BlueCross BlueShield Minnesota

REIMBURSEMENT POLICY

Chiropractic Services

Active

Policy Number: General Coding - 010
Policy Title: Chiropractic Services
Section: General Coding
Effective Date: 07/01/16

Product: ☒Commercial ☐FEP ☒Medicare Advantage ☒Platinum Blue

Description

This policy addresses coverage and reimbursement for chiropractic services.

Definitions

Chiropractic is a form of alternative medicine that emphasizes diagnosis, treatment, and prevention of mechanical disorders of the musculoskeletal system, especially the spine.

Policy Statement

Chiropractic Manipulation Treatment

The chiropractic manipulation treatment (CMT) codes include a pre-manipulation patient assessment, the adjustment, and evaluation of the effect of treatment. The CMT codes 98940-98942 are used to indicate the number of spinal areas manipulated. CMT code 98943 is used to report chiropractic manipulation of one or more of the extra-spinal regions (head region; lower extremities; upper extremities; rib cage; abdomen).

Examination Codes

As noted by the Minnesota Chiropractic Association, an E/M would be appropriate for the following situations:

- **New Patient:** A new patient is one who has not received any professional services from the chiropractor or another chiropractor in the same group practice within the past three years.
- **Established Patient – New Injury or Exacerbation:** The E/M is needed to obtain history and fully evaluate the patient's condition for an initial treatment plan or, in the event of an exacerbation, modify a previous treatment plan.
- **Established Patient – Re-examination:** Periodic examinations are typically performed to formally assess the patient's response to treatment, progress, and make necessary changes to the treatment plan.
- **Chiropractic Manipulation with E/M Visit:** If an evaluation and management service is done with the manipulation, the E/M will deny unless it is submitted with a -25 modifier, signifying significant, separately identifiable illness or injury.

- A level 4 or 5 E/M (99204, 99205, 99214, 99215) will be denied as provider liability because these levels would require significant additional work, and it is seldom appropriate to bill both.

For any of the above circumstances, a -25 modifier must be submitted on the E/M service if there was a significant separately identifiable E/M service.

Effective for dates of service beginning January 1, 2022, Blue Cross will be implementing a 20% reduction in the allowed amount for E&M codes 99202-99380 and 99398-99498 submitted with modifier -25 on a professional claim.

Radiology Coverage Restriction

Blue Cross will not reimburse for many imaging services when billed by a chiropractor. This policy applies to all High-Tech Diagnostic Imaging (HTDI) procedures, including CT scans and MRI services, in addition to the procedures below. This will allow Blue Cross to better manage these high-cost radiology services. These claims will be denied as provider liability.

71260	71550	72192	72193	72194
73221	73721	74150	74160	74170
74183	76140	76496	76536	76800
76856	76870	76977	77080	

Blue Cross will continue to allow chiropractors to order medically necessary radiology services, as permitted by the provider's scope of practice.

Services billed for consultation on X-ray exams performed elsewhere (CPT 76140) will not be payable, as Blue Cross already reimburses for both the professional and technical component of most radiology services. Re-interpretation of a film is a duplication of these other components.

Blue Cross will continue to allow chiropractors to perform, bill and be reimbursed for most traditional X-ray films based on the subscriber's benefits.

Practicing in Multidisciplinary Clinics

Chiropractors practicing in multidisciplinary clinics shall maintain a separate contract and billing number.

Massage Therapy Exclusion

Blue Cross will not reimburse providers for massage therapy services (97124). Massage therapy will deny either as incidental (provider liability) or subscriber liability.

- Massages that are provided as preparation for a physical medicine therapy or chiropractic manipulation are considered an integral part of the therapy. As such, we will deny it as provider liability.
  - Submission of the -59 or -GA modifiers will not affect or change the denial.
- If a massage is billed alone, then it may be denied as a subscriber contract exclusion.

An independent massage therapist is an ineligible provider. When a massage therapist is employed and supervised by the chiropractor, chiropractor should submit procedure code 97124 with a -U7 modifier.

Conjunctive Therapy, Modality: Office, Home or Nursing Home
Therapies must be used in conjunction with adjustment or manipulation on the same day for most contracts. If more than one therapy is done per treatment, documentation must support the necessity for the additional therapy.

Maintenance or Palliative Care and Modifier -AT
Rehabilitation services that would not result in measurable progress relative to established goals are non-covered services. The -AT modifier distinguishes active/corrective treatment from maintenance therapy.

- The -AT modifier should be appended to the chiropractic manipulation (98940-98943) to show active treatment.
- The absence of the -AT modifier would indicate maintenance or palliative care. Claims without the -AT modifier will be benefit denied to the appropriate party – provider or subscriber liability, depending on contract requirements.

Medicare Advantage Policy and Medicare Cost Plan

Medicare coverage of chiropractic services is specifically limited to treatment by means of manual manipulation of the spine to correct a subluxation.

Chiropractors are limited to billing the following codes under Medicare: 98940, 98941 and 98942. Medicare does not cover chiropractic treatment to extraspinal regions (98943) which includes the head, upper and lower extremities, rib cage and abdomen.

When submitting manipulation claims, chiropractors must use an Acute Treatment (AT) modifier to identify services that are active/corrective treatment of an acute or chronic subluxation. The -AT modifier, when applied appropriately, should indicate expectation of functional improvement, regardless of the chronic nature or redundancy of the problem.

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, Blue Cross, and Medicare fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	25	59	AT	GA	U7		
ICD-10 Diagnosis:	N/A						
ICD-10 Procedure:	N/A						
CPT/HCPCS:	71260	71550	72192	72193	72194	73221	73721
	74150	74160	74170	74183	76140	76496	76536
	76800	76856	76870	76977	77080		
	98940	98941	98942	98943			
Revenue Codes:	N/A						

Cross Reference

Cross Reference: N/A

Policy History

03/24/2015	Initial Committee Approval Date
03/24/2016	Annual Policy Review
08/30/2017	Annual Policy Review
12/19/2018	Annual Policy Review
01/01/2017	Code Update
01/07/2019	Annual Policy Review
01/26/2021	Annual Policy Review
11/29/2021	Updated for formatting, added 25 modifier payment reduction verbiage