Chiropractic

Introduction

This section of the *Manual for Physicians and Providers* contains Chiropractic Billing and Coding Guidelines, developed with consideration of the latest coding methodologies from various sources, including but not limited to:

- Coding descriptions and instructions as identified in the latest release of the American Medical Association's (AMA) Current Procedural Terminology (CPT®);
- Healthcare Common Procedure Coding System (HCPCS) developed by the Centers for Medicare & Medicaid Services (CMS), 19th edition (Ingenix Publishing Group);
- Procedural Utilization Facts, Chiropractic Care Standards, A Reference Guide©, 6th edition (Data Management Ventures, Inc.);
- Applicable laws in the State of Florida.

Please note that even though it is not the intent of Blue Cross and Blue Shield of Florida, Inc. (BCBSF) to state inconsistencies between your Professional Services Agreement ("Agreement") with BCBSF/Health Options, Inc. and these Chiropractic Billing and Coding Guidelines, in the event of any inconsistencies between information contained within the two documents, the terms of your Agreement shall govern.

Furthermore, as stipulated within the Schedule A, Description of Reimbursement, section of your Agreement, although the reimbursement methodology and calculation of your allowance is detailed within Schedule A, BCBSF reserves the right to alter or amend the reimbursement methodology within the text of the *Manual for Physicians and Providers* and/or Chiropractic Billing and Coding Guidelines.

Operational Guidelines

In applying the definition of medical necessity to chiropractic services specifically, BCBSF will consider the following:

Treatment by the licensed chiropractic physician should produce or is expected to produce objectively measurable clinical and/or functional improvement in a member's net health outcome as reflected by a decrease in symptoms and an increase in function. Such treatment or services must be determined to be appropriate for the symptoms, diagnosis or care of the member with the condition or conditions, provided specifically for the diagnosis or direct care and treatment of those conditions, consistent with standards of good health practice within the practitioners' own professional community, as well as the other professions available to the member for addressing the presenting problems in an integrative manner. Such service is not primarily for the convenience of the member or the practitioner, is the most professionally appropriate dosage of care or level of service, and is as cost effective as any established alternatives. The necessity for therapeutic intervention exists in the presence of an impairment (illness/injury/condition) evidenced by recognized signs and symptoms, and which is likely to respond favorably to the planned treatment within a reasonably predictable period of time.

Medically necessary chiropractic services are those manual and physical medicine services for which there is a defined acute or initial therapeutic care plan with a goal of improvement in the functional status of the member. If the care is for a severe or chronic condition, there may be an additional period of continuing therapeutic care as part of an active rehabilitation and stabilization of the member's functional status.

BCBSF does not typically reimburse for those categories of chiropractic services commonly described as maintenance care, wellness care, preventive care, palliative care, or supportive care.

- Maintenance care – When the functional status of the member has remained stable for a given illness/condition/injury over approximately four weeks, without functional improvement in the member's net health outcome or expectation of additional objectively measurable clinical improvement.
- Wellness or preventive care – Typically rendered on a regular or periodic basis to help maintain optimal body function, often when there is little or no activity-restricting symptomatology, or in order to support lifestyle activities such as high performance sports.
- Palliative or supportive care – Usually given after chronic symptoms have become stationary following completion of an initial course of therapeutic care; it may be used for repeated treatment of unresolved, recurrent, or chronic conditions including spinal subluxation or segmental dysfunction. Ongoing care after the condition has stabilized or a member's condition has reached a clinical plateau, called Maximum Medical Improvement (MMI), does not qualify as medically necessary.

In consideration of the treatment of low back pain, the following physical therapy treatments are considered to be either not medically necessary, unproven, or ineffective for patients with acute low back pain (less than 3 months):

- Lasers to relieve symptoms of low back pain (have not been proven effective)
- TENS units
- Biofeedback (has not been proven effective for acute back pain)
- Injections into the back (prolotherapy, joint sclerotherapy, and ligamentous injections of sclerosing agents
- "Back School", a type of educational program for low back pain (has not been proven to be more effective than other treatments, and is not covered).

