Test and Measurement Procedure
97750 Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
97755 Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes

Orthotic Management Services:
97760 Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each15 minutes

The following CPT codes for Diagnostic Imaging are separately reimbursed for all Commercial products:
71045 Radiologic examination, chest; single view
71046 Radiologic examination, chest; 2 views
71047 Radiologic examination, chest; 3 views
71048 Radiologic examination, chest; 4 or more views
71100 Radiologic examination, ribs, unilateral; 2 views
71101 Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views
71110 Radiologic examination, ribs, bilateral; 3 views
72020 Radiologic examination, spine, single view, specify level
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, minimum of 2 views
72081 Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed; one view.
72082 Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed; 2 or 3 views.
72083 Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed; 4 or 5 views.

72084 Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed; minimum of 6 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
72170 Radiologic examination, pelvis; 1 or 2 views
72190 Radiologic examination, pelvis complete, minimum of 3 views
72200 Radiologic examination, sacroiliac joints; less than 3 views
72220 Radiologic examination, sacrum and coccyx, minimum of 2 views
73010 Radiologic examination, scapula, complete
73020 Radiologic examination, shoulder; 1 view
73030 Radiologic examination, shoulder; complete, minimum of 2 views
73050 Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction
73070 Radiologic examination, elbow; 2 views
73080 Radiologic examination, elbow; complete, minimum of 3 views
73100 Radiologic examination, wrist; 2 views
73110 Radiologic examination, wrist complete, minimum of 3 views
73120 Radiologic examination, hand; 2 views
73130 Radiologic examination, hand; minimum of 3 views
73140 Radiologic examination, finger(s), minimum of 2 views
73501 Radiologic examination, hip, unilateral, with pelvis when performed; 1 view
73502 Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views
73503 Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views
73521 Radiologic examination, hips, bilateral, with pelvis when performed; 2 views
73522 Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views
73523 Radiologic examination, hips, bilateral, with pelvis when performed; minimum of 5 views
73551 Radiologic examination, femur; 1 view
73552 Radiologic examination, femur; minimum 2 views
73560 Radiologic examination, knee; 1 or 2 views
73562 Radiologic examination, knee; 3 views
73564 Radiologic examination, knee; complete, 4 or more views
73590 Radiologic examination; tibia and fibula, 2 views
73600 Radiologic examination, ankle; 2 views
73610 Radiologic examination, ankle; complete, minimum of 3 views
73620 Radiologic examination, foot; 2 views
73650 Radiologic examination; calcaneus, minimum of 2 views

The following supplies are allowed to be dispensed by Chiropractors for Commercial products only:
NOTE: Medicare Advantage Plan members must obtain these items from a DME provider.
E0720 Transcutaneous electrical nerve stimulation (TENS) device, two lead, localized stimulation
E0730 Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation
A4595 Electrical stimulation supplies, 2 lead, per month (e.g., TENS, NMES)
E0860 Traction equipment, overdoor, cervical

RELATED POLICIES

Advance Notice of Noncoverage
Coding and Payment Guidelines
Medicare Advantage Plans National and Local Coverage Determinations
Non-Reimbursable Health Services
Transcutaneous Electrical Nerve Stimulation (TENS)

PUBLISHED

Provider Update, June 2024
Provider Update, July 2021
Provider Update, March 2020
Provider Update, May 2018
Provider Update, August 2012
Provider Update, September 2011

REFERENCES

1. Centers for Medicare and Medicaid Services. Medicare Coverage Database.
Local Coverage Article: Chiropractic Services – Medical Policy Article (A57889)

CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS