The New 2025 CPT & ICD Changes September 2024

H.J. ROSS® COMPANY

Samuel A. Collins
Director, HJ Ross Information Network
Email sam@hjrosscompany.com

H.J. Ross Company, one of the most highly trusted billing, coding, and compliance companies, has streamlined insurance operations for thousands of chiropractors nationwide for over 40 years. Clients can depend on the H.J. Ross Company to provide the most up to date protocols and procedures, and to be your coach, making it easy for you and your staff to adapt to the changing climate within the insurance industry including codes, laws, and regulations related to the practice of chiropractic.

As director, Dr. Sam Collins believes that you should get paid. His history is firmly rooted in chiropractic, both as a chiropractor from a chiropractic family and now, as he is proudly regarded as The Billing Expert in the chiropractic profession.

Due to our unique ability to stay ahead of the curve on the latest trends and changes in billing and coding by utilizing our direct channel of communication with the insurance companies and organizations that set the guidelines, you can trust you are in good hands!

There is a reason Chiropractors who trusted us with their business 40 years ago still trust us today

Platinum Membership

Expert support for billing & coding logistics, with state-specific compliance

Unlimited phone and email access

Keep **Updated** to stay fully compliant

Review denied claims and revise for ensuring proper reimbursement

CPT & ICD-10 Coding, general health insurance, workers' compensation, personal injury, Medicare, and VA

1 complimentary **Seminar** for the Practitioner *or* Staff Member

Annual **Fee Schedule** adjustments

Online **Document Library**: digital coding reference bank, insurance verification, informed consent, HIPPA, personal injury, fight-back letters, customizable office forms, and more!

ROI : On average, our clients generate >3x the amount of income through proper filing of claims

Monthly **Strategy** Meetings

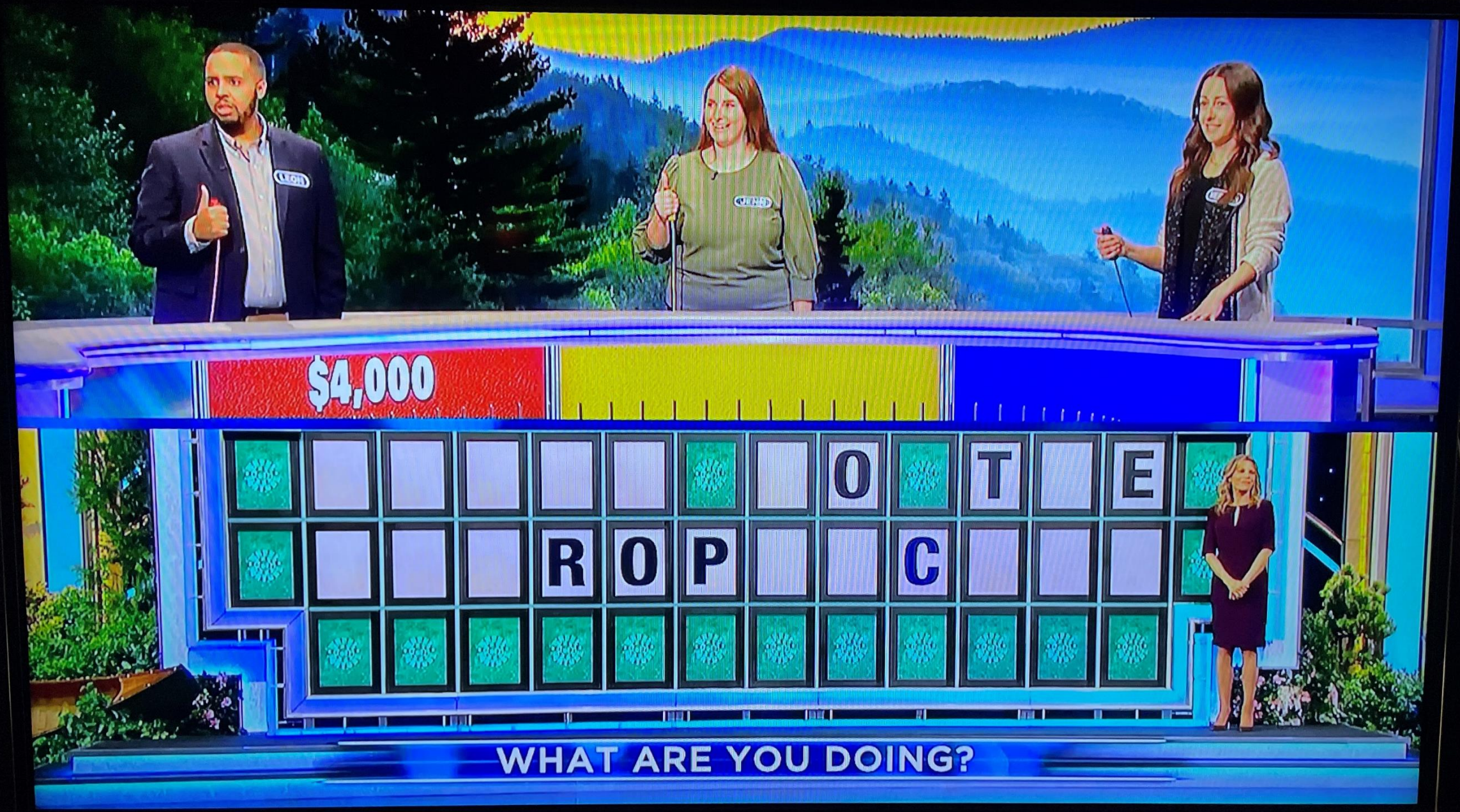
H.J. ROSS COMPANY

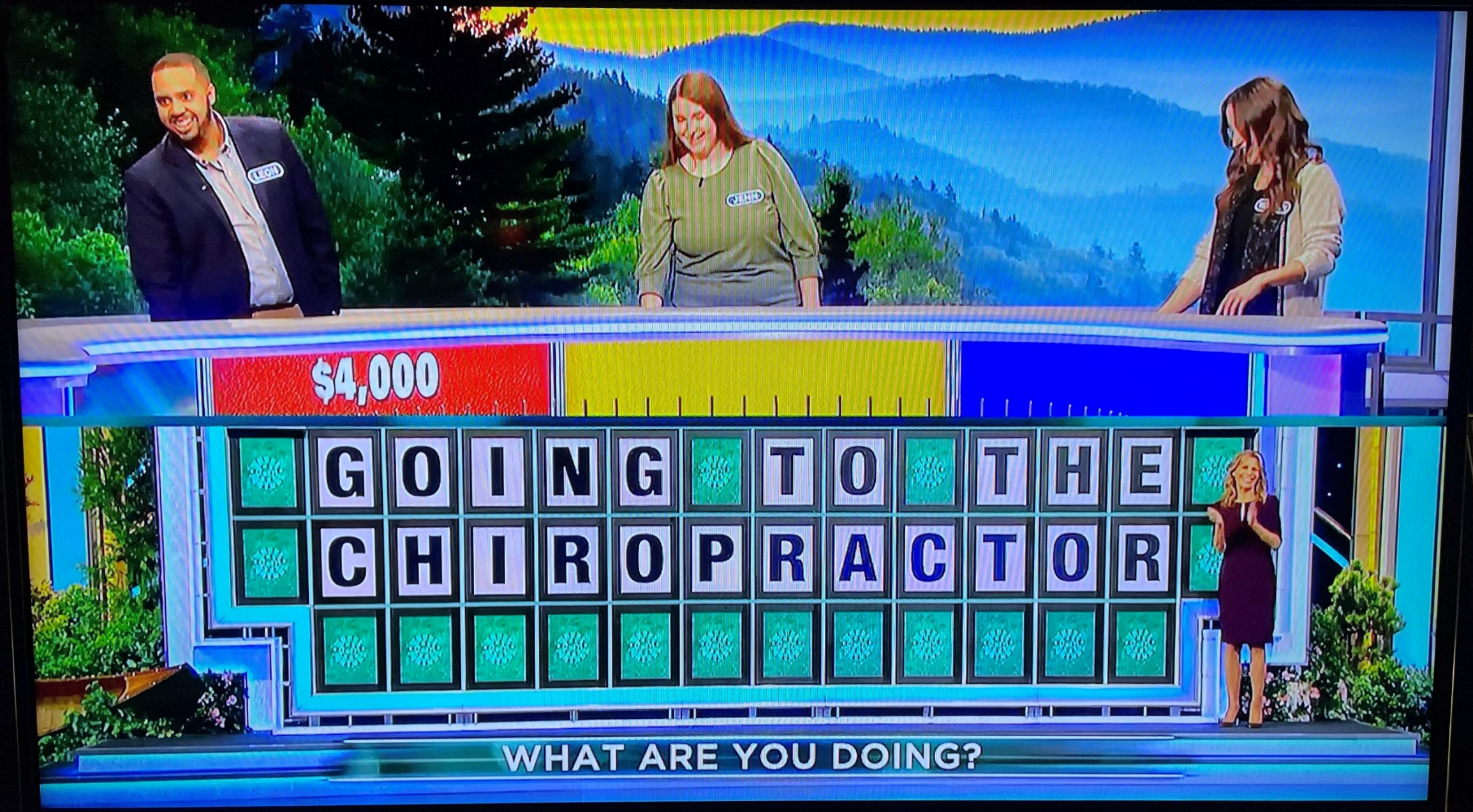
SIGN UP HERE

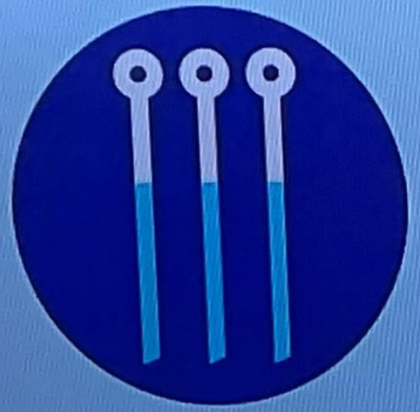
THIS
THERAPEUTIC PROCESS
INVOLVING
BACK & JOINT
MANIPULATION
IS PARTLY FROM
THE GREEK FOR "HAND"

IN 1895
D.D. PALMER
WAS IN ALIGNMENT
AS THE FIRST
THIS TYPE OF
MEDICAL PROFESSIONAL

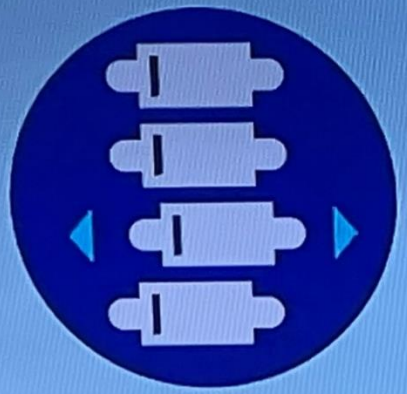
A CHIROPRACTIC
SESSION MAY
INCLUDE THIS
5-LETTER SOUND,
MADE BY
A LOCKED-UP JOINT
BEING FREED


$4,000
O T E
R O P C
WHAT ARE YOU DOING?


$4,000
GOING TO THE
CHIROPRACTOR
WHAT ARE YOU DOING?



Acupuncture visits
$0 copay



Chiropractic visits
$0 copay

AARPMAPlans.com

1-844-754-5667

TTY 711

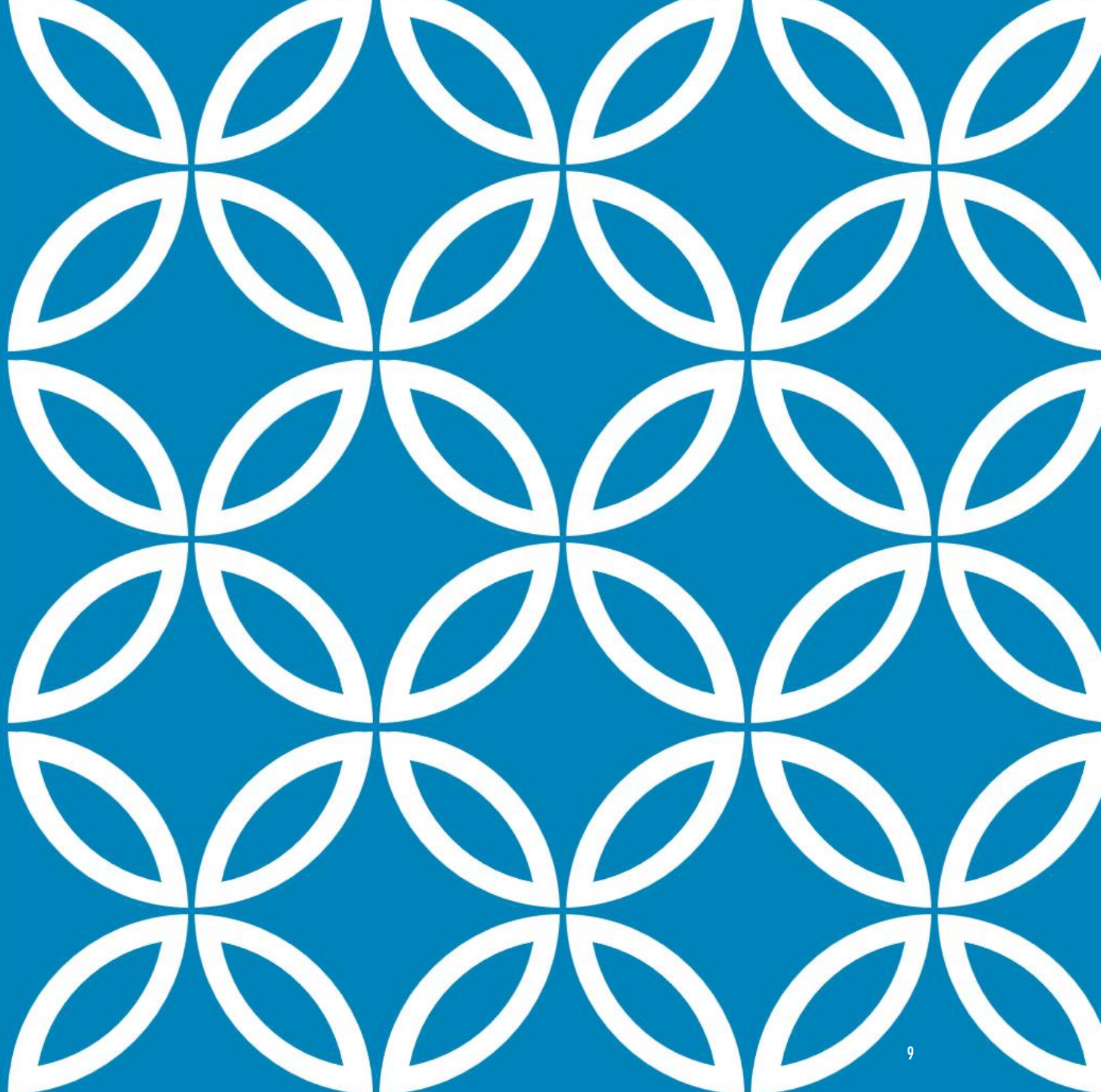
AARP | Medicare Advantage from UnitedHealthcare

The decades from the 1980s through to today were a period of professional maturation and advancement. Chiropractic colleges grew into modern-day educational facilities, enrollments increased and regional and specialized accreditation brought greater recognition of chiropractic by the consuming public.

Employment of chiropractors is projected to grow 9 percent from 2022 to 2032, much faster than the average for all occupations. About 2,600 openings for chiropractors are projected each year, on average, over the decade. (2x national average)

Bureau of Labor and Statistics Occupational Outlook April 17, 2024

THE FOCUS OF CARE TOMORROW WILL BE ON MAINTAINING HEALTH AND WELLNESS, RATHER THAN ATTEMPTING TO TREAT DISEASE AFTER IT HAS BEEN DIAGNOSED. THE PARADIGM SHIFT IS EVIDENT AND WILL BE A MAJOR COURSE CORRECTION IN WHAT HAS BEEN A VERY DIS-EASE FOCUSED WORLD.



Impact of Chiropractic Care on Use of Prescription Opioids

Patients with spinal pain who saw a chiropractor had half the risk of filling an opioid prescription. Among those who saw a chiropractor within 30 days of diagnosis, the reduction in risk was greater as compared with those with their first visit after the acute phase.

James M whedon, DC, MS, andrew W J toler, MS, louis A kazal, MD, serena bezdjian, phd, justin M goehl, DC, MS, jay greenstein, DC pain medicine, pnaa014, doi.Org/10.1093/pm/pnaa014

The adjusted risk of filling an opioid prescription within 365 days of initial visit was 56% lower among recipients of chiropractic care as compared to non-recipients (hazard ratio 0.44; 95% confidence interval 0.40–0.49)

Among older Medicare beneficiaries with spinal pain, use of chiropractic care is associated with significantly lower risk of filling an opioid prescription.

On average about 137,000 Medicare beneficiaries per year suffer opioid overdose

45 STATES HAVE NOW MANDATED CHIROPRACTIC UNDER THE AFFORDABLE CARE ACT

Most plans have chiropractic benefits even when not mandatory

Medicare Part B and C

Medicaid

VA Claims

Personal Injury

Workers' compensation

37 state Attorney Generals, National Governor's Association, State and National treatment guidelines recommend non-pharmaceutical chiropractic/acupuncture treatment for both acute and chronic pain and dysfunction.

"Average per-episode costs for care that begins with a DC / PT / acupuncturist is only $619, compared with $728 for primary care and $1,728 for specialist care. If you make the initial investment in chiropractic / PT acupuncture, significant total-episode savings occur."

"However, first contact with a DC / PT / acupuncturist only occurs in 30 percent of cases, compared to 70 percent for primary (30 percent) or specialist (40 percent) care.“

“The actuaries have done the work, it's presented at the actuarial conference, the net of the increased conservative care will take out about 230 million in annual medical expenditures and reduce opiate prescribing for back pain by 25-26 percent."

American College of Physicians Back Treatment Guidelines - The ACP updated prior guidelines, recommending non-drug treatment first for back pain, including chiropractic manipulative therapy (CMT), osteopathic manipulative therapy (OMT), exercise therapy, acupuncture, massage and yoga.

FDA Education Blueprint for Health Providers Involved in Pain Management: The Blueprint recommends "The [health care provider] should be knowledgeable about which therapies can be used to manage pain and how these should be implemented." Chiropractic and acupuncture are specifically noted as non-pharmacologic therapies that can play an important role in managing pain.

Higher copayments decreased the likelihood of a patient seeing a physical therapist as first provider. Patients with a copayment over $30 were 29% less likely to see a physical therapist first than were patients with no copayment. This association was not evident for chiropractic.

I have not always practiced in a post-pandemic environment

But when I do, I code
Z56.3 Stressful work schedule


PREVENT
PROMOTE
PROTECT
PREPARE


PLAN
A
B
C


RISK MANAGEMENT
TRAINING AND AWARENESS
SECURITY AND PRIVACY MANAGEMENT
EMPLOYEE OVERSIGHT
AUDIT & BREACH MANAGEMENT


Requirements
COMPLIANCE
Policies
parency
Law
Guideline
ulations
Audit
Standards

2024 Department of Health and Human Services Compliance Program

Documentation, Coding, Billing, Medical Necessity, HIPAA-Privacy

Each practice can undertake reasonable steps to implement compliance measures, depending on the size and resources of that practice. Practices can rely, at least in part, upon standard protocols and current practice procedures to develop an appropriate compliance program for that practice. Many practices already have established the framework of a compliance program without referring to it as such.

The incorporation of compliance measures into a physician's practice should not be at the expense of patient care but instead should augment the ability of the physician's practice to provide quality patient care.

7 Components of an Effective Compliance Program This compliance program guidance for individual and small-group practices

1. Conducting internal monitoring and auditing.
2. Implementing compliance and practice standards.
3. Designating a compliance officer or contact.
4. Conducting appropriate training and education.
5. Responding appropriately to detected offenses and developing corrective action.
6. Developing open lines of communication.
7. Enforcing disciplinary standards through well-publicized guidelines.

A well-designed compliance program can:

• Speed and optimize proper payment of claims;

• Minimize billing mistakes;

• Reduce the chances that an audit will be conducted by HCFA or the OIG; and

• Avoid conflicts with the self-referral and anti-kickback statutes. (fee-splitting)

A self-audit is an audit, examination, review, or other inspection performed by and within a physician's or other healthcare professional's business. Self-audits generally focus on assessing, correcting, and maintaining controls to promote compliance with applicable laws, rules, and regulations. The U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG), includes periodic internal monitoring and auditing in its list of the seven elements of an effective compliance program.[1]

1 Federal Register Vol. 65, No. 194. (2000, October 5). Office of Inspector General. OIG Compliance Program for Individual and Small Group Physician Practices. Retrieved December 18, 2017, from https://oig.hhs.gov/authorities/docs/physician.pdf

- Studies indicate an effective compliance program can facilitate an increase in revenue by catching and correcting problems early that would otherwise result in lost income

CHIROPRACTIC TOP ENFORCEMENT VIOLATIONS

Here are examples of frequent violations that may result in disciplinary actions. Visit the Board of Chiropractic Examiners (BCE) website (**www.chiro.ca.gov**) and click on the links for Rules and Regulations (**www.chiro.ca.gov/laws_regs/regulations.pdf**) and the Initiative Act (**www.chiro.ca.gov/laws_regs/initiative_act.shtml**) for more information on all possible grounds of discipline.

BEYOND SCOPE OF PRACTICE

- Performing surgical procedures
- Furnishing/prescribing controlled substances
- Claiming to treat/cure cancer

CONVICTION OF A CRIME(S)

- Theft
- Domestic violence
- DUI
- Vandalism

EXCESSIVE TREATMENT

- Treatment beyond what is reasonable/necessary or within the standard of care
- Failure to document necessity (conduct a thorough exam, diagnose the condition, implement a treatment plan, and conduct follow-up exams to assess progress)

FAILURE TO RELEASE PATIENT RECORDS WITHIN 15 DAYS OF REQUEST

- Includes requests from patient, patient attorney, patient representative, insurance company, or BCE representatives

FALSE AND/OR MISLEADING ADVERTISING

- Sensational claims
- No "D.C." after chiropractor's name
- Fraud/misrepresentation

INSURANCE FRAUD

- Double billing
- Billing for service not rendered
- Upcoding
- Excessive treatment

NEGLIGENCE/INCOMPETENCE

- Physical harm to patient
- Failure to exercise appropriate standard of care

PAYMENT FOR REFERRALS

- Discounts
- Cash/gift cards
- Free services

SEXUAL MISCONDUCT

- Erotic behavior
- Inappropriate touching
- Sexual contact or having sexual relations with a patient, client, customer, or employee

UNLICENSED PRACTICE

- Practicing after license expired
- Failing to promptly renew
- Aiding and abetting unlicensed individuals

VIOLATION(S) INVOLVING DRUGS/ALCOHOL

- DUI
- Possession or use of any illicit drugs
- Practicing while impaired
- Prescription medication abuse

BOARD of CHIROPRACTIC EXAMINERS
STATE OF CALIFORNIA

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

Phone: (916) 263-5355 | Fax: (916) 327-0039
CA Relay Service TT/TDD: (800) 735-2929
Consumer Complaint Toll-Free Hotline: (866) 543-1311
Email: **chiro.info@dca.ca.gov**
"Like" us on **Facebook** and follow us on **Twitter**.

2 REVISED: JUNE 2018
PDE_18-172

Accuracy, Clarity, and Guidelines

WHAT TRIGGERS AUDITS?

- High-level E&M codes done routinely 99204/99214, 99205/99215
- Billing E&M daily
- Routine billing of 4 or more services per visit
- Care that appears preventative or supportive
- Extended care for non-complicated conditions
- Patient/Employee making complaints to the insurer

BlueCross BlueShield
of Oklahoma

April 25, 2023

[redacted]

Re: Medical Records Request/Notification of Time Study Results

Dear Dr. [redacted]

A review conducted by a Blue Cross and Blue Shield of Oklahoma (BCBSOK) certified professional coder of your claims history and medical records has prompted this letter. The review of your provider identification number reflects that since 2021, you have billed for more than 12 hours of services per day on 24 occasions, and more than 8 hours of services per day on at least 73 occasions. On January 17, 2022, you billed for treating 28 patients for a total of 17.75 hours. This information reflects a pattern of billing for an amount of services that could not possibly be performed in a standard business day, especially, when considering that this data only reflects billing for BlueCross and BlueShield patients.

Periodically, Blue Cross and Blue Shield of Oklahoma (BCBSOK), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, selects claims for further review and/or audit. BCBSOK also requests information regarding those claims consistent with privacy rules under HIPAA. This letter is to inform you that a sample of the claims you previously submitted to BCBSOK has been selected for review. The review is designed to ensure the claims were processed in accordance with the patient's then-existing benefit plan structure (paid or denied properly) and that documentation exists to support each billing. This request is consistent with the language in your network agreement/contract. Your network agreement states the following, "Health Care Professional agrees to furnish without charge, upon request, all information reasonably required by THE PLAN to verify and substantiate the provision of Medical Services and the charges for such services…"

For each patient and dates of service listed on the attached sheet, you are requested to provide all currently existing medical records that support the billing of all services. While you must determine what constitutes the HIPAA "minimum necessary" records to support your billings, you should ensure that sufficient documentation is furnished with the initial submission. BCBSOK will make its determination as to whether the claims are supported by the documentation provided and were paid at an appropriate rate based on your initial medical records submission.

Please note that only legible medical records will be accepted for a review. If the original progress notes are not legible, you may submit a typed version of the progress notes, along with the original notes. If non-standard abbreviations are used, provide a key for those abbreviations.

The "Provision of Records" section in your BCBSOK Health Care Professional Agreement, states, "Health Care Professional agrees to furnish without charge all information reasonably required by The Plan to verify and substantiate the provision of services and the charges for such services. Should The Plan not receive the information within sixty (60) days of the original request, The Plan may continue

Historic Distribution of Fail Determinations

Fail Code	2014	2015	2016	2017	2018	2019	2020
Illegible	12%	1%	1%	2%	2%	2%	1%
Service Not Documented	8%	4%	9%	4%	12%	7%	6%
Timed PMR	64%	69%	26%	33%	48%	28%	22%
CMT	2%	1%	2%	1%	0%	.3%	2%
97140	7%	3%	6%	5%	2%	2%	2%
Documentation Not Received	7%	18%	56%	51%		42%	53%
DOS Not Documented					36%	18%	12%
E/M, Estab PT/OT Eval						.3%	1%

blue california

Patient List [redacted]

Case ID	Patient ID	Patient Name	Date of Birth	Date(s) of Service	Claim Number	Claim Line	CPT/HCPS Code	Mod(s)
B120080245100	[redacted]			10/5/2022 - 10/17/2022	[redacted]	1	98941	
	Additional Remarks: No Findings							
B120080245100	[redacted]			10/5/2022 - 10/17/2022	[redacted]	2	97112	59
	Denial Description: Documentation Does Not Support Services Billed Additional Remarks: Not supported. The submitted medical records did not include a detailed description of the specific neuromuscular reeducation performed (type of neuromuscular reeducation). In addition, the submitted medical records do not support the total time required for the billed service.							
B120080245100	[redacted]			10/5/2022 - 10/17/2022	[redacted]	3	98941	59
	Additional Remarks: No Findings							
B120080245100	[redacted]			10/5/2022 - 10/17/2022	[redacted]	4	97110	
	Denial Description: Documentation Does Not Support Services Billed Additional Remarks: Not supported. The submitted medical records did not include a detailed description of the specific therapeutic exercises performed (type of exercises and region(s) treated). In addition, the submitted medical records do not support the total time required for the billed service.							
B120080245100	[redacted]			10/5/2022 - 10/17/2022	[redacted]	5	97112	59
	Denial Description: Documentation Does Not Support Services Billed Additional Remarks: Not supported. The submitted medical records did not include a detailed description of the specific neuromuscular reeducation performed (type of neuromuscular reeducation). In addition, the submitted medical records do not support the total time required for the billed service.							

FIRST COAST
SERVICE OPTIONS, INC.
WHEN EXPERIENCE COUNTS & QUALITY MATTERS

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE

July 26, 2024

[redacted]

Comparative Analysis
Procedure Code: 98941
Provider Number [redacted]

Dear Medicare Physician or Provider:

As your Medicare Administrative Contractor (MAC), First Coast Service Options, Inc. works in conjunction with the Comprehensive Error Rate Testing (CERT) program to measure improper payments in the Medicare program. We use this data to regularly monitor billing details on claim submissions, assist when reviewing medical documentation and improve provider education.

Please note, this information is intended to serve as an educational tool to assist you in preventing potential claim denials. We encourage you to review this information and determine what opportunities may exist to improve your processes.

Your Current Performance	Impact on National CERT Error Rates

For procedure code 98941, you are billing 1,303 services per 100 patients for claims finalized between May 01, 2023 and April 01, 2024. For the same procedure code and time period, your peer group* billed 778 services per 100 patients.
*Peer Group - All billing providers submitting this procedure code within your Jurisdiction.
	• Projected Improper Payments for 98941 **$159,864,807**
	  ○ 92.4% insufficient documentation
	  ○ 5.4% no documentation submitted
	  ○ 1.6% incorrect coding
	• Overall Improper Payment Rate **39.2%**

Common Reasons for Denials for Chiropractic Manipulative Treatment	**Resources/Improvement Opportunities**

• Documentation to support current episode of care is due to an acute condition for a new problem or an exacerbation of a chronic problem.
• Documentation to support mechanism of trauma or cause leading the beneficiary to seek treatment.
• Documentation to support active/corrective treatment vs maintenance therapy.
	Visit our website at medicare.fcso.com for helpful resources:
	• Provider Specialties:
	  ○ Chiropractic services
	• CERT Resources Center (Claims Review Programs):
	  ○ Documentation Checklists
	• Learning Center:
	  ○ Events Calendar

Sincerely,

Jamie Short, RN, CPC
Targeted Education Supervisor
Phone: 717-526-6391 / FAX: 717-728-8743
Jamie.short@novitas-solutions.com

2020 Technology Parkway Suite 100 Mechanicsburg, PA 17050 www.fcso.com

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

THE STANDARD

Good documentation practice helps ensure that your patients receive appropriate care from you and other providers who may rely on your records for patient's past medical histories.

The chart notes reflect and can identify the services were performed by what was documented

E&M services match the level billed based on medical decision-making or time

CMT reflects the diagnosis and regions manipulated

Therapies identify the service provided by what, where, and time with an indication of the purpose or outcome

Another provider can read the notes and clearly identify the service and could perform the service based on what was documented.

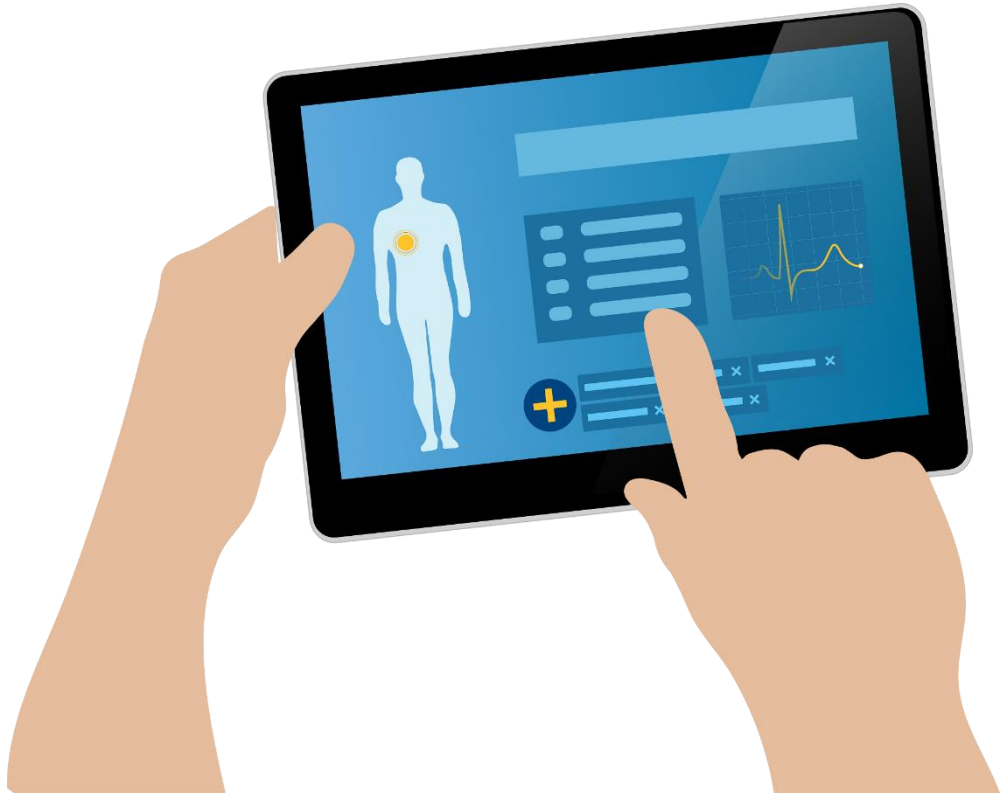
OCCAM'S RAZOR - GOLD STANDARD

ELECTRONIC HEALTH RECORDS

Templates can be useful tools; however, providers should use caution when using templated language.

BlueCross and Blue Shield discourage templates that provide limited options and/or space for the collection of information, such as checkboxes, predefined answers, choices to be circled, etc.

Templates can be useful but require some personal patient information not just a checkbox



ELECTRONIC HEALTH RECORDS

Cut and paste shortcuts have pitfalls

"Services are considered not documented when cloned documentation is identified. Services are denied due to lack of documentation and failure to meet the documentation requirements of BCBS Medical Policy CAM 065."

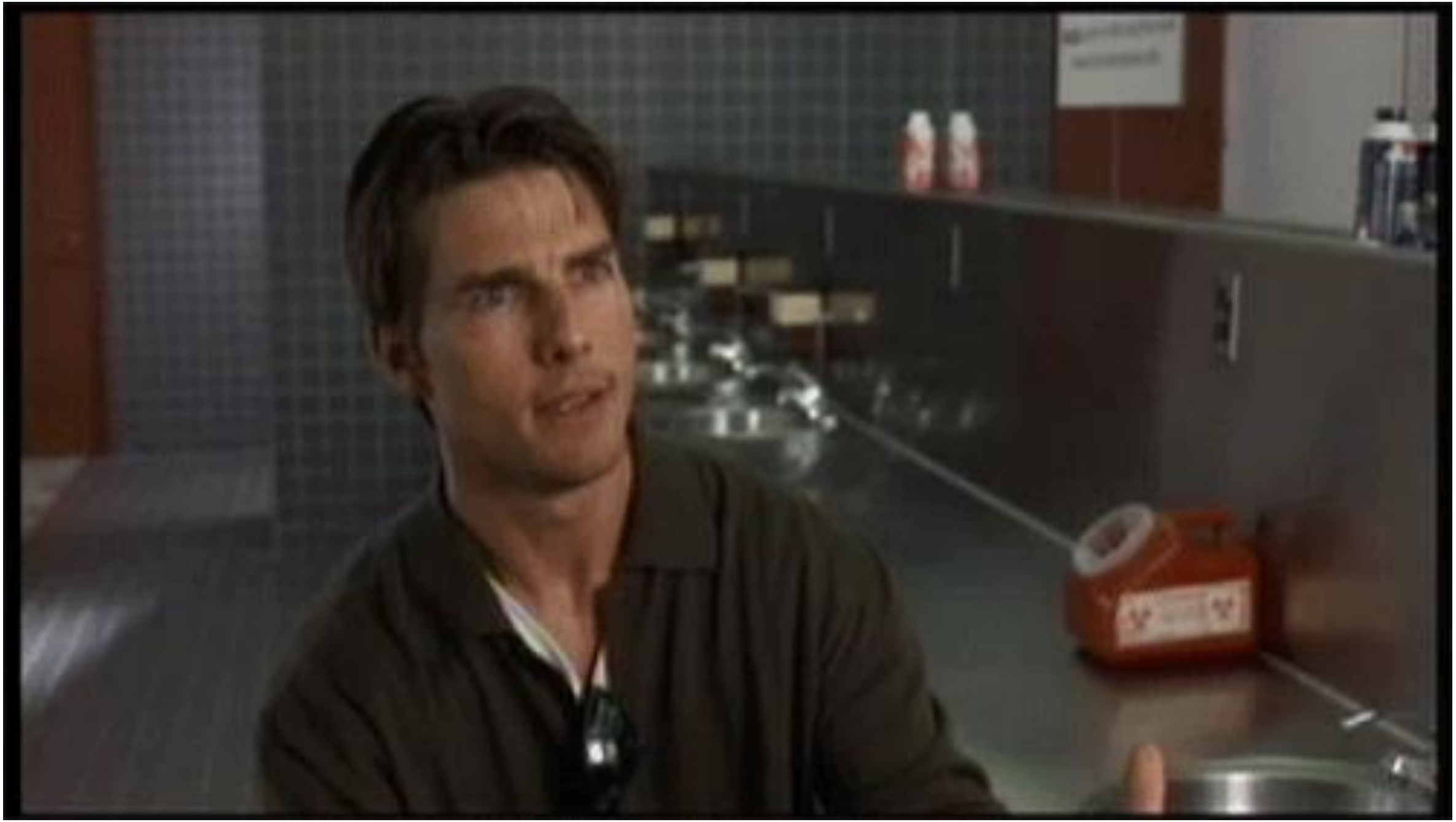
Avoidance of abbreviations (use only standard abbreviations well known to your peers)

How will you respond & defend and audit?

Never assume, KNOW!

ChiroSecure

RISK MANAGEMENT



INFORMATION VS. AFFIRMATION

BlueCross®
BlueShield®
Federal Employee Program®

Request for refund or overpayment
Do you have to refund?...

Subscriber Number:
Patient Name:

Dear Billing Department ,

In regards to the request for repayment for claim: the request made to you was a voluntary overpayment reqeust. Because you are an in network provider you do not have to pay back any overpayment if the overpayment was discovered 365 days or more after the claim finalized.

If you have further questions, please contact us at the address listed below or call toll free (800) 824-8839.

Sincerely,

Kelsey Steinbeiss

INSURANCE COMPANY REQUESTING REFUND ON OVERPAYMENT

Note this does not apply to Medicare, Workers' Compensation, Self-Insured Plans, and Managed Care

Date

Blue Shaft Insurance Co.

Re: Sally Adams
Claim # 44-8980
Dates of Service: (dates)

Dear Sirs:

On (date), we received a letter from your company requesting that we refund the amount of $276.00 to Blue Shaft for a payment that was made in error *(beyond policy limits)* back in (date).

First of all, I reviewed Ms. Adams's records and I do not show that we have an overpayment resulting in a credit on her account.

Secondly, I do not feel that you have the right to place this burden upon my office by asking us to correct your error, chase down this past patient, and ask her to make an additional payment to our office for a new balance that simply appeared out of nowhere!

I would like to bring to your attention the cases of*: In Federated Mutual Insurance Company vs. Good Samaritan Hospital, (Neb.1974) 214 N.W.2d 493*, where the court held that the insurance company could not recover the mistaken overpayment and determined that "the insurance company is in the best position to know what the policy limits are and must bear the responsibility for their own mistake." As well as, *The City of Hope National Center vs. Western Life Insurance Company, 2 Daily Journal D.A.R. 10728, Decided July 31, 1992,* where the court held that, *in the absence of fraud,* a health care provider is not legally obligated to refund payments it receives from an insurer if the insurer subsequently determines that they were paid in error.

Based on these and other court decisions, I will not be sending your company a refund for $276.00 for the erroneous reimbursement payment you are claiming as due.

Sincerely,
John C. Smith, DC

Statute of Limitations of Recoupment

- CT – 5 years
- KT, IA, IN, NC, NY, OH, OK – 2 Years
- AL, AR, DC, MD ME, NH, NJ, TN– 18 Months
- FL, MA, MO, MT, VA – 12 months
- GA – 90 days
- NE – 6 months
- SC, TX -180 days
- AZ, CA, WA, WV – 1 year
- UT – 36 months
- CO – 30 days
- LA – Same as carrier submission
- AK, DE, HI, ID, IL, KS, NV, OR, PA, MI, MN, MS, ND, NM, RI, SD, VT, WI – No Statute

Subject: Second Request

ATTENTION BILLING SUPERVISOR:

As a result of a routine review of claim payments, we previously notified you that there were some differences between the amount paid to you and the amount which should have been paid in accordance with our contracts/policies.

Please refer to the enclosed document for the overpayment reason for the claim(s) indicated.

Our records indicate that the overpayment(s), as noted on the enclosed document, is not eligible to be offset from future claim payments. Therefore, we must request that you issue a check or money order payable to us in the above amount. If you have mailed your payment, please disregard this letter.

Please issue a refund check payable to ***Aetna*** *in the amount of the total balance due as stated above. Please include a copy of this letter and enclosure with your payment to ensure proper identification and credit to your file and send to the following address:*

AETNA
PO BOX 14079
LEXINGTON KY 40512-4079

No Thank You

If you disagree with this request for recovery of overpayment, you may submit your written dispute, including the rationale, with a copy of the overpayment letter to the address at the top of this letter.

If you have any questions, please contact our provider customer service center at 888-632-3862. Thank you for your attention.

Sincerely,

Aetna
Overpayment Department

F00562100000100000100000J1G1ABD7530F

WHAT IS INSURANCE?

- Health Insurance?
- Sick Insurance
- Not preventative in design
- It aids in paying for services does not pay in full, in most instances

WHY INSURANCE? IS IT WORTH IT?

Cash Practice

- Cash
- Prompt Pay
- Prepay

Insurance Practice

- Standard
- PPO
- HMO (EPO)
- HSA or FSA
- Automobile (Personal Injury)
- Workers' Compensation
- Veterans Administration
- Medicaid (Medi-Cal)
- Medicare

92% of Americans have some health insurance but this does not mean they are all good insurance

INSURANCE

- Insurance aids in payment and rarely covers 100%
- New patients
- Someone may be more apt to try Chiropractic
- You are not required to bill insurance and may simply provide a receipt or “superbill” for patient to submit to insurance if they have it

VARIANCE OF INSURANCE REIMBURSEMENT

Some plans may pay more than several hundred dollars per visit for chiropractic-related services

Other plans may pay as little as $25-$60 maximum per day

Some plans have no benefits however, most plans do have some benefits for chiropractic

Visits may be limited and combined with PT, and Acupuncture

Deductibles can vary widely – If someone has a $1000 deductible, they are very likely a "cash patient"

SHOULD I JOIN A PPO/HMO?

Sam,
I have a question about United Healthcare Medicare advantage up to 9-27-23, (EOB date 10-19-23) United paid $41.24 for 98941 and $78.53 for the 99213.

On 11-1-23 the EOB's with the treatment date 10-9-23, (98941) are now being processed and paid at $28.00. And the code 99212 and 99213 are being paid at 0.12 and 0.13.

Do you know what is happening? Or are these processed in error and I need to call United Healthcare.

The claims are processed as “in-network.” When you are “in-network,” they pay $28 for 98940 and bundle the EM to equal $28.25

When you were “out of network” they paid $41.24 and $78.53

Did you not vet this before enrollment as we discussed at the seminars?

PPO Discounts

IN NETWORK

Out of Network

ASH

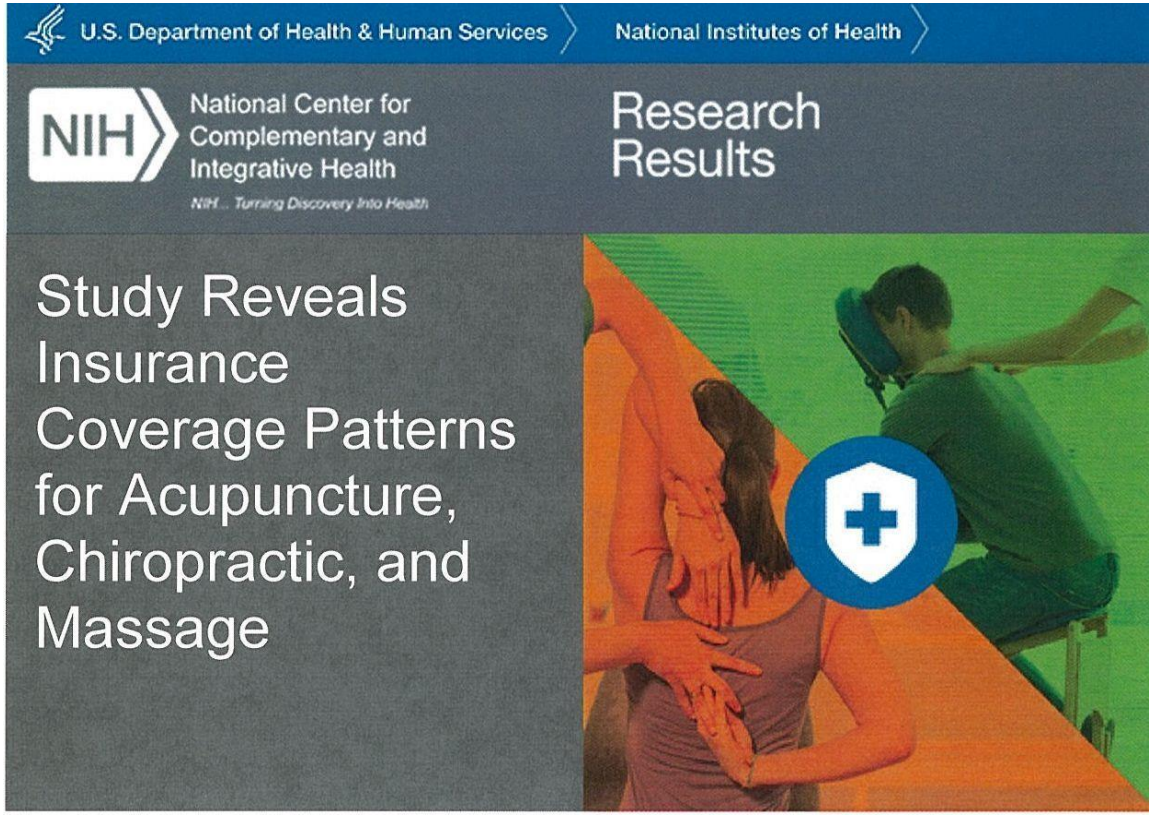
Under Cigna Healthcare, there is section called "Claims-based reimbursement" and it says as follows:

"Benefit plans administered by ASH Group for Client may include reimbursement of ASH Group services utilizing a claims-based reimbursement methodology. Under the claims based reimbursement methodology, Client and ASH Group have agreed upon and established a separate Client-ASH Group Fee Schedule. The Client-ASH Group Fee Schedule includes the Fee Schedule amounts in effect between ASH Group and Contracted Practitioner plus an allocation for ASH Group's care coordination, clinical integration, and administrative services that have been delegated by Client. Upon payment to ASH Group by Client, for clinical services that are determined to Medically Necessary Services, **ASH Group shall reimburse Contracted Practitioner in accordance with the Fee Schedules in effect between ASH Group and Contracted Practitioner, less any Member out-of-pocket expense. ASH Group will retain any remaining portion of payment by Client as reimbursement for ASH Group's care coordination, clinical integration and administrative services provided to Client.** ASH Group shall identify the Member out-of-Pocket expense Contracted Practitioner is permitted to collect and any payment made by ASH Group for Medically Necessary Services for Covered Conditions."

BARRIERS TO CARE

Z91.190 Patient's noncompliance with other medical treatment and regimen due to financial hardship

Data suggest that Americans are **increasingly willing to pay out-of-pocket** for acupuncture, chiropractic, or massage care that isn't covered by health insurance, reports a new study led by the National Center for Complementary and Integrative Health.

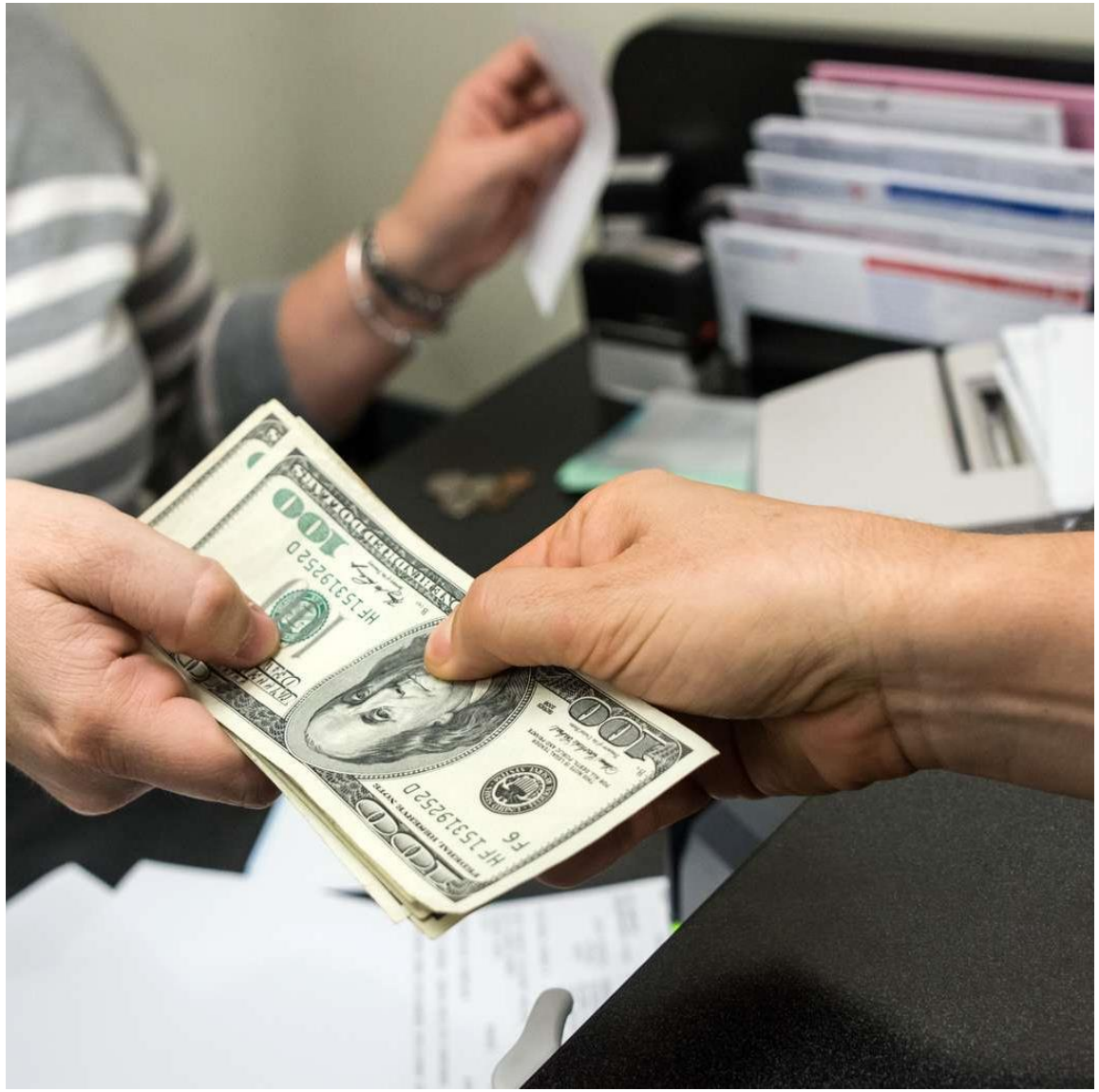


Higher copayments decreased the likelihood of a patient seeing a physical therapist as first provider. Patients with a copayment over $30 were 29% less likely to see a physical therapist first than were patients with no copayment. This association was not evident for chiropractic.

APTA
American Physical Therapy Association

CASH AND PROMPT PAY DISCOUNTS

- Discounts
- Waiving co-pay or deductible
- Hardships



Cash and Prompt Pay

Waiving co-payment, co-insurance and deductible. If a physician's office routinely fails to collect the patient's portion of the care, it is considered a violation of both the Anti-Kickback Statute (AKS) AND the False Claims Act. OIG and the Department of Justice recognize that there are cases of financial hardship and make allowances for those unable to pay. They also recognize when a physician makes a reasonable effort to collect from a patient, but does not receive payment. It is the *routine waiver* of the patient responsibility that can cause serious consequences.

A reasonable "discount" for payment at the time of service, or so called "bookkeeping" discount can be within legal bounds. What's key, however, is how the provider sets discount policies.

Helping patients afford care is the compassionate and right thing to do. But offering a cash rate that is substantially lower than the insurance rate is and may be considered fraud.

What is reasonable? **OIG Advisory Opinion No. 08-03 provides protocol for such discounts.**

Following the broad guidance of the OIG, in a recent opinion, they O.K.'d a 5%-15% "Prompt Payment" discount for a particular hospital

Think defensible, what is the actual bookkeeping savings for not doing the administrative and clerical work associated with billing insurance not to mention the waiting period for payment and you are on the right track.

Charging 5-15% more for identical services where the additional burden of billing and collection is eliminated is certainly reasonable. However charging significantly more than the rate charged for a pay in full at the time of service patient would not be considered fair or reasonable. Certainly there is a cost to the added work but not double the cost of the actual chiropractic service.

UnitedHealthcare

09/20/2023

Sent via fax: [redacted]

[redacted]

UHC SIU Case Number: [redacted]

Re: Request for Records

Dear Sir or Madam:

As part of UnitedHealthcare's role to monitor the appropriateness of paid medical claims and verify adherence to standard billing procedures, we request your assistance with a compliance review for your patients, who are UnitedHealthcare members.

Please assist us in this review by completing the Attestation of Proof of Member Responsibility (Attestation)[1] and submitting proof that our members paid their copays, coinsurance, and/or deductible for each of the claims listed on the attached Attestation. Proof of payment includes, but is not limited to, credit card/check receipts, patient ledgers and/or payment contracts. If the member received a hardship waiver, please provide the supporting documentation.

If our members have not yet paid their copays, coinsurance, and/or deductible, please assist us by completing the Attestation and providing documentation of your attempt(s) to collect each member's responsibility or documentation of your waiver of each member's responsibility, including but not limited to hardship waivers.

Please submit the requested information in **PDF format via a secured electronic format,** along with a copy of this letter and an executed copy of the Attestation within 30 days of the date of this letter to:

Johnice Williams-Cruse
Fax: 855-458-8296
Email: johnice.williams@uhc.com

Thank you for your cooperation and assistance. Please contact us at 866-763-1821 if you have any questions or require additional information.

Sincerely,

Johnice Williams-Cruse

Dear Sir or Madam:

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Please submit the requested information in **PDF format via a secured electronic format,** along with a copy of this letter and an executed copy of the Attestation within 30 days of the date of this letter to:

Rhina Bustamante
Fax: 844-738-8850
Email: rhina.bustamante@uhc.com

Thank you for your cooperation and assistance. Please contact us at 763-361-0559 if you have any questions or require additional information.

07178

Anthem

Services provided by Anthem HealthChoice Assurance Inc., Anthem HealthChoice HMO, Inc. and/or Anthem HP, LLC. Independent licensees of the Blue Cross Blue Shield Association.

[redacted]

CHECK/EFT DT: [redacted]
CHECK/EFT:

BCBS PPO NY

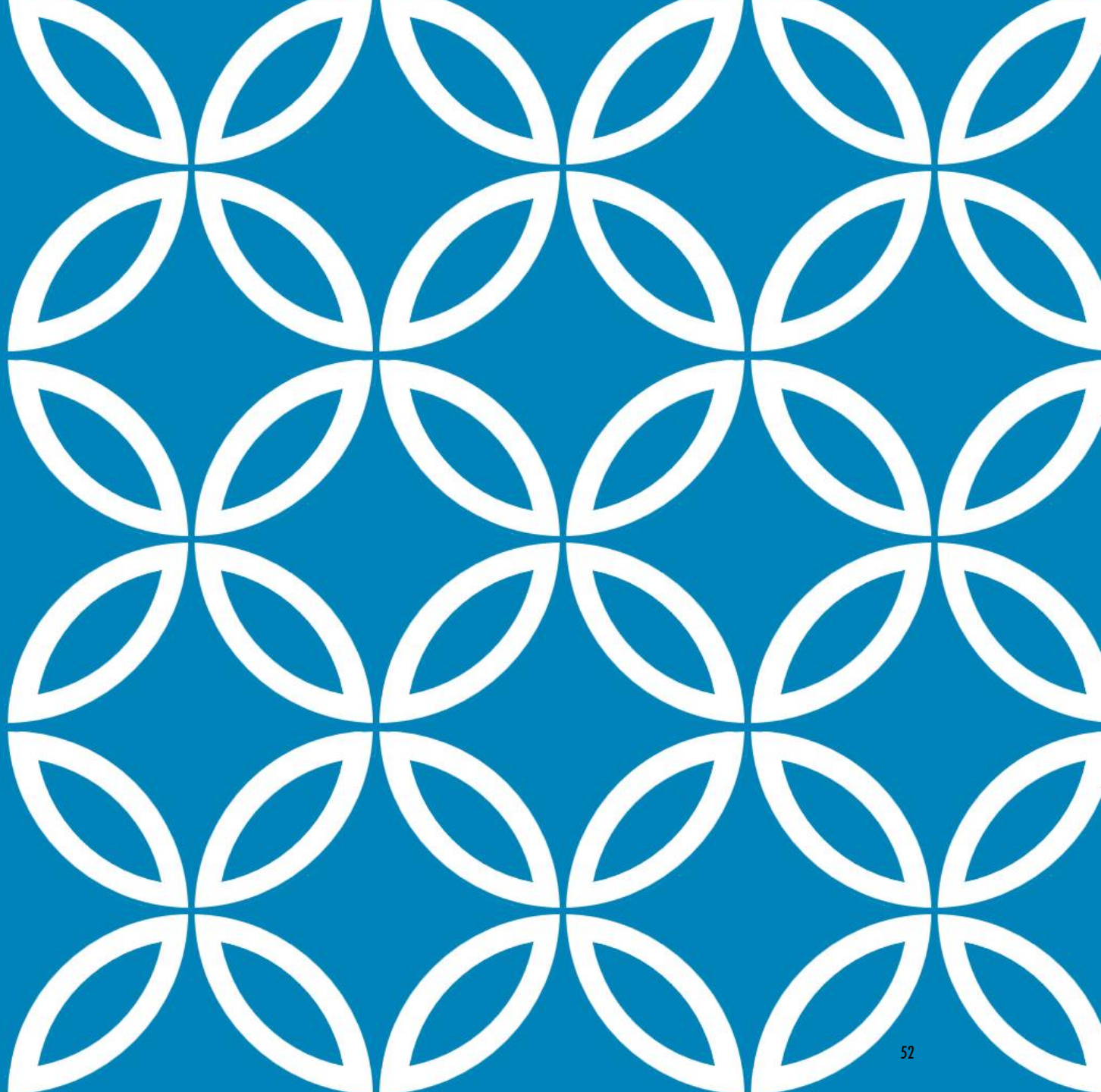
SERVICE DATE(S)		SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: [redacted]					INSURED'S ID: [redacted]					PATIENT NAME:				FOR INQUIRIES CALL:
PATIENT ACCOUNT#:					CLAIM NUMBER:					RECEIVED DATE: [redacted]				(800) 713-4173
SERVICE PROVIDER NAME:					SERVICE PROVIDER ID:					EXPL CD: AXE		APPEALS CODE: NA		
NETWORK: OUT OF NETWORK					RELATIONSHIP TO INSURED:				PLAN TYPE: PPO	DRG RCVD: N/A				
03/20/2024	03/20/2024	98940	11	200.00	91.32	0.00	0.00	36.52	0.00	0.00		145.20 833 45 067 2		54.80
03/20/2024	03/20/2024	98943	11	300.00	86.49	0.00	0.00	34.59	0.00	0.00		248.10 833 45 067 2		51.90
03/20/2024	03/20/2024	97012 ,GP	11	275.00	37.56	0.00	0.00	15.02	0.00	0.00		252.46 833 45 067 2		22.54
03/20/2024	03/20/2024	97032 ,GP	11	275.00	38.13	0.00	0.00	15.25	0.00	0.00		252.12 833 45 067 2		22.88
03/20/2024	03/20/2024	97110 ,GP	11	275.00	98.43	0.00	0.00	39.37	0.00	0.00		215.94 833 45 067 2		59.06
03/20/2024	03/20/2024	97124 ,GP	11	550.00	0.00	0.00	0.00	0.00	0.00	0.00		550.00 801 204		0.00
		TOTAL:		1,875.00	351.93	0.00	0.00	140.75	0.00	0.00		1,663.82		211.18
		TOTAL NET PAID												211.18

SERVICE DATE(S)		SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: [redacted]					INSURED'S ID: [redacted]					PATIENT NAME: PATN[redacted]				FOR INQUIRIES CALL:
PATIENT ACCOUNT#:					CLAIM NUMBER:					RECEIVED DATE: 05/24/2024				(800) 713-4173
SERVICE PROVIDER NAME:					SERVICE PROVIDER ID:					EXPL CD: AXE		APPEALS CODE: NA		
NETWORK: OUT OF NETWORK					RELATIONSHIP TO INSURED:				PLAN TYPE: PPO	DRG RCVD: N/A				
03/29/2024	03/29/2024	98940	11	200.00	91.32	0.00	0.00	36.52	0.00	0.00		145.20 833 45 067 2		54.80
03/29/2024	03/29/2024	98943	11	300.00	86.49	0.00	0.00	34.59	0.00	0.00		248.10 833 45 067 2		51.90
03/29/2024	03/29/2024	97012 ,GP	11	275.00	37.56	0.00	0.00	15.02	0.00	0.00		252.46 833 45 067 2		22.54
03/29/2024	03/29/2024	97032 ,GP	11	275.00	38.13	0.00	0.00	15.25	0.00	0.00		252.12 833 45 067 2		22.88
03/29/2024	03/29/2024	97110 ,GP	11	275.00	98.43	0.00	0.00	39.37	0.00	0.00		215.94 833 45 067 2		59.06
03/29/2024	03/29/2024	97124 ,GP	11	550.00	0.00	0.00	0.00	0.00	0.00	0.00		550.00 801 204		0.00
		TOTAL:		1,875.00	351.93	0.00	0.00	140.75	0.00	0.00		1,663.82		211.18
		TOTAL NET PAID												211.18

SERVICE DATE(S)		SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: [redacted]					INSURED'S ID: [redacted]					PATIENT NAME:				FOR INQUIRIES CALL:
PATIENT ACCOUNT#:					CLAIM NUMBER:					RECEIVED DATE: 05/24/2024				(800) 713-4173
SERVICE PROVIDER NAME:					SERVICE PROVIDER ID:					EXPL CD: AXE		APPEALS CODE: NA		
NETWORK:					RELATIONSHIP TO INSURED:				PLAN TYPE: PPO	DRG RCVD: N/A				
03/08/2024	03/08/2024	98940	11	200.00	89.85	0.00	0.00	35.94	0.00	0.00		146.09 833 45 067 2		53.91
03/08/2024	03/08/2024	98943	11	300.00	85.08	0.00	0.00	34.03	0.00	0.00		248.95 833 45 067 2		51.05
03/08/2024	03/08/2024	97012 ,GP	11	275.00	36.93	0.00	0.00	14.77	0.00	0.00		252.86 833 45 067 2		22.16
03/08/2024	03/08/2024	97032 ,GP	11	275.00	37.53	0.00	0.00	15.01	0.00	0.00		252.48 833 45 067 2		22.52
03/08/2024	03/08/2024	97110 ,GP	11	275.00	96.81	0.00	0.00	38.72	0.00	0.00		216.91 833 45 067 2		58.09
03/08/2024	03/08/2024	97124 ,GP	11	550.00	0.00	0.00	0.00	0.00	0.00	0.00		550.00 801 204		0.00
		TOTAL:		1,875.00	346.20	0.00	0.00	138.47	0.00	0.00		1,667.27		207.73
		TOTAL NET PAID												207.73

ARE PROMPT PAY, CASH DISCOUNTS, DUAL FEES LEGAL?