Coding and Billing for Covered Services

To qualify for reimbursement, all services must be performed in the office (place of service 11) within the practice of chiropractic medicine by a:

- Licensed Chiropractic Physician;
- Certified Chiropractic Physician's Assistant under the supervision of a licensed Chiropractic Physician or group of chiropractic physicians certified by the Florida Board of Chiropractic Medicine; or
- Registered Chiropractic Assistant, Licensed Physical Therapist, Licensed Massage Therapist or Licensed Acupuncturist employed and under the direct supervision and responsibility of a licensed Chiropractic Physician or Certified Chiropractic Physician's Assistant.

Providers are to submit procedure codes for reimbursement in accordance with generally accepted standard coding guidelines. It is BCBSF's position that chiropractic physicians cannot subcontract to Physical Therapists, Massage Therapists, or Acupuncturists in order to render chiropractic services to BCBSF members and bill BCBSF for those services underneath the chiropractic physician's scope of services. Should a qualified chiropractic provider as described above desire to refer a BCBSF member to one of the ancillary providers listed who is not an employee, the qualified provider should follow normal referring provider practices.

BCBSF reimburses for most services provided by a Doctor of Chiropractic subject to the member's benefits. Select member benefit agreements can limit coverage for chiropractic services. Always verify member benefits prior to rendering services. All services provided must be clinically indicated, medically necessary, in accordance with each member agreement, and appropriately documented in the medical record.

The member must have a significant neuromusculoskeletal condition necessitating appropriate, medically necessary evaluation and treatment services.

There must be a reasonable expectation of recovery or improvement in function to support the onset and continuation of a therapeutic level care plan.

Management of long term spinal conditions wherein care is not essential to improving the member's net health outcome is not considered medically necessary and not a covered service subject to member's benefits.

Chiropractic coverage in the office includes the following services, modalities, and procedures according to the member benefit agreement and provider's reimbursement policies as detailed below. Chiropractic services are subject to current procedural coding edits. (CPT codes are subject to change.)

- Evaluation and management
- Chiropractic manipulative treatment
- Physical medicine and rehabilitation
- Acupuncture (with certification by the Florida Board of Chiropractic Medicine)
- Diagnostic imaging (diagnostic plain film X-rays)
- Laboratory

Refer to the latest release of AMA's CPT for further information including complete descriptions of recognized codes, definitions of commonly used terms (e.g., new and established patient), instructions for selecting a service or procedure, and various clinical examples.

Additionally, these Chiropractic Billing and Coding Guidelines should be read in conjunction with BCBSF's Medical Coverage Guidelines available on our website, *www.bcbsfl.com*.

Evaluation and Management

Evaluation and management (E/M) codes are reimbursable only once per episode of care for the initial evaluation of a new or unrelated condition or injury. Re-examinations within an episode of care are reimbursable no more frequently than a monthly basis to assess patient progress, current clinical status, and to determine the need for any further medically necessary care. An episode of care is defined as evaluation, management, and treatment of a specific illness, injury, or condition related to an established date of onset and/or mechanism of injury, and comprising all services and procedures rendered during a planned course of care leading to resolution and/or stabilization of the condition with attainment of maximum clinical improvement by the member. Clinically indicated and medically necessary spinal and/or extraspinal manipulation on the same date of service may be reimbursed, subject to the member benefit agreement.

Chiropractic Manipulative Treatment

Chiropractic manipulative treatment (CMT) is a form of manual treatment to influence joint and neurophysiological function. This treatment may be accomplished using a variety of techniques.

When similar or identical procedures are performed, but are qualified by an increased level of complexity, only the definitive or most comprehensive service performed should be reported. This logic is supported by CMS's guideline for More Extensive Procedure found in the National Correct Coding Policy Manual for Part B Medicare Carriers, Chapter I, which states, "…the less extensive procedure is included in the more extensive procedure." Therefore only one CMT service of the spinal region (procedures 98940-98942) or extraspinal region (98943) is eligible for payment on a single date of service. Furthermore, payment is limited to one clinically indicated and medically necessary physical medicine modality or procedure code per patient, per date of service. Payment is allowed for one clinically indicated and medically necessary extraspinal manipulation code (i.e., 98943-51) in combination with a spinal manipulation code (i.e.,

98940, 98941, or 98942) per date of service. Refer to the Chiropractic Modalities section for a complete listing of CPT physical medicine modality and procedure codes. BCBSF reserves the right to change the contents of the listing in accordance with revisions to industry standards, AMA/CPT guidelines, and with normal annual fee schedule coding updates.

