Payment Policy | Chiropractic Services

EFFECTIVE DATE:07|21|2009
POLICY LAST UPDATED: 04|17|2018

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 neuromusculotskeletal complaints, especially of the spine. Treatment may be of the lower back, thoracic, and cervical areas of the spine.[3] Chiropractors use the recuperative powers of the body to restore and maintain health without drugs or surgery.

MEDICAL CRITERIA
Not applicable. This is a reimbursement policy only.

PRIOR AUTHORIZATION
Prior authorization review is not required.

POLICY STATEMENT
Chiropractic services are covered for all Commercial products.

BlueCHiP for Medicare specifically limits chiropractic services to **manual manipulation only (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation.** 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. [2]

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

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

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 BlueCHiP for Medicare.

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.

CPT 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,[5] while a chiropractic physician's scope of practice is limited.

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.[1] 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.

CODING

Per diem 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 per diem rates:

- Evaluation and Management (E&M) Services (99201-99205, 99211-99215); (*New or **Established Patients)
- Chiropractic Manipulation Services (98940-98943)
- Physical Medicine and Rehabilitation Modality Codes (97012-97036)
- Physical Medicine and Rehabilitation Therapeutic Procedure Codes (97110-97530)
- Physical Medicine and Rehabilitation Test and Measurement 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 ((97760, 97761, 97763)

*A **new patient** is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

An **established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

NOTE: Per diem E&M service reimbursement rates vary between new and established patients.

Per diem rates **do not apply** to BlueCHiP for Medicare.

- 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 that service rendered.

- Codes listed below for laboratory procedures, radiological examinations and durable medical equipment are not part of the per diem 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.

BlueCHiP for Medicare
BlueCHiP for Medicare limits services to manual manipulation only and **all other services performed or ordered by a chiropractor are non-covered.** An Advance Beneficiary Notice (ABN) is not used for items or services provided under the BlueCHiP for Medicare program. 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. BlueCHiP for Medicare members will be held harmless.

BlueCHiP for Medicare allows chiropractic providers to order **but not perform or interpret** X-rays and/or diagnostic tests.

The following CPT codes are the only manipulation codes covered for BlueCHiP for Medicare:

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

ICD-10 CM 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

The following CPT codes are covered for all Commercial products and are included in the per diem 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 BlueCHiP for Medicare)

Evaluation and Management Services:
99201 New patient; 10 minutes face-to-face
99202 New patient; 20 minutes face-to-face
99203 New patient; 30 minutes face-to-face
99204 New patient; 45 minutes face-to-face
99205 New patient; 60 minutes face-to-face
99211 Established patient; 5 minutes face-to-face
99212 Established patient; 10 minutes face-to-face
99213 Established patient; 15 minutes face-to-face
99214 Established patient; 25 minutes face-to-face

99215 Established patient; 40 minutes face-to-face

Physical Medicine and Rehabilitation Modalities:

Note: When any of the CPT 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 15 minutes
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 15 minutes
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 re-education 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 Procedures:

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, each 15 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; minimum of 4 views
72052 Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies
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
73520 Radiologic examination, hips, bilateral, minimum of 2 views of each hip, including anteroposterior view of pelvis
73521 Radiologic examination, hips, bilateral, with pelvis when performed; 2 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 HCPCS codes for allowed to be dispensed by Chiropractors for Commercial products only. **Blue CHiP for Medicare 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, over door, cervical

The following CPT codes for **Muscle and Range of Motion Testing** are not separately reimbursed for all BCBSRI products:
95831 Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk
95832 Muscle testing, manual (separate procedure) with report; hand, with or without comparison with normal side
95833 Muscle testing, manual (separate procedure) with report; total evaluation of body, excluding hands
95834 Muscle testing, manual (separate procedure) with report; total evaluation of body, including hands
95851 Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section
95852 Range of motion measurements and report (separate procedure); hand, with or without comparison with normal side

FOR INTERNAL USE ONLY:

While the chiropractic Physician Fee Schedule may include more codes than is contained within this policy, local chiropractors can only file and be reimbursed according to the codes listed in the policy as they more accurately reflect the services that would typically fall within the scope of a chiropractor's licensure.

RELATED POLICIES

Coding and Payment Guidelines

PUBLISHED

Provider Update, May 2018
Provider Update, August 2012
Provider Update, September 2011
Provider Update, October 2009
March/April 2004

REFERENCES

1. Centers for Medicare and Medicaid Services. Medicare Coverage Database. Local Coverage Determination (LCD): Chiropractic Services (L33613) (Last Updated 12/1/15. Accessed 12/3/2015 https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33613&ContrId=313&ver=13&ContrVer=1&CntrctrSelected=313*1&Cntrctr=313&s=47&DocType=Active&bc=AggAAAIAAAAAAA%3d%3d&

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