The legal rules differ by state.



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CALIFORNIA PROMPT PAY (CASH) DISCOUNT LAW

Business and Professions Code 657.

(a) The Legislature finds and declares all of the following:
(1) Californians spend more than one hundred billion dollars ($100,000,000,000) annually on health care.
(2) In 1994, an estimated 6.6 million of California's 32 million residents did not have any health insurance and were ineligible for Medi-Cal.
(3) Many of California's uninsured cannot afford basic, preventative health care resulting in these residents relying on emergency rooms for urgent health care, thus driving up health care costs.
(4) Health care should be affordable and accessible to all Californians.
(5) The public interest dictates that uninsured Californians have access to basic, preventative health care at affordable prices.
(b) To encourage the prompt payment of health or medical care claims, health care providers are hereby expressly authorized to grant discounts in health or medical care claims when payment is made promptly within time limits prescribed by the health care providers or institutions rendering the service or treatment.
(c) Notwithstanding any provision in any health care service plan contract or insurance contract to the contrary, health care providers are hereby expressly authorized to grant discounts for health or medical care provided to any patient the health care provider has reasonable cause to believe is not eligible for, or is not entitled to, insurance reimbursement, coverage under the Medi-Cal program, or coverage by a health care service plan for the health or medical care provided. Any discounted fee granted pursuant to this section shall not be deemed to be the health care provider's usual, customary, or reasonable fee for any other purposes, including, but not limited to, any health care service plan contract or insurance contract.
(d) "Health care provider," as used in this section, means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

NY Office of General Counsel

May a chiropractic group charge its patients who pay by cash lower rates than it charges patients who pay by credit card for the same services?

A chiropractic group that charges its uninsured patient's lower rates than it charges its insured patients for the same services may be in violation of N.Y. Penal Law § 176.05 (McKinney 1999).

A chiropractic group that charges patients who pay by cash lower rates than it charges patients who pay by credit card for the same services may be in violation of N.Y. Penal Law § 176.05 (McKinney 1999).

If the insurer is paying the chiropractic group a percentage of the usual and customary fee, then the waiving of co-payment fees on a regular basis and the charging of lower rates to non-insureds, or to patients who pay by cash, may be construed as insurance fraud because these practices may suggest that the chiropractic group's usual and customary fee is not being accurately reported to the insurer. When a rate discount is provided, the question arises as to whether the discounted rate is the service provider's usual and customary charge, making the non-discounted rate an inflated rate. Thus, waiving co-payment amounts and charging higher rates to insureds than to non-insureds, or to those who pay by credit card, for the same services may constitute insurance fraud under N.Y. Penal Law § 176.05(2) (McKinney 1999).

NY Office of General Counsel

If a chiropractor were to charge a lower fee for services to "non-insurance" patients – that is, patients without insurance or whose contractual benefits under an insurance policy have been exhausted – than to patients whose cost of services is covered by insurance, could the chiropractor's conduct alone constitute insurance fraud?

- No. If a chiropractor charges a lower fee to non-insurance patients who pay cash, that activity would not constitute insurance fraud, because neither the chiropractor nor the insured would submit any claim for services to an insurer, self-insurer, purported insurer, or any agent thereof. **However, if a chiropractor submits a claim to an insurer for an insured patient, or issues a bill to an insured patient for services knowing that the bill will be presented to the insurer, then the chiropractor would be wise to fully disclose to the insurer that it charges non-insurance patients who pay cash a lower fee.**
- Thus, the prudent chiropractor should fully disclose to the insurer that it charges non-insurance patients who pay cash a lower fee.
- Note that there are two messages here. First, OGC warns that "the chiropractor runs the risk of being charged with a fraudulent insurance act." Second, OGC cuts back on this warning, by saying that "the prudent chiropractor should fully disclose to the insurer that it charges non-insurance patients who pay cash a lower fee."

WASHINGTON ADMINISTRATIVE CODE

WAC 246-808-545

Improper billing practices

The following acts shall constitute grounds for which disciplinary action may be taken:

(1) Rebating or offering to rebate to an insured any payment to the licensee by the third-party payor of the insured for services or treatments rendered under the insured's policy.

(2) Submitting to any third-party payor a claim for a service or treatment at a greater or an inflated fee or charge than the usual fee the licensee charges for that service or treatment when rendered without third-party reimbursement.

OREGON REVISED STATUTES 742.525

(1) Except as provided in subsection (2) of this section, a provider shall charge a person who receives personal injury protection benefits or that person's insurer the lesser of:

a) An amount that does not exceed the amount the provider charges the general public; or

b) An amount that does not exceed the fee schedules for medical services published pursuant to **ORS 656.248 (Medical service fee schedules)** for expenses of medical, hospital, dental, surgical and prosthetic services.

MINNESOTA CASH DISCOUNTS

72A.20 METHODS, ACTS, AND PRACTICES WHICH ARE DEFINED AS UNFAIR OR DECEPTIVE

Subd. 39.**Discounted payments by health care providers; effect on use of usual and customary payments.**

An insurer, including, but not limited to, a health plan company as defined in section 62Q.01, subdivision 4; a reparation obligor as defined in section 65B.43, subdivision 9; and a workers' compensation insurer shall not consider in determining a health care provider's usual and customary payment, standard payment, or allowable payment used as a basis for determining the provider's payment by the insurer, the following discounted payment situations:

(1) care provided to relatives of the provider;

(2) care for which a discount or free care is given in hardship situations; and

(3) care for which a discount is given in exchange for cash payment.

Best Practice

If a healthcare provider does make a business judgment to charge non-insureds a lesser charge, the healthcare provider should at the least be sure to disclose this to your insurer(s); that the usual and customary charge is clear; and that any cash discount has a logical basis or can readily be explained in way that creates an argument against potential kickback concerns.

Discount Medical Plans

Discount medical plans are NOT insurance, a health insurance policy, Medicare prescription drug plan or qualified health plan under the Affordable Care Act. This plan (The Plan) provides discounts only on chiropractic services offered by providers who have agreed to participate in The Plan. The range of discounts for medical or ancillary services offered under The Plan

Discount Medical Programs (CHUSA)

Provider

Offer affordable “in-network” fees to cash, underinsured and out of network patients.

Offer Medicare & Federally insured patients legal discounts on non-covered services.

Maintain UCR charges and reimbursements when coverage is available.

Set and accept discounts you choose; discounts NOT dictated by a network

Patient

No claims, forms or limits on the number of visits

Memberships of $39.00 is for the year and covers legal dependents

Network discounts keep care affordable for the entire family

amazon

TARGET®

99¢ only STORES®

THE JOINT®
...the chiropractic place

COSTCO®
WHOLESALE

PACKAGES AND PLANS
"JOINT MODEL"

Fee for service (visits) not time

Refund policy for unused

No expiration

SECTION 80.13. Prepaid Treatment Plans

(a) A licensee may accept prepayment for services planned but not yet delivered, but must provide the following:

(1) The plan must be cancellable by either party at any time for any reason without penalty of any kind to the patient.

(2) Upon cancellation of the plan the patient shall receive a complete refund of all fees paid on a pro rata basis of the number of treatments provided compared to total treatments contracted.

(3) The plan must provide for a limited, defined number of visits.

(4) The patient's file must contain the proposed treatment plan, including enumeration of all aspects of evaluation, management, and treatment planned to therapeutically benefit the patient relative to the condition determined to be present and necessitating treatment.

(A) The patient's financial file must contain documents outlining any necessary procedures for refunding unused payment amounts in the event that either the patient or the doctor discharge the other's services or therapeutic association.

(B) The treatment plan in such cases where prepayment is contracted must contain beginning and ending dates and a breakdown of the proposed treatment frequency.

(5) A contract for services and consent of treatment document must be maintained in the patient's file that specifies the condition for which the treatment plan is formulated.

(6) If nutritional products or other hard goods including braces, supports, or patient aids are to be used during the proposed treatment plan, the patient documents must state whether these items are included in the gross treatment costs or if they constitute a separate and distinct service or fee.

(b) This rule does not create any exemptions from any requirements applicable under the Texas Insurance Code.

Source Note: The provisions of this §80.13 adopted to be effective March 9, 2011, 36 TexReg 1511

THE JOINT MODEL

FLORIDA PREPAY PLANS

Florida Statute 460.411

Funds must be in a separate designated account from $501 and not more than $1500

Advances for costs and expenses of examination or treatment is to be held in trust and must be applied only to that purpose.

Montana also requires monies to be put aside in an escrow account

GEORGIA RULE 100-7-.08 CONTRACTUAL PRE-PAYMENTS FOR SERVICES

1. It is considered unprofessional conduct for any chiropractor to enter into a financial contract which obligates a patient for care or payment for care using coercion, duress, fraud, overreaching diagnosis, harassment, intimidation or undue influence

a) Any services provided prior to the signing of the contract must not be included in the contract.

b) The patient must be given a permanent copy of the signed contact; and the contract must provide a clearly defined refund policy typed in not less than 12-point font. An initial line must be next to the refund policy and must be initialed by the patient.

The contract must contain the statement "There is insufficient evidence to suggest that not receiving chiropractic care will lead to death, paralysis, disability or permanent harm." Said statement must be typed in not less than 12 point font

2. Any chiropractor who enters into a pre-payment financial contract with a patient must allow the patient 48 hours to sign and return the contract. During this 48-hour evaluation period from the time when a copy of the written contract is provided to the patient; no content of the contract can be changed.

3. Any chiropractor who enters into a pre-paid financial contract with a patient shall determine and record the patient's clinical objective which the pre-paid care is designed to achieve and provide the patient with a copy of this objective.

NY OFFICE OF GENERAL COUNSEL

RE: Chiropractic Packages

Question Presented:

May a doctor of chiropractic offer a discounted package of treatments in New York?

Conclusion:

So long as any insurer is not deceived, such packages would not be contrary to the New York Insurance Law (McKinney 2000 and 2005 Supplement).

Unless a health care professional submits false or misleading information to an insurer concerning his or her charges, which knowing submission might be health insurance fraud, the Insurance Department does not regulate how such a professional charges his or her patients.

However, if a chiropractor submits a claim to an insurer for an insured patient, or issues a bill to an insured patient for services knowing that the bill will be presented to the insurer, then the chiropractor would be wise to fully disclose to the insurer that it charges non-insurance patients who pay cash a lower fee.

BEST PRACTICE

- Clear financial disclosure
- Plan of care
- Refund policy

	RVU							RVU
CMT			Acupuncture				E&M	
98940	0.82		97810	1.15			99202	2.17
98941	1.18		97811	0.85			99203	3.35
98942	1.52		97813	1.36			99204	5.02
98943	0.77		97814	1.10			99205	6.62
							99211	0.70
Physical Medicine			Dry Needle				99212	1.70
97010	0.19		20560	0.77			99213	2.73
97012	0.42		20561	1.11			99214	3.85
97014	0.37						92215	5.42
G0283	0.35							
97016	0.35		Trigger Point Injection					
97018	0.17		20552	1.58			Prolonged Services	
97022	0.51		20553	1.82			99358	2.65
97024	0.22						99359	1.13
97026	0.20		Therapeutic Injection				99417	0.92
97028	0.25		96372	0.43			G2212	0.96
97032	0.43							
97033	0.58						Preventative Medicine	
97034	0.42						99401	1.15
97035	0.42						99402	1.87
97036	1.05						99403	2.57
97039	0.00						99404	3.28
97110	0.88							
97112	1.01						X-ray	
97113	1.10						72040	1.19
97116	0.88						72050	1.61
97124	0.91						72052	1.88
97139	0.00						72070	0.99
97140	0.81						72072	1.19
97150	0.54						72074	1.34
97530	1.10						72082	2.11
97533	1.87						72100	1.20
97535	0.98						72110	1.56
97537	0.95						72114	1.84
97542	0.95						72120	1.22
97545	0.00							
97546	0.00		Interprofessional Telephhone				Telephone & Online	
97750	1.02		99446	0.53			99441	1.69
97755	1.15		99447	1.08			99442	2.72
97760	1.43		99448	1.60			99443	3.85
97761	1.25		99449	2.13				
97763	1.57						99421	0.45
97799	0.00						99422	0.88
0552T	0.00						99423	1.40

	RVU							RVU
CMT			Acupuncture				E&M	
98940	0.82		97810	1.15			99202	2.17
98941	1.18		97811	0.85			99203	3.35
98942	1.52		97813	1.36			99204	5.02
98943	0.77		97814	1.10			99205	6.62
							99211	0.70
Physical Medicine			Dry Needle				99212	1.70
97010	0.19		20560	0.77			99213	2.73
97012	0.42		20561	1.11			99214	3.85
97014	0.37						92215	5.42
G0283	0.35							
97016	0.35		Trigger Point Injection					
97018	0.17		20552	1.58			Prolonged Services	
97022	0.51		20553	1.82			99358	2.65
97024	0.22						99359	1.13
97026	0.20		Therapeutic Injection				99417	0.92
97028	0.25		96372	0.43			G2212	0.96
97032	0.43							
97033	0.58						Preventative Medicine	
97034	0.42						99401	1.15
97035	0.42						99402	1.87
97036	1.05						99403	2.57
97039	0.00						99404	3.28
97110	0.88							
97112	1.01						X-ray	
97113	1.10						72040	1.19
97116	0.88						72050	1.61
97124	0.91						72052	1.88
97139	0.00						72070	0.99
97140	0.81						72072	1.19
97150	0.54						72074	1.34
97530	1.10						72082	2.11
97533	1.87						72100	1.20
97535	0.98						72110	1.56
97537	0.95						72114	1.84
97542	0.95						72120	1.22
97545	0.00							
97546	0.00		Interprofessional Telephhone				Telephone & Online	
97750	1.02		99446	0.53			99441	1.69
97755	1.15		99447	1.08			99442	2.72
97760	1.43		99448	1.60			99443	3.85
97761	1.25		99449	2.13				
97763	1.57						99421	0.45
97799	0.00						99422	0.88
0552T	0.00						99423	1.40

$60.00 / 0.82 = 73.17 98940

73.17 x 1.18 = $86.34 98941

73.17 x 3.35 = $245.12 99203

73.17 x 0.88 = $64.38 97110

Every code has a relative value meaning a comparison from one to the other. For example, if a code is valued at 0.75 and another code is valued at 1.0 then the codes would be 25% different

For example, the RVU for 98940 is 0.82 and for 98941 is 1.18

Meaning the value or charge between them would be about 36%

If you know the fee of one code, you can then establish the fees for any other code based on that code with the other's relative value

For example, if you charge $60 for 98940 and have established that is the fair and reasonable fee you can then do every other code based on that fee

$60.00 / 0.82 = 73.17 98940

73.17 x 1.18 = $86.34 98941

73.17 x 3.35 = $$245.12 99203

73.17 x 0.88 = $64.38 97110

Take the value of the service and divide it by its RVU; that number becomes your conversion factor and multiply it by any other code RVU for the rate of that code based on the price of your primary service.

This is how plans determine fees (note ASH et al do not) including Medicare, WC, PI, non-PPO plans et al

You will often find codes way below what is reasonable based on what a plan allows.

Tell me what they allow for one code, and you can figure out what they allow by RVU

www.hjrosscompany.com

New York
2024 CHIROPRACTIC FEE SCHEDULE
National Government Services

Locality/Area	Counties
01	Manhattan
02	Bronx, Brooklyn, Nassau, Rockland, Staten Island, Suffolk, Westchester
03	Columbia, Delaware, Dutchess, Greene, Orange, Putnam, Sullivan, Ulster
04	Queens
99	Albany, Oneida, Allegany, Onondaga, Broome, Ontario, Cattaraugus, Orleans, Cayuga, Oswego, Chautauqua, Otsego, Chemung, Rensselaer, Chenango, Saratoga, Clinton, Schenectady, Cortland, Schoharie, Erie, Schuyler, Essex, Seneca, Franklin, Steuben, Fulton, St. Lawrence, Genesee, Tioga, Hamilton, Tompkins, Herkimer, Warren, Jefferson, Washington, Lewis, Wayne, Livingston, Wyoming, Madison, Yates, Monroe Montgomery, Niagara

	Region	Par Fee	Non-Par Fee	Limiting Charge
98940	**1**	**29.95**	**28.45**	**32.72**
98941	**1**	**42.86**	**40.72**	**46.83**
98942	**1**	**55.02**	**52.27**	**60.11**
98940	2	30.42	28.90	33.24
98941	2	43.46	41.29	47.48
98942	2	55.71	52.92	60.86
98940	**3**	**28.85**	**27.41**	**31.52**
98941	**3**	**41.39**	**39.32**	**45.22**
98942	**3**	**53.21**	**50.55**	**58.13**
98940	4	28.85	27.41	31.52
98941	4	41.39	39.32	45.22
98942	4	53.21	50.55	58.13
98940	**99**	**26.18**	**24.87**	**28.60**
98941	**99**	**37.78**	**35.89**	**41.27**
98942	**99**	**48.76**	**46.32**	**53.27**

$29.95/ 0.82 = 36.52 98940
36.52 x 1.18 = $43.10 98941

I emailed all attendees their state specific information to the email you registered under, if you did not get it Please email sam@hjrossnetwork.com And indicate your state

99203 36.52 x 3.35 = 122.34

97110 36.52 x 0.88 = $32.13

New York Medicare 2024

97810	42.65
97811	31.28
97813	50.42
97814	42.74
99202	81.06
99203	125.18
99204	186.91
99205	246.47
99211	26.29
99212	63.55
99213	101.54
99214	142.89
99215	205.85
97012	15.37
97016	12.93
97018	6.45
97022	19.07
97024	8.36
97026	7.60
97028	9.44
97032	15.75
97033	21.44
97034	15.50
97035	15.50
97036	39.32
97110	32.27
97112	37.07
97113	40.57
97116	32.27
97124	33.75
97140	29.66
97150	19.82
97530	40.70

Region 01 Mahattan

97810	43.47
97811	31.89
97813	51.50
97814	46.08
99202	83.02
99203	128.28
99204	191.35
99205	252.33
99211	26.94
99212	65.1
99213	103.85
99214	146.05
99215	217.58
97012	15.63
97016	13.19
97018	6.65
97022	19.52
97024	8.61
97026	7.83
97028	9.70
97032	16.02
97033	21.87
97034	15.81
97035	15.81
97036	40.25
97110	32.82
97112	37.71
97113	41.33
97116	32.82
97124	34.44
97140	30.16
97150	20.17
97530	41.51

Region 2 Bronx, Brooklyn, Nassau, Rockland, Staten Island, Suffolk, Westchester

2024 TEXAS MEDICARE CHIROPRACTIC FEE SCHEDULE

- 09 - Brazoria
- 11 - Dallas
- 15 - Galveston
- 18 - Houston (Harris County)
- 20 - Beaumont (Jefferson County)
- 28 - Ft. Worth (Tarrant County)
- 31 - Austin (Travis County)
- 99 - Rest of the State

Limiting charge applied to unassigned claims by non-participating providers.