The chiropractic manipulative treatment codes include a pre-manipulation patient assessment. Additional E/M services may be reported separately using modifier 25, if the member's condition requires a significant separately identifiable E/M service, above and beyond the usual pre-service and post-service work associated with the procedure.

When multiple procedures are performed at the same session by the same provider, the modifier 51 may be appended to the additional CPT codes (excluding E/M codes).

For purposes of CMT, the five spinal regions referred to are:

- Cervical region (includes atlanto-occipital joint)
- Thoracic region (includes costovertebral and costotransverse joints)
- Lumbar region
- Sacral region
- Pelvic (sacroiliac joint) region

The five extraspinal regions referred to are:

- Head (including temporomandibular joint, excluding atlanto-occipital) region
- Upper extremities
- Lower extremities
- Rib cage (excluding costotransverse and costovertebral joints)
- Abdomen

Physical Medicine and Rehabilitation

The selection of appropriate physical medicine modalities and procedures should be based on the desired physiological response in correlation to the stages of healing. In most conditions or injuries, utilization of one carefully selected modality or procedure in combination with CMT is adequate to achieve a successful clinical outcome.

All decisions made by a chiropractic physician regarding the use of supportive physical medicine modalities and procedures shall be predicated upon a properly documented clinical rationale, which is consistent with current educational and practice standards. The details of all modalities or procedures provided shall be recorded when performed, including time for all constant attendance modalities and therapeutic procedures.

97140, manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes, will not be separately reimbursed when billed with 98940-98943 (CMT) for the same region. Modifier 59 should be used with 97140 when billed with a CMT code, but performed on a different anatomical region.

It is not appropriate to bill 97124, massage, for myofascial release. For myofascial release, 97140 should be reported and is reimbursable if it is not billed with a CMT code pertaining to the same anatomical region. When reporting or billing for 97112 (neuromuscular reeducation) and 97124 (massage) as well as all other physical medicine modalities and therapeutic procedures, the details of the procedure shall be recorded in the medical record, including clinical rationale, anatomical site, description of service, and time (as required by the selected procedure code).

Acupuncture

A chiropractic provider may not use acupuncture until certified by the Florida Board of Chiropractic Medicine for acupuncture services. (Qualified chiropractic providers are identified within Coding and Billing for Covered Services.)

Acupuncture is reported based on 15-minute increments of personal (face-to-face) contact with the patient, not the duration of acupuncture needle(s) placement.

If no electrical stimulation is used during a 15-minute increment, use 97810 or 97811. If electrical stimulation of any needle is used during a 15-minute increment, use 97813 or 97814. Only one code may be reported for each 15-minute increment. Use either 97810 or 97813 for the initial 15-minute increment. Only one initial code is reported per day.

The Federal Employee Program does not include benefits for acupuncture when performed by a chiropractor.

Diagnostic Imaging

The fundamental purpose of diagnostic imaging is to gain diagnostic information regarding the member in terms of diagnosis, prognosis and therapy planning. Studies are performed at the request of a practitioner with the informed consent of the patient. The primary directive of the treating practitioner is to use radiology to confirm or contribute to the clinical picture. Diagnostic imaging, especially plain film radiographs, continues to be a mainstay in the assessment of chiropractic patients. [1]

If the treating chiropractic provider refers the reading or interpretation of a radiology service to a radiologist, reimbursement for the professional component of that service will only be made to the radiologist, and the treating chiropractic provider should not bill for that component.

The professional component, signified by the addition of modifier 26 to the X-ray procedure code, represents the participation and services rendered by a licensed practitioner to perform the diagnostic interpretation of each study. It is required to document the diagnostic conclusions of the study by a written and signed radiology report.