	Region	Par Fee	Non-Par Fee	Limiting Charge
98940	**9**	**$27.06**	**$21.46**	**$29.57**
98941	**9**	**$38.99**	**$33.06**	**$42.59**
98942	**9**	**$50.25**	**$44.32**	**$54.90**
98940	11	$27.06	$21.45	$29.56
98941	11	$38.96	$33.02	$42.56
98942	11	$50.20	$44.27	$54.85
98940	**15**	**$27.01**	**$21.45**	**$29.51**
98941	**15**	**$38.92**	**$33.02**	**$42.52**
98942	**15**	**$50.16**	**$44.27**	**$54.80**
98940	18	$27.23	$21.65	$29.75
98941	18	$39.14	$33.23	$42.76
98942	18	$50.40	$44.49	$55.06
98940	**20**	**$25.72**	**$20.70**	**$28.10**
98941	**20**	**$37.16**	**$31.84**	**$40.60**
98942	**20**	**$48.01**	**$42.69**	**$52.45**

2024 TEXAS MEDICARE CHIROPRACTIC FEE SCHEDULE

98940	28	$26.96	$21.41	$29.46
98941	28	$38.83	$32.95	$42.42
98942	28	$50.05	$44.17	$54.68
98940	**31**	**$27.35**	**$21.53**	**$29.88**
98941	**31**	**$39.30**	**$33.14**	**$42.94**
98942	**31**	**$50.57**	**$44.41**	**$55.25**
98940	99	$26.20	$20.94	$28.62
98941	99	$37.79	$32.22	$41.28
98942	99	$48.76	$43.19	$53.27

TEXAS BILLING ADDRESSES

Novitas Solutions
Attn: Part B Claims
PO Box 3108
Mechanicsburg, PA 17055-1824

2024 Texas Workers' Compensation Conversion Rate

$67.81 x RVU

Courtesy of H.J. Ross Network

MICHIGAN
2024 CHIROPRACTIC FEE SCHEDULE
WPS

Locality 01 - Macomb, Oakland, Washtenaw, Wayne

Locality 99 - All other Counties

Limiting charge applied to unassigned claims by non-participating providers.

	Region	Par Fee	Non-Par Fee	Limiting Charge
98940	**01**	**$26.97**	**$21.48**	**$29.47**
98941	**01**	**$38.73**	**$32.92**	**$42.32**
98942	**01**	**$49.85**	**$44.04**	**$54.46**
98940	99	$25.89	$20.82	$28.28
98941	99	$37.35	$31.99	$40.81
98942	99	$48.23	$42.86	$52.69

Michigan Workers' Compensation
RVU conversion $47.66 (E&M, Medicine, Physical Medicine & Radiology)

Michigan Personal Injury
200% of Medicare rates

Michigan Medicare/VA 2023

Local 1		Local 99	
97810	39.40	97810	37.23
97811	$29.96	97811	$28.28
97813	46.48	97813	43.86
97814	$38.05	97814	$37.10
99202	74.36	99202	69.63
99203	116.28	99203	108.58
99204	172.05	99204	161.63
99205	227.25	99205	213.57
99211	23.47	99211	21.90
99212	58.04	99212	54.31
99213	92.74	99213	87.21
99214	131.14	99214	123.58
99215	187.35	99215	173.49
97012	14.75	97012	14.08
97016	12.04	97016	11.40
97018	5.96	97018	5.48
97022	17.42	97022	16.31
97024	7.64	97024	7.03
97026	6.97	97026	6.41
97028	8.66	97028	8.02
97032	14.75	97032	14.08
97033	20.13	97033	19.05
97034	14.74	97034	13.96
97035	14.74	97035	13.96
97036	35.27	97036	33.01
97110	29.93	97110	28.58
97112	34.32	97112	32.74
97113	37.34	97113	35.46
97116	29.93	97116	28.58
97124	30.58	97124	28.90
97140	27.58	97140	26.36
97150	18.12	97150	17.29
97530	37.66	97530	36.65

PI
200% of Medicare rates

WC
$47.66 conversion from RVU

Locality 1
Macomb, Oakland, Washtenaw, and

Locality 99
All other counties

MINNESOTA MEDICARE
2024 CHIROPRACTIC FEE SCHEDULE

Claims Address

National Government Services, Inc.
Attn: Claims
P.O. Box 6475
Indianapolis, IN 46206-6475

	Region	Par Fee	Non-Par Fee	Limiting Charge
98940	All	26.91	25.56	29.39
98941	All	38.79	36.85	42.38
98942	All	49.99	47.49	54.61

Minnesota Workers' Compensation

- 2023-2024 conversion factors -- Minnesota Rules
  For dates of service from Oct. 1, 2023 through Sept. 30, 2024, the conversion factors are as follows:
  - for medical/surgical services in part 5221.4030: $67.17
  - for pathology/laboratory services in part 5221.4040: $61.09;
  - for physical medicine/rehabilitation services in part 5221.4050: $60.32; and
  - for chiropractic services in part 5221.4060: $52.27

noridian
Healthcare Solutions

Medicare Administrative Contract (MAC) Jurisdiction F

Alaska, Arizona, Idaho, Montana, North Dakota,
Oregon, South Dakota, Utah, Washington, Wyoming

Medicare Part B

2024 Medicare Fees AZ

Limiting charge applied to unassigned claims by non-participating providers.

	Region	Par Fee	Non-Par Fee	Limiting Charge
98940	**All**	$26.52	$25.19	$28.97
98941	**All**	$38.21	$36.30	$41.75
98942	**All**	$49.27	$46.81	$53.83

AZ Workers Compensation RVU Conversion $69.00

99202 $126.80
99203 $194.54
99204 $291.24

99211 $41.11
99212 $99.59
99213 $159.23
99214 $226.39

Chiropractic Care Visits
CMT codes 98940, 98941, 98942 and 98943 are not used in workers' compensation.

Chiropractic care visits are defined as office or other outpatient visits involving subjective and objective assessment of patient status, management and treatment. The levels of treatment are based on clinical complexity (similar to established patient evaluation and management services).

2050A Level 1: Chiropractic Care Visit (straightforward complexity)..... $ $46.98
2051A Level 2: Chiropractic Care Visit (low complexity) ..... $ 60.18
2052A Level 3: Chiropractic Care Visit (moderate complexity) ..... $ 73.32

Level	Decision making	Typical # of regions manipulated	Typical face to face time
2050A	Straightforward	Up to 2	Up to 10-15 minutes
2051A	Low	Up to 3-5	Up to 15-20 minutes
2052A	Moderate	Up to 5 or more	Up to 25-30 minutes

Physical Medicine Treatment
CPT® physical medicine codes 97001-97799 are not payable to chiropractic physicians.

Services that can be billed
Use local code **1044M** for physical medicine modalities or procedures (including the use of traction devices) by attending provider not board certified/qualified in Physical Medicine and Rehabilitation (PM&R).

1044M Physical medicine modality(ies) and/or procedure(s) by attending doctor who isn't board qualified or certified in physical medicine and rehabilitation." The maximum fee for the code is **$49.06**.
Limited to 6 units per claim except when practicing in a remote location where no licensed PT is available.

WASHINGTON
2023 CHIROPRACTIC FEE SCHEDULE
Noridian Administrative Services- Medicare Part B

Enrollment, Claims, Appeals & Correspondence
Medicare Part B
PO Box 6700
Fargo, ND 58108-6700

2023 Deductible $226

Locality 2 – Seattle (King County)

Locality 99 – Rest of state

	Region	Par Fee	Non-Par Fee	Limiting Charge
98940	**02**	**$30.79**	**$29.25**	**$33.64**
98941	**02**	**$44.09**	**$41.89**	**$48.17**
98942	**02**	**$56.98**	**$54.13**	**$62.25**
98940	99	$28.08	$26.68	$30.68
98941	99	$40.40	$38.38	$44.14
98942	99	$52.38	$49.76	$57.22

BlueCross BlueShield
of Illinois

Please review this update to the Boeing Health Care Plan's allowance for non-network providers. Keep it for future reference.

Boeing Health Care Plan Revises Maximum Allowance Effective January 1, 2021

Non-Network Provider Maximum Allowance

The purpose of this notice is to advise you of an update to the predetermined percentage of Medicare's allowed charge for non-network provider services and supplies beginning with the 2021 plan year. According to our records, you submitted one or more claims for Boeing Health Care Plan members during 2020.

Under the terms of the Boeing Health Care Plan, the covered charge for a service (or supply) provided by a non-network provider is the maximum allowable cost, which is the lesser of (a) the provider's actual charge for the service or supply, (b) the provider's normal charge for a similar service or supply, or (c) a predetermined percentage of Medicare's allowed charge for that service or supply.

Starting January 1, 2021, the Boeing Health Care Plan is updating the predetermined percentage of Medicare's allowed charge to the percentages listed here in order to align it more closely with market standards. Professional Services: 175%; Outpatient Facility Services: 215%; Inpatient Facility Service: 240%.

Questions?

Boeing Member Services is available Monday through Friday, 5 a.m. to 5 p.m. PT (8 a.m. to 8 p.m. ET and 7 a.m. to 7 p.m. CT).

ICD Diagnosis

(A) M99.00 **(B)** M54.2 **(C)** M79.1 **(D)** M54.6 **(E)** M99.08 **(F)** M54.5 **(G)** M46.06 **(H)** R51 **(I)** R42 **(J)** M51.24 **(K)** S14.2XXA **(L)** S34.21XA

Submitted Charges

Date of Service	Line	POS	Proc. Code	Mod.	Dx Ptr	Units	Amount Charged	Amount Allowed	Explanation Codes
03/26/2018	1	11	98941			1	$75.00	$75.00	
03/28/2018	2	11	98941			1	$75.00	$75.00	
03/30/2018	3	11	98941			1	$75.00	$75.00	
	4	11	97112			1	$35.00	$35.00	
04/02/2018	5	11	98941			1	$75.00	$75.00	
04/04/2018	6	11	98941			1	$75.00	$75.00	
04/09/2018	7	11	98941			1	$75.00	$75.00	
04/11/2018	8	11	98941			1	$75.00	$75.00	
04/16/2018	9	11	98941			1	$75.00	$75.00	
04/18/2018	10	11	98941			1	$75.00	$75.00	
04/20/2018	11	11	98941			1	$75.00	$75.00	
	12	11	99213	25		1	$105.00	$0.00	X7140
04/23/2018	13	11	98940			1	$60.00	$56.00	C14
04/27/2018	14	11	98941			1	$75.00	$75.00	
04/13/2018	15	11	98941			1	$75.00	$75.00	
			Totals:				**$1,100.00**	**$991.00**	

Explanation Code Guide

C14 The amount allowed was reviewed using the Fair Health Relative Value Benchmark Database.

Provider inquiries regarding this explanation of benefits should be directed to (800)215-5171.

LINE	DOS	PROC . CODE	MOD	DESCRIPTION	UNITS	CHARGE	"PEN REDUCTION	PROVIDER REIMBURSE	EXPLANATION
1	6/12/19	99203		Office/outpatient new low mdm 30-44 minutes	1	140.00	0.00	0.00	NCCI_E04
ICD Ref	1,2,3,4,5,6,7,8,9,10								
2	6/12/19	98940		Chiropractic manipulative tx spinal 1-2 regions	1	75.00	0.00	65.00	UCR80
ICD Ref	1,2,3,4,5,6,7,8,9,10								
3	6/12/19	97140		Manual therapy tqs 1/> regions each 15 minutes	1	55.00	0.00	55.00	
ICD Ref	1,2,3,4,5,6,7,8,9,10								
4	6/12/19	97014		Appl modality 1/> areas elec stimj unattended	1	30.00	0.00	30.00	
ICD Ref	1,2,3,4,5,6,7,8,9,10								
5	6/13/19	98940		Chiropractic manipulative tx spinal 1-2 regions	1	75.00	0.00	65.00	UCR80
ICD Ref	1,2,3,4,5,6,7,8,9,10								
6	6/13/19	97140		Manual therapy tqs 1/> regions each 15 minutes	1	55.00	0.00	55.00	
ICD Ref	1,2,3,4,5,6,7,8,9,10								
7	6/13/19	97014		Appl modality 1/> areas elec stimj unattended	1	30.00	0.00	30.00	
ICD Ref	1,2,3,4,5,6,7,8,9,10								
8	6/13/19	72100		Radex spine lumbosacral 2/3 views	1	180.00	0.00	170.38	UCR80
ICD Ref	1,2,3,4,5,6,7,8,9,10								

65/.80 = 81.25 Conversion Factor

Relative Value Units

2020	RVU							RVU	
CMT			Acupuncture				E&M		
98940	0.80	65	97810	1.05		INITIAL	99201	1.29	105
98941	1.15	93	97811	0.80		EXAMS	99202	2.14	174
98942	1.50	122	97813	1.17			99203	3.03	246
98943	0.79	64	97814	0.96			99204	4.63	
							99205	5.85	
Physical Medicine			Dry Needle				99211	0.65	
Hot PK 97010	0.18	15	20560	0.74		Reexams	99212	1.28	104
Mech txn 97012	0.43	35	20561	1.10			99213	2.11	171
97014	0.41						99214	3.06	249
G0283	0.39						92215	4.11	
97016	0.35								
97018	0.17						Prolonged Services		
97022	0.51						99354	3.66	
97024	0.2						99355	2.78	
Inf. red 97026	0.18	15					99358	3.15	
97028	0.23						99359	1.54	
EMS 97032	0.42	34							
97033	0.59						Preventative Medicine		
97034	0.43						99401	0.71	
97035	0.41						99402	1.45	
97036	1.00						99403	2.13	
97039	0.00						99404	2.85	
T.Exer 97110	0.87	71							
NMR 97112	1.00	81					X-ray		
97113	1.1						72040	1.07	
Gait Training 97116	0.86	70					72050	1.42	
msg 97124	0.83	67					72052	1.67	
97139	0.00						72070	0.89	
Mobiliz. 97140	0.80	65					72072	1.08	
97150	0.52						72074	1.21	
ADL 97530	1.12	91					72082	1.90	
97532	1.47						72100	1.07	
ADL + Home managmt 97533	0.97						72110	1.36	
97535	0.93	76					72114	1.67	
97537	0.94						72120	1.11	
97542	0.94								
97545	0.00		Interprofessional Telephhone				Telephone & Online		
97546	0.00		99446	0.51			99441	0.40	
97750	0.99		99447	1.03			99442	0.78	
97755	1.09		99448	1.54			99442	1.14	
ORTH mngmt 97760	1.40	114	99449	2.05					
ORTH w/ out 97761	1.19	97					99421	0.43	
97763	1.50						99422	0.86	
97799	0.00						99423	1.39	

USAA®

ADJUSTMENT

This is not a bill
Original
Provider Copy

California

Company

Receive Date
Service Provider
20-4509457

Member Number :
Date Of Loss :
Customer Service :
Fax :

Billing Provider :

Patient

Patient Account # :

The enclosed information is to inform you of the adjusting decision that has been made by USAA concerning your claim for payment of medical bills pursuant to your available coverages. Please review the billed services noted below for accuracy of treatment received. If the services billed do not reflect the treatment that you received, please immediately contact your USAA claims representative. If this form indicates that further information is requested from the provider in order to make a payment decision, please request that your provider supply that information. If you or your provider have questions concerning the information contained on this form or any accompanying physician's letter, or do not agree with the adjusting decision of USAA, please see the last page of this form for instructions regarding the procedure for obtaining answers to questions or to formally appeal this adjusting decision. Payments reflected on this EOR are sent separately from this EOR.

Dates Of Service : 11/14/2019 to 02/11/2020

ICD REF	ICD	POA	IND	DIAGNOSIS DESCRIPTION
1	S13.4XXA		ICD-0	Sprain lig cerv spine initial enc
2	G44.309		ICD-0	Post-trauma headache uns not intrct
3	M26.601		ICD-0	Right temporomandibular jnt d/o uns
4	M53.84		ICD-0	Oth spec dorsopathies thor region
5	S39.012A		ICD-0	Strain musc fasc tendon lw back init
6	M79.602		ICD-0	Pain in left arm
7	M79.601		ICD-0	Pain in right arm

LINE NR	DATE OF SERVICE	CPT CODE	MOD	DESCRIPTION	UNITS	BILLED AMOUNT	†PENALTY REDUCTION	REIM AMOUNT	REASON CODE
73	11/14/19	99213	25	Office outpatient visit 15 minutes	1.00	171.00	0.00	171.00	
ICD Ref	1,2,3,4,5,6,7								
74	11/14/19	98941		Chiropractic manipulative tx spinal 3-	1.00	93.00	0.00	93.00	
ICD Ref	1,2,3,4,5,6,7								
75	11/15/19	98940		Chiropractic manipulative tx spinal 1-	1.00	65.00	0.00	65.00	
ICD Ref	1,2,3,4,5,6,7								
76	11/18/19	98940		Chiropractic manipulative tx spinal 1-	1.00	65.00	0.00	65.00	

AMERICAN FAMILY CONNECT PROPERTY AND CASUALTY INSURANCE COMPANY
PO BOX 19018
GREEN BAY WI 54307-9851

EXPLANATION OF BENEFITS. THIS IS NOT A BILL.

RECONSIDERATION (REV 2)

Claim Information

Claim Number:
Claimant Name:
Date of Loss: 01/08/2020
Policy Holder / No.: [redacted]
State of Jurisdiction
Coverage Type:

Bill Number: [redacted]
Date Received: 08/27/2020

Provider Information

Name:
Address:

Provider File #:
Specialty:
TIN:
NPI:
Region:
Zip of Service:

ICD Diagnosis

(A) S13.4XXA **(B)** G44.319 **(C)** S63.642A **(D)** S23.3XXA **(E)** S33.8XXA **(F)** M79.2

Submitted Charges

Date of Service	Line	POS	Proc. Code	Mod.	Dx Ptr.	Units	Amount Charged	Amount Allowed	Explanation Codes
02/08/2020	1	11	99202	25		1	$174.00	$174.00	X3407
	2	11	98940			1	$65.00	$65.00	
	3	11	98943			1	$64.00	$64.00	
02/21/2020	4	11	98940			1	$65.00	$65.00	
	5	11	98943			1	$64.00	$64.00	
	6	11	97110			1	$71.00	$71.00	
02/29/2020	7	11	98941			1	$93.00	$93.00	
	8	11	98943			1	$64.00	$64.00	
	9	11	97110			1	$71.00	$71.00	
03/03/2020	10	11	A9300			1	$122.00	$122.00	
			Sub Totals:				**$853.00**	**$853.00**	
			Previous Amount Allowed					($651.00)	
			Totals:				**$853.00**	**$202.00**	

Explanation Code Guide

X3407	Payment for this bill was made to the patient's attorney per his/her request. Payment to the provider is now the patient and/or attorney responsibility.

For assistance/questions regarding the amount allowed, call 1.800.872.5246
and refer to our claim number when calling.
CONNECT by American Family, PO Box 19018, Green Bay, WI 54307
If you have additional information you would like us to consider, please mail to the above address. We will then notify you of any changes to our initial determination within 30 days of receipt of your correspondence.

Date: 12/18/2020; **Adjuster:** COMEAU, AMANDA; **Phone:** 800.872.5246 EXT 33071

GEICO
geico.com

EOR #: GG1551399

EXPLANATION OF REVIEW

Delaware

Receive Date : 03/24/2021

Service Provider

Claim Number

Date Of Loss

Patient

Case Number

Billing Provider

Patient Account #

Adjuster Name

51-0405455

Carrier : GEICO

PO Box 9505
Fredericksburg, VA 22403-9504

Dates Of Service : 02/10/2021 - 02/10/2021

Diagnostic Codes	Description
M99.01	Seg somatic dysf cervical region
M53.1	Cervicobrachial syndrome
M99.02	Seg somatic dysf thoracic region
M54.6	Pain in thoracic spine
M99.03	Seg somatic dysf lumbar region
M54.5	Low back pain
M99.04	Seg somatic dysf sacral region
S33.6XXA	Sprain si joint initial encounter
M99.05	Seg somatic dysf pelvic region
S33.8XXA	Sprain oth parts lumb spn pelv init
V43.52XA	Car drvr inj coll oth car traf init

* See 2nd Page Highlights →

LINE	DOS	PROC CODE	MOD	DESCRIPTION	UNITS	CHARGE	REDUCTION	*PEN REDUCTION	PROVIDER REIMBURSE	EXPLANATION
1	02/10/21	98942		Chiropractic manipulative tx spinal 5 regions	1.0	$109.00	$4.00	$0.00	$105.00	765
2	02/10/21	97810		Acupuncture 1/> ndles w/o elec stimj init 15 min	1.0	$125.00	$12.00	$0.00	$113.00	765
3	02/10/21	97124	59	Ther px 1/> areas each 15 minutes massage	4.0	$0.00	$0.00	$0.00	$0.00	765
4	02/10/21	97124	59	Ther px 1/> areas each 15 minutes massage	3.0	$165.00	$15.00	$0.00	$150.00	765

01496

Anthem BlueCross

SPINE AND SPORTS INSTITUT
PROVIDER ID NO: 261557863

CHECK/EFT DT: 01/04/22
CHECK/EFT: 9800695100

[redacted]

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: [redacted]				INSURED'S ID: [redacted]						PATIENT NAME: [redacted]			FOR INQUIRIES CALL:
PATIENT ACCOUNT#:				CLAIM NUMBER:						RECEIVED DATE: 12/31/2021			(855) 466-4633
SERVICE PROVIDER NAME:				SERVICE PROVIDER ID:						EXPL CD: 757			
NETWORK:				RELATIONSHIP TO INSURED:						PLAN TYPE: PPO	DRG RCVD: N/A		APPEALS CODE: ASO
12/01/2021 12/01/2021	97530	11	100.00	98.58	0.00	0.00	0.00	0.00	0.00		1.42	015 45	98.58
12/01/2021 12/01/2021	97110	11	85.00	22.78	0.00	0.00	0.00	0.00	0.00		62.22	015 45	22.78
12/01/2021 12/01/2021	97140	11	70.00	20.93	0.00	0.00	0.00	0.00	0.00		49.07	015 45	20.93
12/01/2021 12/01/2021	98940	11	60.00	60.00	0.00	0.00	0.00	0.00	0.00		0.00		60.00
12/01/2021 12/01/2021	97014	11	34.00	3.40	0.00	0.00	0.00	0.00	0.00		30.60	015 45	3.40
	TOTAL:		349.00	205.69	0.00	0.00	0.00	0.00	0.00		143.31		205.69
	TOTAL NET PAID												205.69

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: [redacted]				INSURED'S ID: [redacted]						PATIENT NAME: [redacted]			FOR INQUIRIES CALL:
PATIENT ACCOUNT#:				CLAIM NUMBER:						RECEIVED DATE: 12/31/2021			(855) 466-4633
SERVICE PROVIDER NAME:				SERVICE PROVIDER ID:						EXPL CD: 757			
NETWORK:				RELATIONSHIP TO INSURED:						PLAN TYPE: PPO	DRG RCVD: N/A		APPEALS CODE: ASO
11/29/2021 11/29/2021	97530	11	100.00	98.58	0.00	0.00	0.00	0.00	0.00		1.42	015 45	98.58
11/29/2021 11/29/2021	97110	11	85.00	22.78	0.00	0.00	0.00	0.00	0.00		62.22	015 45	22.78
11/29/2021 11/29/2021	97140	11	70.00	20.93	0.00	0.00	0.00	0.00	0.00		49.07	015 45	20.93
11/29/2021 11/29/2021	98940	11	60.00	60.00	0.00	0.00	0.00	0.00	0.00		0.00		60.00
11/29/2021 11/29/2021	97014	11	34.00	3.40	0.00	0.00	0.00	0.00	0.00		30.60	015 45	3.40
	TOTAL:		349.00	205.69	0.00	0.00	0.00	0.00	0.00		143.31		205.69
	TOTAL NET PAID												205.69

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: [redacted]				INSURED'S ID: [redacted]						PATIENT NAME: [redacted]			FOR INQUIRIES CALL:
PATIENT ACCOUNT#:				CLAIM NUMBER:						RECEIVED DATE: 12/31/2021			(855) 466-4633
SERVICE PROVIDER NAME:				SERVICE PROVIDER ID:						EXPL CD: 757			
NETWORK:				RELATIONSHIP TO INSURED:						PLAN TYPE: PPO	DRG RCVD: N/A		APPEALS CODE: ASO
11/23/2021 11/23/2021	97530	11	100.00	98.58	0.00	0.00	0.00	0.00	0.00		1.42	015 45	98.58
11/23/2021 11/23/2021	97110	11	85.00	22.78	0.00	0.00	0.00	0.00	0.00		62.22	015 45	22.78
11/23/2021 11/23/2021	97140	11	70.00	20.93	0.00	0.00	0.00	0.00	0.00		49.07	015 45	20.93
11/23/2021 11/23/2021	98940	11	60.00	60.00	0.00	0.00	0.00	0.00	0.00		0.00		60.00
11/23/2021 11/23/2021	97014	11	34.00	3.40	0.00	0.00	0.00	0.00	0.00		30.60	015 45	3.40
	TOTAL:		349.00	205.69	0.00	0.00	0.00	0.00	0.00		143.31		205.69

Patient Name:	[redacted]	ID Number:	[redacted]

Group No:
Health Plan/Insurance Co:
Treating Practitioner:
Claim No:
Received: 05/20/2024
Original Claim Received: 05/20/2024
Diagnosis: M54.2, M54.50, M54.6

Benefits:
Visits per year: 20
Office Copay: $10.00

					MEMBER RESPONSIBILITY					
Date of Service	Procedure Code	Provider Billed Amount	Provider Allowed Amt	COB	Coinsurance*	Copay	Deductible	Other Responsibility	Not Allowed Amt	Explanation Codes
04/09/2024	98941	$80.00	$27.00	$0.00	$0.00	$10.00	$0.00	$0.00	$0.00	
04/09/2024	98943	$80.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	11
04/09/2024	97112	$60.00	--	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	78
04/09/2024	97110	$60.00	--	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	78
TOTALS:		**$280.00**	**$27.00**	**$0.00**	**$0.00**	**$10.00**	**$0.00**	**$0.00**	**$0.00**	

Provider Allowed Amount:	$27.00	+ EFT Bonus:	$0.00
COB Amount:	$0.00	+ ETP Incentive:	$0.34
*Member Responsibility :	$10.00	- ETP Admin. fee:	$0.00
		+ Interest/Penalty:	$0.00
		- Previously Paid:	$0.00
Not Allowed Amount:	$0.00	Total Amount Paid:	$17.34
****Claim Payment :**	**$17.00**		
*****Additional Member Responsibility :**	**$0.00**		

***Secondary Payor should Coordinate Benefits with the Claim Payment amount.*

Comments
Please note, any funds due will be mailed separately or directly deposited into the account on file.

Explanation Codes:
11 - Reimbursement for this service is included in an all-inclusive maximum daily rate with another service billed for the same date of service. (97)

78 - Reimbursement for this service is included in an all-inclusive maximum daily rate with another service billed for the same date of service. (97)

L.P. CHIROPRACTOR

I recently agreed to participate with American Specialty Health. They handle Cigna. My payments went down from $75 per treatment to $40 per treatment.

→

In response to my article in *Dynamic Chiropractic*

per condition before additional approval is required from Aetna. As before, the plans never cover visits that are not medically necessary and there is an overall coverage limit of 90 visits per year (for all short-term rehabilitation therapies, combined).

Changes to coverage for chiropractic services
Currently, chiropractic services are covered as an alternative care benefit. You pay a co-pay for each covered chiropractic visit and you are limited to a combined total of 20 alternative care (acupuncture, chiropractic, homeopath and naturopath) visits per year.

Beginning on January 1, 2024, chiropractic visits will instead be covered as a short-term rehabilitation benefit. That means you will owe coinsurance (10% for the Full-Time Plan and 20% for the Part-Time Plan) for each covered visit after you have satisfied your annual deductible (Full-Time Plan $250 Individual/$500 Family and Part-Time Plan $550 Individual/$1,100 Family). You'll be limited to 30 chiropractic visits per condition unless Aetna approves additional visits based on medical necessity. Chiropractic visits will count toward the overall limit on short-term rehabilitation therapies (90 visits per year).

All other plan rules will continue to apply. For example, the plans will continue to exclude chiropractic manipulation or therapy while under anesthesia.

CHANGES TO HMSA MEDICAL PLANS

Change to applied behavior analysis coverage
Beginning on January 1, 2024, Applied Behavior Analysis will be covered at the same benefit level as outpatient Behavioral Health – Hospital and Facility Services.

For more information about this change contact HMSA at 1-800-776-4672 or log into your account at HMSA.com. All other plan rules continue to apply.

EVALUATION & MANAGEMENT 2024 UPDATE

NEW PATIENT
A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

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

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

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

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

ESTABLISHED PATIENT
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

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.

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

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

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

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

99202-99215 CODE SELECTION

Code selection levels are now based on:

- Total Time
  - Spent by the provider on the day of visit face-to-face and non-face-to-face

OR

- Level of Medical Decision Making (MDM)
  - Severity and complexity of presenting problem
  - Four types of MDM are recognized: straightforward, low, moderate, and high

TIME NOW REPRESENTS TOTAL PROVIDER TIME SPENT ON DATE OF SERVICE, INCLUDING

Physician or other qualified health care professional time includes the following activities,

Preparing to see the patient (eg, review of tests)

Obtaining and/or reviewing separately obtained history

Performing a medically appropriate examination and/or evaluation

Counseling and educating the patient/family/caregiver

Documenting clinical information in the electronic or other health record

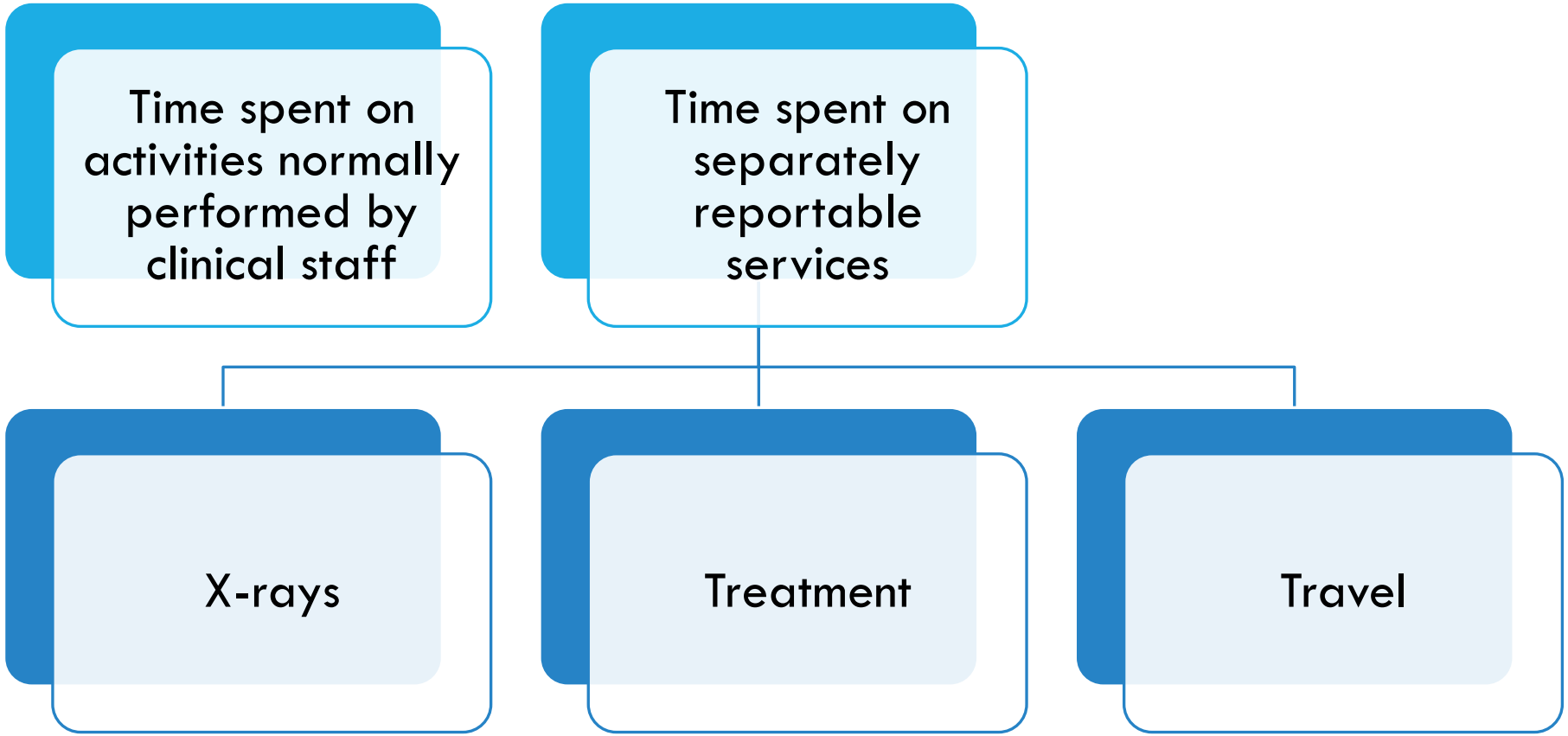
Ordering medications, tests, or procedures

Referring and communicating with other health care professionals (when not separately reported)

Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver

Care coordination (not separately reported)

WHAT TIME DOES NOT COUNT



MEDICAL REVIEW WHEN PRACTITIONERS USE TIME TO SELECT VISIT LEVEL

Reviewers will use the medical record documentation to objectively determine the medical necessity of the visit and accuracy of the documentation of the time spent (whether documented via a start/stop time or documentation of total time) if time is relied upon to support the E/M visit

MEDICAL DECISION MAKING

Includes 4 levels

- Straightforward
- Low
- Moderate
- High

A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified healthcare professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice.

New Patient

99202 Meet or exceed15 min
99203 30 minutes
99204 45 minutes
99205 60 minutes

Medical Decision Making *

99202 1 self limited or minor problem
99203 2 or more / acute injury
99204 Acute complicated injury
99205 Threat to life or bodily function

	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
	N/A	N/A	N/A	N/A
	Straightforward	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
		or
		• 1 stable acute illness;
		or
		• acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

	Moderate	**Moderate**
		• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• **2** or more stable chronic illnesses;
		or
		• **1** undiagnosed new problem with uncertain prognosis;
		or
		• **1** acute illness with systemic symptoms;
		or
		• **1** acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

	High	**High**
		• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• **1** acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization or escalation of hospital-level of care
				• Decision not to resuscitate or to de-escalate care because of poor prognosis
				• Parenteral controlled substances

27

FARMERS INSURANCE

RECEIVED
APR 06 2021
By: RH

Toll Free: (800) 435-7764
Fax: (877) 217-1389
Email: myclaim@farmersinsurance.com
National Document Center
P.O. Box 268993
Oklahoma City, OK 73126-8993

April 6, 2021

RE: Claim Number
Insured:
Policy Number
Loss Date: 07/10/2019
Injured Party:
Subject: Important Claim Information

Dear Dr.

We are in receipt of your appeal to reconsider the downcoding for the charge of 99214 for date of service 2/3/21. Unfortunately, we are unable to reconsider our decision as according to documentation you submitted, 20 or 25 minutes was spent with the patient. Per 2021 CPT E/M service guidelines, a total time of 30 minutes is required to bill 99214.

If you have any questions or concerns, call me at (952) 882-5475.

Thank you.

Farmers Insurance Company of Oregon

Madonna de Moraes

Madonna de Moraes
Med/PIP Claims Representative
(952) 882-5475

COVID-19 Notice – In light of the national health emergency, I am currently working from home. I can be reached by telephone and e-mail; my phone number and email address have not changed. E-mail communications are preferred to avoid any potential delays caused by mailing. If you are unable to email and hard copies of communications are required, they may be sent to our National Document Center at P.O. Box 268994, Oklahoma City, OK 73126-8994. We are unable to receive deliveries at any location from FedEx, UPS or any other courier at this time, as our claims office locations have been temporarily closed.

Enclosure(s):
Medical Report -

American Specialty Health.

American Specialty Health Group, Inc.

LETTER SENT VIA USPS

October 25, 2023

1033554

[redacted]

Practitioner ID: [redacted]

Dear Dr. [redacted]

Thank you for your participation as a contracted chiropractic practitioner for American Specialty Health Group (ASH Group). No response to this letter is necessary; the purpose of the letter is to clarify and provide information regarding ASH Group's expectations for the examination of patients by contracted practitioners to include a basic neurologic exam when appropriate to the patient's presentation.

It has come to our attention through the Clinical Services Program process that the examination protocols used in your office may be inconsistent with the expectations of ASH Group, which have been established by our clinical committees through an evaluation of professionally recognized standards of practice. On the following Medical Necessity Review (MNR) Form(s) on which an examination was documented, it was noted by the reviewing Clinical Quality Evaluator that the patient complaints and/or the diagnosis(es) supported the need for a complete basic neurologic examination; however, such an examination was not documented.

Patient Name	MNR Form Number
[redacted]	

ASH clinical committees have determined that it is not appropriate to render chiropractic treatment to a patient without first having performed an adequate health history and examination which should be documented in the patient's medical record. When relevant to the patient's presenting complaints, the examination should include deep tendon reflexes and further screening including muscle strength and sensory function in the area(s) of complaint. If the patient has a significant complaint of unexplained headache, a neurologic screening exam should include evaluation of motor, sensory, visual, auditory, vestibular and cerebellar functions.

Procedure Code/National Drug Code (Proc Cd/NDC):

99214 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

98941 - Chiropractic manipulative treatment (CMT); spinal, 3-4 regions

Modifier/Package (Mod/Pkg):

25 - Significant, separately identifiable E/M by the same physician on the same day of procedure/service

Explanation Code:

998 - See Comments Section

6869 - We have received your correspondence/appeal relative to the dates of services referenced above. As the information submitted does not contain any new information, our previously issued payment decision stands. Should you have any questions, please contact the undersigned.

8150 - The documentation submitted does not support a separate significant identifiable evaluation and management code on this date of service. If additional documentation is received the evaluation and management code will be reconsidered.

Additional Comments:

Progressive is now accepting e-bills. For more information, including Progressive's payer ID, please visit www.progressive.com/suppliers

998-For any E and M code to be reimbursed, we need seperate,detailed doctor notes from that date that go"above and beyond" the normal daily evaluation that is included in the CMT code.

Important Information:

Anthem

California | Commercial

[redacted]

Call Sam

Subject: Claims data analysis of Modifier 25

Dear [redacted]

Thank you for the care you provide to our members. We value our business relationship with our Anthem Blue Cross (Anthem) care provider partners and seek educational opportunities to further foster collaboration to help ensure proper coding and payment of claims. We regularly review submitted claims data in an effort to observe coding trends and billing patterns for providers in the same geographic area and peer group.

We reviewed the use of significant, separately identifiable Evaluation and Management services appended with Modifier 25 as part of our ongoing claims data review. Paid claims data for Anthem members for dates of service between 11/01/2021 and 10/31/2022 was analyzed for the purpose of identifying those providers who appear to fall outside of the expected utilization.

The review indicated your utilization of Modifier 25 is outside the expected billing distribution determined by the billing behavior of other providers within your peer group.

We recognize that many factors may impact the coding of your significant, separately identifiable Evaluation and Management services appended with Modifier 25. Our goal is to partner with you to further understand your coding methodologies and billing practices and to assist providers with understanding documentation and reporting guidelines to support the level of care billed for each service.

For more information, please see the American Medical Association (AMA) Current Procedural Terminology (CPT®) Book, Appendix A explanation of Modifier 25 as a significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of procedure or other service.

We appreciate the services you provide and your commitment to the healthcare needs of our members. The intent of this letter is to serve as an educational resource. If you need further information about the data analysis referenced in this letter, please reach out to the Provider Education team via *email* (PEducationZ4@Anthem.com) (Please include your National Provider Identifier or NPI) at your earliest convenience.

DENIAL OF E/M CODE
ON THE SAME DAY AS CMT

Date

Double Standards Insurance Company
P. 0. Box 1000
Any City, CA 90000

Re:
Dates of Service:

Attention Claims Review:

This letter is in response to your denial of Evaluation and Management services performed on (date) and (date). Your reason for the denial of these charges is "*this procedure is already included in the Chiropractic Manipulation Treatment procedure billed on the same day.*"

It is reported in the CPT manual (2024 Professional Edition page 873) that the CMT procedure includes a pre- and post-manipulation patient assessment, however, the evaluation and management service performed on (date) was not routine, the evaluation and management service provided was a separately identifiable evaluation and management service, above and beyond the usual pre-service and post-service work associated with the manipulation procedure.