The technical component, represented by the addition of modifier TC to the X-ray procedure code, is that portion of radiology services that includes providing the facilities, equipment, resources, personnel, supplies and support needed to perform and produce the diagnostic study.

Global billing combines both the technical and professional components in the service provided, wherein the practitioner selects the specific CPT code for the X-ray series without a modifier. [2]

Please note in consideration of the above information that member benefits and procedure code edits prevail.

Should advanced imaging radiology services become required, refer to the BCBSF Provider Directory at *www.bcbsfl.com* for a listing of participating Independent Diagnostic Testing Centers. Examples of advanced imaging radiology studies include MRIs, CTs, and PET scans.

[1] Procedural Utilization Facts, Chiropractic Care Standards, A Reference Guide©, 6th Edition. Woodstock, Data Management Ventures, Inc., 2000.
[2] Ibid.

Providers rendering radiology services are required to take part in any utilization management program in which BCBSF participates. Refer to the National Imaging Associates (NIA) Fast Tracker on the BCBSF website for a complete listing of all procedures and guidelines of participation with this program.

Laboratory

For BlueCare, BlueMedicare HMO, BlueMedicare PPO and BlueOptions members, covered in-office laboratory services are restricted to the list of in-office laboratory codes found in Coding and Filing Claims section. For laboratory services not found on this list, the member should be referred to BCBSF's preferred participating laboratory, Quest Diagnostics, Inc.

For BlueChoice and Traditional members, members may be referred to any of BCBSF's contracted laboratories, including Quest Diagnostics, Inc.

Laboratory services for select health and musculoskeletal conditions may comprise one or more of the procedure codes on the list of in-office laboratory codes. Claims as clinically indicated, medically necessary, and within the scope of practice of the licensed chiropractic physician. Reimbursement for routine venipuncture for collection of specimen (36415) is only payable when paired with modifier 90 and when the laboratory sample is drawn in the chiropractor's office, but the sample is sent to an offsite laboratory for processing. Reimbursement of specific laboratory codes is subject to the member benefit agreement.

Non-Covered Services

The services included below (but not limited to) are outside the definition of medical necessity, are typically not covered under BCBSF's member benefit agreements, and are therefore excluded as a covered service:

- When provided by a practitioner who ordinarily resides in the member's home or who is a family member; or
- For which no charge is made, or for which the member would not be required to pay if they did not have this benefit.

The chiropractic provider is advised to verify member benefits prior to the provision of services to a member in order to determine the extent of non-covered services.

Chiropractic Modalities

CPT Code	Description
Physical Medicine and Rehabilitation	
Supervised Modalities The application of a modality that does not require direct (one-on-one) patient contact by the provider.	
64550	Application of surface (transcutaneous) neurostimulator
97012	Traction, mechanical
97014	Electrical stimulation (unattended)
97016	Vasopneumatic devices
97018	Paraffin bath
97022	Whirlpool
97024	Diathermy (e.g., microwave)
97028	Ultraviolet
Constant Attendance Modalities The application of a modality that requires direct (one-on-one) patient contact by the provider.	
97032	Electrical stimulation (manual)
97033	Iontophoresis
97034	Contrast baths
97035	Ultrasound
97036	Hubbard tank
Therapeutic Procedures Physician or therapist required to have direct (one-on-one) patient contact. Therapeutic procedure, one or more areas, each 15 minutes.	
97110	Therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic senses, posture, and/or proprioception for sitting and/or standing activities
97113	Aquatic therapy with therapeutic exercises
97116	Gait training (includes stair climbing)
97124	Massage, including effleurage, pertissage and/or tapotement (stroking, compression, percussion)
97140	Manual therapy techniques, 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
97535	Self-care/home management training (e.g., ADL), each 15 minutes
Tests and Measurements (Requires direct on-on-one patient contact)	
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
Orthotic Management and Prosthetic Management	
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes
Acupuncture	
97810	Without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97811	Without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)
97813	With electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97814	With electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)