This separate and distinct nature of the exam was indicated on the billing 1500 claim form with the evaluation and management code having modifier 25.

A detailed and separate examination was necessary and beyond the scope of the pre-manipulation assessment. A copy of the actual examination is enclosed so you may see that the evaluation & management service of 99203 was significantly separate and distinct from the treatment provided on the same day.

Since this was indicated to you on the claim by adding modifier -25, I feel your denial is unreasonable and, accordingly, expect reimbursement for these unfairly denied services, along with interest now due, within 10 days of your receipt of this letter.

If we continue to receive your blanket denials whenever Evaluation and management services are properly reported and billed. In that case, I will notify your insured of your tactics and assist in filing for assistance with the Department of Insurance.

My patient and I await your response.

PROLONGED E&M SERVICES

99417 Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)

Eligible for separate reimbursement when billed in addition to CPT new/established level 5 Evaluation and Management codes 99205/99215 for office or other outpatient E/M services. The level 5 office or other outpatient E/M code must be selected using only time as the basis of selection and after the total time has been exceeded. (Anthem C-08011 Commercial Reimbursement Policy)

CMS

G2212 Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99205, 99215, 99483 for office or other outpatient evaluation and management services)

(do not report G2212 on the same date of service as 99358, 99359, 99415, 99416). (do not report G2212 for any time unit less than 15 minutes)

REVIEW OF RECORDS

99358 Prolonged evaluation and management service before and/or after direct patient care, first hour *(30-60 minutes)*

99359 each additional 30 minutes (List separately in addition to code for prolonged services)

Codes 99358 and 99359 are used to report the total duration of non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service, even if the time spent by the physician or other qualified health care professional on that date is not continuous. Code 99358 is used to report the first hour of prolonged service on a given date regardless of the place of service. It should be used only once per date.

Prolonged service of less than 30 minutes total duration on a given date is not separately reported. Code 99359 is used to report each additional 30 minutes beyond the first hour. It may also be used to report the final 15 to 30 minutes of prolonged service on a given date.

Do not use on the same date as an E&M as the record review time would be counted towards the E&M service

TELEMEDICINE

Here are the temporary provisions **extended until the end of December, 2024.**

Expansion which allows telehealth services be provided in any site in the United States where the beneficiary is located, including the patient's home

Qualified occupational therapist, qualified physical therapists, qualified speech language pathologist, and qualified audiologists may continue to be telehealth providers

Continued coverage and payment of services included on the Medicare telehealth services list as of March 15, 2020 until December 31, 2024

TELEMEDICINE DEFINITION

The provider uses an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home.

PATIENT LOCATION

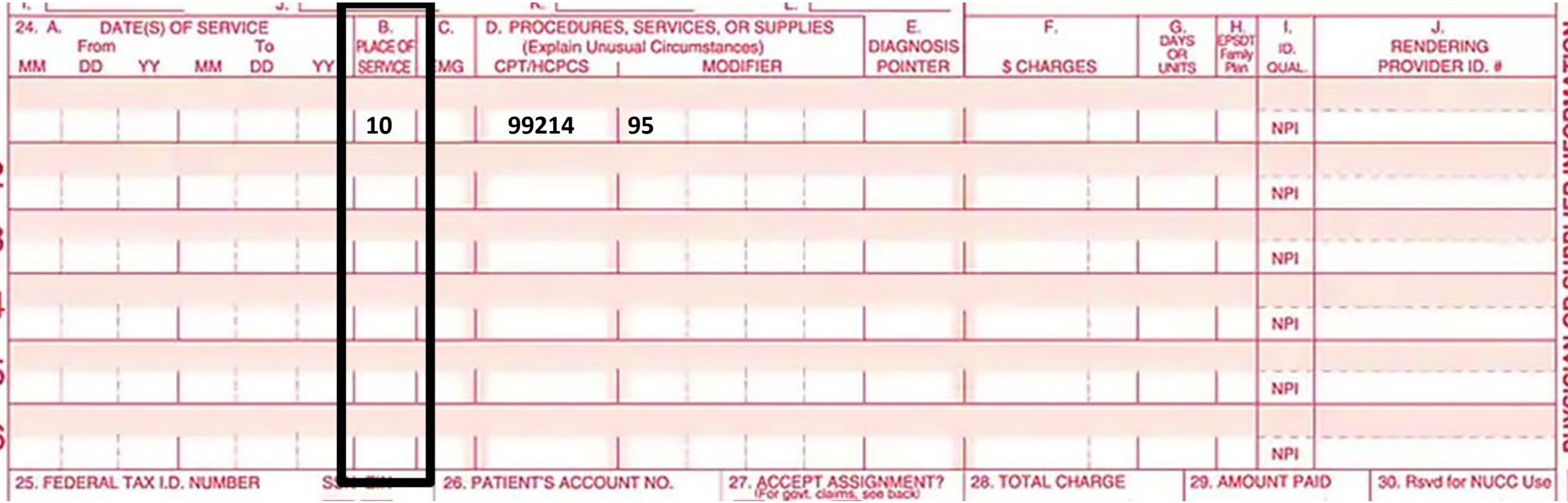
Proper Licensure: Make sure you are licensed both in the state where you are located, and in the state where your telemedicine patient is located. If your patient is in another state, and you aren't licensed there, check to see about licensing reciprocity. Many states have been extending reciprocity to help address the COVID-19 crisis.

The key is to make sure you have licenses required in your area to practice telemedicine.

TELEMEDICINE BILLING

- Most likely and appropriate coding for interactive audio-video are E&M codes
- Some therapies are allowed
- Place of service 02 location other than patient home or 10 patient home
- Modifier 95 on the E&M Service

Place of service for these codes is 02 or 10



	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1							10		99214	95					NPI	
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) | 28. TOTAL CHARGE | 29. AMOUNT PAID | 30. Rsvd for NUCC Use

PHYSICIAN OR SUPPLIER INFORMATION

95 Modifier

Modifier 95 means: "synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system."

ONLINE DIGITAL EVALUATION AND MANAGEMENT SERVICES

99421 Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 5-10 minutes

99422	11—20 minutes
99423	21 or more minutes

These are patient-initiated E/M services for the assessment and management of the patient. These are not intended for the no evaluative electronic communication of test results, scheduling of appointments, or other communication that does not include E/M.

On-line communication (email essentially but through a secure portal as part of EHR)

If the patient had an E/M service within the last seven days, these codes may not be used for that problem.

If the inquiry is about a new problem these codes may be billed. Do not use if the online inquiry addresses and issue that was part of an E/M or service in the past 7 days

Billing is cumulative for a 7-day period and not billed for each interaction

TELEPHONE CALLS

99441 5-10 minutes of medical discussion
99442 11-20 minutes of medical discussion
99443 21-30 minutes of medical discussion

- The call must be initiated by the established client or their parent/guardian if they're a minor.
- The length of the phone call must be documented, as well as the nature of the service and other pertinent information.
- The call can't be related to an E/M service you performed and reported within the last 7 days

CMS LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2022-

99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99211	Office/outpatient visit est
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est

97110	Therapeutic exercises	Available up Through December 31, 2023
97112	Neuromuscular reeducation	Available up Through December 31, 2023
97116	Gait training therapy	Available up Through December 31, 2023
97530	Therapeutic activities	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97535	Self care mngment training	Available up Through December 31, 2023
97750	Physical performance test	Available up Through December 31, 2023
97755	Assistive technology assess	Available up Through December 31, 2023
97760	Orthotic mgmt&traing 1st enc	Available up Through December 31, 2023
97761	Prosthetic traing 1st enc	Available up Through December 31, 2023

Chiropractic Therapy

Electronic Visits

Home Health and Hospice Telehealth Services

Physical Health, Occupational and Speech Therapy

Remote Patient Monitoring

Telehealth

Telehealth State Provision Exceptions

Virtual Check-Ins

Chiropractic Therapy

Last update: May 13, 2021, 11:02 a.m. CT

UnitedHealthcare will temporarily reimburse telehealth services submitted by chiropractors when provided by qualified health care professionals and rendered using interactive audio-video technology for Medicaid and Individual and fully insured Group Market health plan members. Medicare Advantage coverage limitations still apply, as well state laws and regulations. Benefits will be processed in accordance with the member's plan.

Reimbursable codes are limited to the specific set of codes listed here. UnitedHealthcare will reimburse eligible codes on a CMS 1500 form using the place of service that would have been reported had the services been furnished in person along with a 95 modifier, or on a UB04 form with applicable revenue codes.

Originating Site Expansion

UnitedHealthcare is continuing its expansion of telehealth access, including temporarily waiving the Centers for Medicare & Medicaid Services (CMS) originating site requirements.

OPTUM™

Benefit Impact
Note: Member's benefits may vary according to benefit design. Member benefit language should be reviewed before applying the terms of this policy. • Telehealth visits and services are applicable to health plan coverage limitations. • Telehealth visits and services must be eligible for separate payment when performed face-to-face • Deductibles and co-payments are the same as in-person visits, unless otherwise stated. • Unless otherwise stated, telehealth services are reimbursed at the same rate as they would when performed in an office setting • Telehealth visits and services are subject to the same utilization management policies and payment audit programs as with in-person (face-to-face) visits

Definitions

Term	Description
Distant Site	The location of a physician or other qualified health care professional at the time the service being furnished via a telecommunications system occurs
Originating Site	The location of a patient at the time the service being furnished via a telecommunications system occurs
Qualified Health Care Professional	An individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service
Store-and-Forward Technology	Technologies that collect images and data to be transmitted and interpreted later
Telehealth	Telehealth services are live, interactive audio and visual transmissions of a clinician-patient encounter from one site to another using telecommunications technology

Telehealth Services for Chiropractors and Therapists (PT, OT, SLP)

This policy is limited to the following CPT codes®. The codes available to bill as telehealth services are categorized by professional discipline. The inclusion of a code in this section does not guarantee that it will be reimbursed. For further information about reimbursement guidance, please refer to the member's specific health plan coverage documents.

CPT Code®	Description
Chiropractic	
99202	Office/outpatient visit new patient
99203	Office/outpatient visit new patient
99204	Office/outpatient visit new patient
99205	Office/outpatient visit new patient
99212	Office/outpatient visit established patient
99213	Office/outpatient visit established patient
99214	Office/outpatient visit established patient
99215	Office/outpatient visit established patient
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97116	Gait training therapy
97530	Therapeutic activities, one-to-one patient contact, each 15 minutes
97535	Self-care management training
97750	Physical performance test
97755	Assistive technology assessment
97760	Orthotic management and training 1st encounter

97761	Prosthetic training 1st encounter
Physical Therapy	
97161	Physical therapy evaluation – low complexity
97162	Physical therapy evaluation – moderate complexity
97163	Physical therapy evaluation – high complexity
97164	Physical therapy re-evaluation
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97116	Gait training therapy
97530	Therapeutic activities, one-to-one patient contact, each 15 minutes
97535	Self-care management training
97750	Physical performance test
97755	Assistive technology assessment
97760	Orthotic management and training 1st encounter
97761	Prosthetic training 1st encounter
Occupational Therapy	
97165	Occupational therapy evaluation – low complexity
97166	Occupational therapy evaluation – moderate complexity
97167	Occupational therapy evaluation – high complexity
97168	Occupational therapy re-evaluation
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97116	Gait training therapy
97530	Therapeutic activities, one-to-one patient contact, each 15 minutes
97535	Self-care management training
97750	Physical performance test
97755	Assistive technology assessment
97760	Orthotic management and training 1st encounter
97761	Prosthetic training 1st encounter
Speech-Language Therapy	
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder
92521	Evaluation of speech fluency
92522	Evaluation of speech sound production
92523	Evaluation of speech sound production
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
96105	Assessment of Aphasia and Cognitive Performance Testing
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97116	Gait training therapy
97129	Therapeutic interventions that focus on cognitive function
97130	Each additional 15 minutes (use in conjunction with 97129)
97530	Therapeutic activities, one-to-one patient contact, each 15 minutes
97535	Self-care management training
97750	Physical performance test
97755	Assistive technology assessment
97760	Orthotic management and training 1st encounter
97761	Prosthetic training 1st encounter

Unfortunately, you can satisfy every billing requirement and still not be reimbursed by the insurance company for client calls, since these codes are often not covered. That's why it's important to check the contract to see if these codes are covered and have a policy in place to ensure you're compensated for your time if they're not.

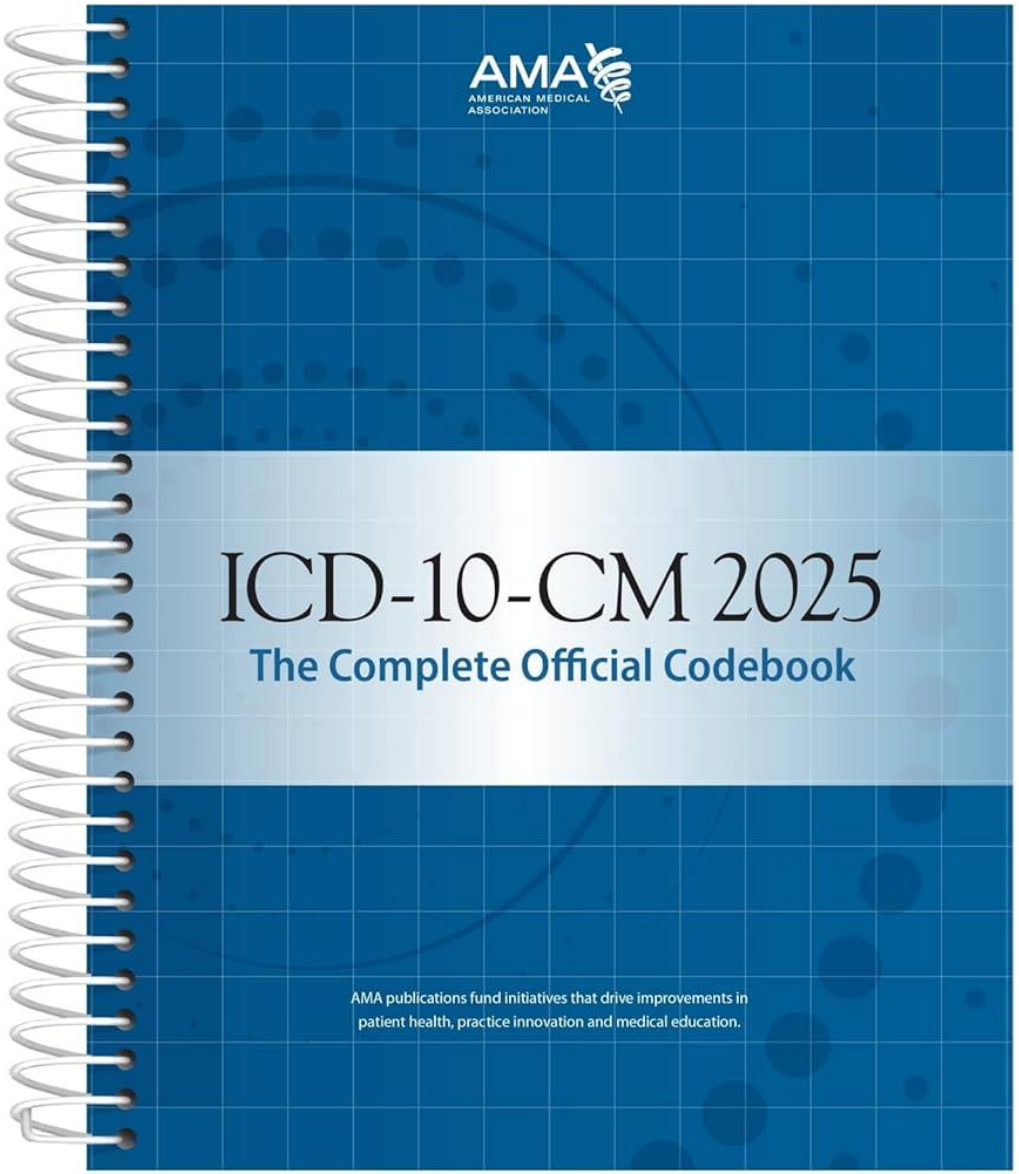
The best place to do this is on the Consent for Services form you have your client's sign. Make part of this form your out-of-session contact policy, stating that clients will be liable for all charges not covered by insurance. Naturally, this will exclude Qualified Medicare Beneficiaries and some Medicaid clients, who can't be billed for anything, but it will cover your bases with all other clients.

coding matters!

because your dura maters®

74,260 Codes

- 252 Additions
- 36 Deletions
- 13 Revisions



Lumbar Disc

Deleted:

M51.36 Other intervertebral disc degeneration, lumbar

Added:

M51.360 Other intervertebral disc degeneration, lumbar region with discogenic back pain

M51.361 Other intervertebral disc degeneration, lumbar region with lower extremity pain only

M51.362 Other intervertebral disc degeneration, lumbar region with discogenic back pain and lower extremity pain

M51.369 Other intervertebral disc degeneration, lumbar region without mention of lumbar back pain or lower extremity pain

Lumbar Disc

Deleted:

M51. 37 Other intervertebral disc degeneration, lumbosacral region

Added:

M51.370 Other intervertebral disc degeneration, lumbosacral region with discogenic back pain only

M51.371 Other intervertebral disc degeneration, lumbosacral region with lower extremity pain only

M51.372 Other intervertebral disc degeneration, lumbosacral region with discogenic back pain and lower extremity pain

M51.379 Other intervertebral disc degeneration, lumbosacral region without mention of lumbar back pain or lower extremity

MULTIFIDUS MUSCLES, LUMBAR SPINE

Added

M62.85
Dysfunction of the multifidus muscles, lumbar region

Synovitis and Tenosynovitis

DELETED:

M65.9 SYNOVITIS AND TENOSYNOVITIS, UNSPECIFIED

Added:

M6590 Unspecified synovitis and tenosynovitis, unspecified site
M65911 Unspecified synovitis and tenosynovitis, right shoulder
M65912 Unspecified synovitis and tenosynovitis, left shoulder
M65.919 Unspecified synovitis and tenosynovitis, unspecified shoulder
M65.921 Unspecified synovitis and tenosynovitis, right upper arm
M65.922 Unspecified synovitis and tenosynovitis, left upper arm
M65.929 Unspecified synovitis and tenosynovitis, unspecified upper arm
M65.931 Unspecified synovitis and tenosynovitis, right forearm
M65.932 Unspecified synovitis and tenosynovitis, left forearm
M65.939 Unspecified synovitis and tenosynovitis, unspecified forearm
M65.941 Unspecified synovitis and tenosynovitis, right hand
M65.942 Unspecified synovitis and tenosynovitis, left hand
M65.949 Unspecified synovitis and tenosynovitis, unspecified hand

Synovitis and Tenosynovitis

ADDED:

M65.951 UNSPECIFIED SYNOVITIS AND TENOSYNOVITIS, RIGHT THIGH

M65.952 UNSPECIFIED SYNOVITIS AND TENOSYNOVITIS, LEFT THIGH

M65.959 UNSPECIFIED SYNOVITIS AND TENOSYNOVITIS, UNSPECIFIED THIGH

M65.961 UNSPECIFIED SYNOVITIS AND TENOSYNOVITIS, RIGHT LOWER LEG

M65.962 UNSPECIFIED SYNOVITIS AND TENOSYNOVITIS, LEFT LOWER LEG

M65.969 UNSPECIFIED SYNOVITIS AND TENOSYNOVITIS, UNSPECIFIED LOWER LEG

- M65.971 Unspecified synovitis and tenosynovitis, right ankle and foot
- M65.972 Unspecified synovitis and tenosynovitis, left ankle and foot
- M65.979 Unspecified synovitis and tenosynovitis, unspecified ankle and foot
- M65.98 Unspecified synovitis and tenosynovitis, other site
- M65.99 Unspecified synovitis and tenosynovitis, multiple sites

Sick Care (Healthcare) Reality

New:

Z59.71
Insufficient health insurance coverage

Existing:

Z59.41 Food insecurity
Z59.12 Inadequate housing utilities
Z59.6 Low income
Z59.86 Financial insecurity
Z62.1 Parental overprotection
Z62.0 Inadequate parental supervision of control
Z62.892 Sibling Rivalry

Diagnosis Accuracy

What picture are you painting?

Woman With a Parasol

Rembrandt – Self Portrait


-Do you think she's pretty?
-She's a full-on Monet.
From far away it's okay,
but up close it's a big old mess.

UnitedHealthcare Insurance Company
KINGSTON SERVICE CENTER
P.O. BOX 30985
SALT LAKE CITY, UT 84130

UnitedHealthcare

[redacted]

Patient:
Patient Acct #:
Date of Service
Provider:
Claim ID:
Claim #:
Member:
Member ID:
Group:
Group #:
Letter ID:

[redacted]

November 3, 2020

Dear [redacted] Dc:

We received the above claim for [redacted]. This claim represents the patient's 30th visit. Please provide the following information if you anticipate the patient's current therapy will continue. We will review the information to determine the coverage of additional therapy.

Please provide the following information if patient therapy will continue:

- Initial evaluation with monthly updates
- Treatment plan with specific, measurable goals
- Documentation of objective and measurable progress toward treatment goals
- Anticipated date of discharge

Mail the information and this letter to the above return address. Keep a copy for your records.

Please note that the information in this letter does not guarantee that therapy is covered by the patient's health benefit plan or represent a treatment decision. Payment is based on the terms of the patient's plan and eligibility when the services are received. All treatment decisions are made between the patient and the treating physician.

Questions? We're here to help.
If you have questions about this letter, please call 800-842-9905.

Sincerely,
The UnitedHealthcare Team

Go Paperless!
UHCprovider.com/paperles

Head and Spine (Axial Skeleton)	
	Headaches
R51.0	Orthostatic headache
R51.9	Headache, unspecified
G44.86	Cervicogenic, Headache
G44.209	Tension-type headache, unspecified, not intractable
G44.219	Episodic tension-type headache, not intractable
G44.229	Chronic tension-type headache, not intractable
G43.009	Migraine without aura, not intractable, without status migrainosus
G43.109	Migraine with aura, not intractable, without status migrainosus
G43.909	Migraine, unspecified, not intractable, without status migrainosus
G43..E01	Chronic migraine with aura, not intractable, with status migrainosus
G43.E09	Chronic migraine with aura, not intractable, without status migrainosus
G43..E11	Chronic migraine with aura, intractable, with status migrainosus
G43.E19	Chronic migraine with aura, intractable, without status migrainosus
G44.89	Other headache syndrome
	Traumatic Headache
G44.309	Post-traumatic headache, unspecified, not intractable
G44.319	Acute post-traumatic headache, not intractable
G44.329	Chronic post-traumatic headache, not intractable
	Concussion
S06.0X0A	Concussion without loss of consciousness, initial encounter
S06.0XAA	Concussion with loss of consciousness status unknown, initial encounter
F07.81	Post concussion syndrome (postconucssional syndrome)
	TMJ
M26.601	Right temporomandibular (TMJ) joint disorder, unspecified
M26.602	Left temporomandibular (TMJ) joint disorder, unspecified
M26.603	Bilateral temporomandibular (TMJ) joint disorder, unspecified
S03.41XA	Sprain of jaw, right side, initial encounter
S03.42XA	Sprain of jaw,left side, initial encounter
S03.43XA	Sprain of jaw, bilateral , initial encounter
M79.11	Myalgia, muscle of mastication
	Cervical Spine
	Subluxation
M99.00	Segmental somatic dysfunction head region
M99.01	Segmental somatic dysfunction cervical region
M99.10	Subluxation complex (vertebral) of head region
M99.11	Subluxation complex (vertebral) of cervical region

	Pain
M54.2	Cervicalgia
M25.50	Pain in joint unspecified (specify cervical spine)
M53.81	Other specified dorsopathies, occipito-atlanto-axial region (syndromes)
M53.82	Other specified dorsopathies, cervical region (syndromes)
M53.83	Other specified dorsopathies, cervicothoracic region (syndromes)
	Nerve
M53.0	Cervicocranial syndrome
M53.1	Cervicobrachial syndrome
M54.11	Radiculopathy occipito-atlanto-axial region
M54.12	Radiculopathy cervical region
M54.13	Radiculopathy cervicothoracic region
G54.0	Brachial plexus disorders (thoracic outlet syndrome)
G54.2	Cervical root disorders, not elsewhere classified
S14.2XXA	Injury of nerve root of cervical spine, initial encounter
S14.3XXA	Injury of brachial plexus, initial encounter
	Muscle Tendon
M46.01	Spinal enthesopathy occipito-atlanto-axial region
M46.02	Spinal enthesopathy cervical region
M46.03	Spinal enthesopathy cervicothoracic region
M79.12	Myalgia of auxiliary muscles, head and neck
	Sprain and Strain
S13.4XXA	**Sprain** of ligaments of cervical spine initial encounter
S16.1XXA	**Strain** of muscle, fascia and tendon at neck level initial encounter
S13.8XXA	Sprain of joints and ligaments of other parts of neck, initial encounter
	Spondylosis Arthritis
M47.891	Other spondylosis, occipito-atlanto-axial region
M47.892	Other spondylosis, cervical region
M47.893	Other spondylosis, cervicothoracic region
	Spondylolisthesis, Deforming Dorsopathies, Curvature, Torticollis
M43.11	Spondylolisthesis, occipito-atlanto-axial region
M43.12	Spondylolisthesis, cervical region
M43.13	Spondylolisthesis, cervicothoracic region
M40.03	Postural kyphosis cervicothoracic
M40.12	Other secondary kyphosis cervical
M40.13	Other secondary kyphosis cervicothoracic
M43.8X1	Other specified deforming dorsopathies occipitoatlantoaxial
M43.8X2	Other specified deforming dorsopathies cervical
M43.8X3	Other specified deforming dorsopathies cervicothoracic
M43.6	Torticollis
G24.3	Spasmodic torticollis
	Disc
M50.10	Cervical disc disorder with radiculopathy unspecified cervical region
M50.11	Cervical disc disorder with radiculopathy high cervical (C2-3 C3-4)
M50.121	Cervical disc disorder at C4-C5 level with radiculopathy
M50.122	Cervical disc disorder at C5-C6 level with radiculopathy

M50.122	Cervical disc disorder at C5-C6 level with radiculopathy
M50.123	Cervical disc disorder at C6-C7 level with radiculopathy
M50.13	Cervical disc disorder with radiculopathy, cervicothoracic region
M50.20	Cervical disc displacement unspecified cervical region
M50.21	Cervical disc displacement C2-3, C3-4 region
M50.220	Other cervical disc displacement, mid-cervical region, unspecified level
M50.221	Other cervical disc displacement at C4-C5 level
M50.222	Other cervical disc displacement at C5-C6 level
M50.223	Other cervical disc displacement at C6-C7 level
M50.23	Cervical disc displacement C7-T1 region
M50.30	Cervical disc degeneration, unspecified cervical region
M50.31	Cervical disc degeneration high cervical C2-3 C3-4
M50.320	Other cervical disc degeneration, mid-cervical region, unspecified level
M50.321	Other cervical disc degeneration at C4-C5 level
M50.322	Other cervical disc degeneration at C5-C6 level
M50.323	Other cervical disc degeneration at C6-C7 level
M50.33	Cervical disc degeneration cervicothoracic region C7-T1
M50.80	Other cervical disc disorders unspecified cervical region
M50.81	Other cervical disc disorders, high cervical region (C2-3 C3-4)
M50.820	Other cervical disc disorders, mid-cervical region, unspecified level
M50.821	Other cervical disc disorders at C4-C5 level
M50.822	Other cervical disc disorders at C5-C6 level
M50.823	Other cervical disc disorders at C6-C7 level
M50.83	Other cervical disc disorders, cervicothoracic region
M50.90	Cervical disc disorder, unspecified cervical region
M50.91	Cervical disc disorder, unspecified high cervical (C2-3 C3-4)
M50.920	Unspecified cervical disc disorder, mid-cervical, unspecified level
M50.921	Unspecified cervical disc disorder at C4-C5 level
M50.922	Unspecified cervical disc disorder at C5-C6 level
M50.923	Unspecified cervical disc disorder at C6-C7 level
M50.93	Unspecified cervical disc disorder cervicothoracic region
	Thoracic Spine
	Subluxation
M99.02	Segmental somatic dysfunction thoracic region
M99.12	Subluxation complex (vertebral) of thoracic region
M99.08	Segmental somatic dysfunction of rib cage
	Pain
M54.6	Pain in thoracic spine
M25.50	Pain in joint unspecified (specify thoracic spine)
M53.84	Other specified dorsopathies, thoracic region
M53.85	Other specified dorsopathies, thoracolumbar region
	Nerve
M54.14	Radiculopathy thoracic (neuritis)
M54.15	Radiculopathy thoracolumbar
G54.0	Brachial plexus lesions (thoracic outlet syndrome)
G54.3	Thoracic root disorders, not elsewhere classified
G58.0	Intercostal Neuropathy

	Muscle Tendon
M46.04	Spinal enthesopathy thoracic region
M46.05	Spinal enthesopathy thoracolumbar region
M79.18	Myalgia, other site
	Sprain and Strain
S23.3XXA	Sprain of ligaments of thoracic spine initial encounter
S29.012A	Strain of muscle and tendon of back wall of thorax initial encounter
S23.8XXA	Sprain of other specified parts of thorax, initial encounter
	Spondylosis Arthritis
M47.894	Other spondylosis, thoracic region
M47.895	Other spondylosis, thoracolumbar region
	Spondylolisthesis & Deforming Dorsopathies
M43.14	Spondylolisthesis, thoracic region
M43.15	Spondylolisthesis, thoracolumbar region
M43.8X4	Other specified deforming dorsopathies thoracic
M43.8X5	Other specified deforming dorsopathies thoracolumbar
	Scolioisis
M41.23	Scoliosis idiopathic, cervicothoracic
M41.24	Scoliosis idiopathic, thoracic
M41.25	Scoliosis idiopathic, thoracolumbar
M41.30	Thoracogenic scoliosis, unspecified
M41.34	Thoracogenic scoliosis, thoracic region
M41.35	Thoracogenic scoliosis, thoracolumbar
	Disc
M51.04	Intervertebral disc disorders with myelopathy, thoracic region
M51.14	Intervertebral disc disorders with radiculopathy, thoracic region
M51.24	Thoracic intervertebral disc displacement
M51.25	Thoracolumbar intervertebral disc displacement
M51.34	Thoracic or thoracolumbar disc degeneration
M51.35	Thoracolumbar intervertebral disc degeneration
M51.44	Schmorl's nodes thoracic region
M51.84	Other intervertebral disc disorders, thoracic region
	Lumbar and Lumbosacral Spine
	Subluxation
M99.03	Segmental and somatic dysfunction, lumbar region
M99.04	Segmental and somatic dysfunction, sacral , sacrococcygeal, sacroiliac regions
M99.05	Segmental and somatic dysfunction, hip, pelvis, pubic region
M99.13	Subluxation complex (vertebral) of lumbar region
M99.14	Subluxation complex (vertebral) of sacral region
M99.15	Subluxation complex (vertebral) of pelvic region
	Pain
M54.50	Low back pain, unspecified
M54.51	Vertebrogenic low back pain
M54.59	Other low back pain
M25.50	Pain in joint unspecified (specify lumbar or LS spine)
M53.3	Sacrococcygeal disorders, not elsewhere classified

M53.86	Other specified dorsopathies, lumbar region
M53.87	Other specified dorsopathies, lumbosacral region
M53.88	Other specified dorsopathies, sacral & sacrococcygeal region
M53.2X8	Spinal instabilities, sacral and sacrococcygeal region Disorder of sacrum)
	Nerve
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.18	Radiculopathy, sacrococcygeal region
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
G54.1	Lumbosacral plexus disorders
G54.4	Lumbosacral root disorders, not elsewhere classified
G57.01	Lesion of sciatic nerve, right lower limb (piriformis syndrome)
G57.02	Lesion of sciatic nerve, left lower limb (piriformis syndrome)
G57.03	Lesion of sciatic nerve, bilateral lower limb (piriformis syndrome)
S34.21XA	Injury of nerve root of lumbar spine, initial encounter
S34.22XA	Injury of nerve root of sacral spine, initial encounter
S34.4XXA	Injury of lumbosacral plexus, initial encounter
S74.01XA	Injury of sciatic nerve at hip and thigh level, right leg, initial encounter
S74.02XA	Injury of sciatic nerve at hip and thigh level, left leg, initial encounter
	Muscle Tendon
M46.06	Spinal enthesopathy lumbar region
M46.07	Spinal enthesopathy lumbosacral region
M46.08	Spinal enthesopathy, sacral and sacrococcygeal region
M79.18	Myalgia, other site
	Sprain and Strain
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
S39.012A	Strain of muscle, fascia and tendon of lower back, initial encounter
S33.6XXA	Sprain of sacroiliac joint, initial encounter
S33.8XXA	Sprain of other parts of lumbar spine and pelvis, initial encounter
S33.9XXA	Sprain of unspecified parts of lumbar spine and pelvis, initial encounter
	Spondylosis Arthritis
M47.895	Other spondylosis, thoracolumbar region
M47.896	Other spondylosis, lumbar region
M47.897	Other spondylosis, lumbosacral region
M47.898	Other spondylosis, sacral and sacrococcygeal region
	Spondylolisthesis
M43.16	Spondylolisthesis, lumbar region
M43.17	Spondylolisthesis, lumbosacral region
M43.18	Spondylolisthesis, sacral and sacrococcygeal region
M43.8X6	Other specified deforming dorsopathies lumbar
M43.8X7	Other specified deforming dorsopathies lumbosacral
M43.8X8	Other specified deforming dorsopathies sacral and sacrococcygel

	Scolioisis
M41.26	Scoliosis idiopathic,lumbar
M41.27	Scoliosis idiopathic, lumbosacral
	Disc
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.26	Intervertebral disc displacement, lumbar region
M51.27	Intervertebral disc displacement, lumbosacral region
M51.36	Other intervertebral disc degeneration, lumbar region (deleted 10-1-2024)
M51.360	Other intervertebral disc degeneration, lumbar region with discogenic back pain (added 10-1-2024)
M51.361	Other intervertebral disc degeneration, lumbar region with lower extremity pain only (added 10-1-2024)
M51.362	Other intervertebral disc degeneration, lumbar region with discogenic back pain and lower extremity pain (added 10-1-2024)
M61.369	Other intervertebral disc degeneration, lumbar region without mention lumbar back pain orlower extremity pain (added 10-1-20
M51.37	Other intervertebral disc degeneration, lumbosacral region (deleted 10-1-2024)
M51.370	Other intervertebral disc degeneration, lumbosacral region with discogenic back pain (added 10-1-2024)
M51.371	Other intervertebral disc degeneration, lumbosacral region with lower extremity pain only (added 10-1-2024)
M51.372	Other intervertebral disc degeneration, lumbosacral region with discogenic back pain and lower extremity pain (added 10-1-20
M61.379	Other intervertebral disc degeneration,LS region without mention lumbar back pain orlower extremity pain (added 10-1-2024)
M51.45	Schmorl's Nodes thoracolumbar region
M51.46	Schmorl's Nodes lumbar region
M51.47	Schmorl's Nodes lumbosacral region
M51.85	Other intervertebral disc disorders, thoracolumbar region
M51.86	Other intervertebral disc disorders, lumbar region
M51.87	Other intervertebral disc disorders, lumbosacral region
M51.9	Unspecified thoracic, TL and LS intervertebral disc disorder
M51.A0	Intervertebral annulus fibrosus defect, lumbar region, unspecified size
M51.A1	Intervertebral annulus fibrosus defect, small, lumbar region
M51.A2	Intervertebral annulus fibrosus defect, large, lumbar region
M51.A3	Intervertebral annulus fibrosus defect, lumbosacral region, unspecified size
M51.A4	Intervertebral annulus fibrosus defect, small, lumbosacral region
M51.A5	Intervertebral annulus fibrosus defect, large, lumbosacral region
	Miscellaneous Spine and Spine Related
	Muscle
M79.10	Myalgia, unspecified site
M79.11	Myalgia of muscles of mastication
M79.12	Myalgia of auxiliary muscles, head and neck
M79.18	Myalgia, other site
M79.2	Neuralgia and neuritis, unspecified
M79.7	Fibromyalgia
M62.81	Muscle weakness
M62.5A0	Muscle wasting and atrophy, not elsewhere classified, back, cervical
M62.5A1	Muscle wasting and atrophy, not elsewhere classified, back, thoracic
M62.5A2	Muscle wasting and atrophy, not elsewhere classified, back, lumbosacral
M62.5A9	Muscle wasting and atrophy, not elsewhere classified, back, unspecified level
M62.85	Dysfunction of the multifidus muscles, lumbar region (added 10-1-2024)
M60.88	Other myositis, other site

M62.830	Muscle spasm of back
M62.838	Other muscle spasm
M24.50	Contracture, unspecified joint
M72.9	Fibroblastic disorder, unspecified
	Stiffness, Pain, Nerve
M25.60	Stiffness of unspecified joint, not elsewhere classified (spine)
M25.78	Osteophyte, vertebrae
M53.3	Sacrococcygeal disorders, not elsewhere classified
M53.9	Dorsopathy, umspecified
G54.8	Other nerve root and plexus disorders
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified
G55	Nerve root and plexus compressions in diseases classified elsewhere
	Spondylisthesis, Malformation, Ligament
M43.19	Spondylolisthesis, multiple sites in spine
Q76.2	Congenital spondylolisthesis
Q76.49	Other congenital malformations of spine, not associated with scoliosis
M24.80	Other specific joint derangements of unspecified joint, not elsewhere classified
M24.9	Joint derangement, unspecified
	Ligament Laxity and Biomechanical Lesions
M24.28	Disorder of ligament, vertebrae (ligament laxity)
M99.80	Other biomechanical lesions, of head region
M99.81	Other biomechanical lesions, of cervical region
M99.82	Other biomechanical lesions, of Thoracic region
M99.83	Other biomechanical lesions, of lumbar region
M99.84	Other biomechanical lesions, of sacral region
M99.84	Other biomechanical lesions, of pelvic region
	Spinal Stenosis
M48.01	Spinal stenosis occipito-atlanto-axial region
M48.02	Spinal stenosis cervical region
M48.03	Spinal stenosis cervicothoracic region
M48.04	Spinal stenosis thoracic region
M48.05	Spinal stenosis thoracolumbar region
M48.061	Spinal stenosis, lumbar region without neurogenic claudication
M48.062	Spinal stenosis, lumbar region with neurogenic claudication
M48.07	Spinal stenosis lumbosacral region
M48.08	Spinal stenosis sacral and sacrococcygeal region
	Post surgical
M96.1	Postlaminectomy syndrome, not elsewhere classified
Z98.890	Other specified postprocedural states (post surgical pain)
G89.18	Acute post procedural pain
G89.28	Other chronic post procedural pain
	Pregnancy
Z33.1	Pregnant state, incidental
M54.59	Other low back pain
M53.86	Other specified dorsopathies, lumbar region

M53.87	Other specified dorsopathies, lumbosacral region
O99.89	Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium (low back pain pregnancy)
	Pain
G89.0	Central pain syndrome
G89.11	Acute pain due to trauma
G89.12	Acute post-thoracotomy pain
G89.18	Other acute post procedural pain
G89.21	Chronic pain due to trauma
G89.22	Chronic post-thoracotomy pain
G89.28	Other chronic post procedural pain
G89.29	Other chronic pain
G89.3	Neoplasm related pain (acute) (chronic)
G89.4	Chronic pain syndrome (Chronic pain associated with psychosocial dysfunction)
R52	Pain, unspecified
	Fatigue
G93.31	Postviral fatigue syndrome
R53.1	Weakness (Asthenia NOS)
R53.81	Other malaise (debility, general physical deterioration, malaise NOS, nervous debility)
R53.82	Chronic fatigue, unspecified (chronic fatigue syndrome)
R53.83	Other fatigue (lack of energy, lethargy, tiredness)
R54	Age related physical debility (frailty, old age, senescence, senile asthenia, senile debility)

MY CLAIM WAS DENIED FOR DIAGNOSIS?

Incorrectly reported per ICD10 Guidelines

Line Level Information View Code Audit Rationale

Service Dates	Proc/Rev	DX	HCPCS	Billed	Paid	Ineligible	Reason/Remark Codes	Discount	Copay	Coins	Deductible	Mods	Unit/ Time/ Miles
04/18/2022 04/18/2022	9894	G541, M50321		$55.00	$0.00	$55.00	V67	$0.00	$0.00	$0.00	$0.00		1

Parameter Type	Created Line Indicator	Action	Edit Source
Action Required	Submitted on Claim	Not Reimbursable	WHO
Edit Location	**Procedure Code**	**Modifier Code**	**Unit Count**
ICD-10 Guidelines	98941		1

Cotiviti Edit Description

98941 WAS SUBMITTED WITH A DIAGNOSIS CODE PAIR THAT SHOULD NOT BE REPORTED TOGETHER BASED ON ICD-10 EXCLUDES1 NOTE; THEREFORE 98941 IS NOT REIMBURSABLE.

Cotiviti Edit Rationale

According to the ICD-10 Official Guidelines for Coding and Reporting, the billed service has been denied because it was reported with one or more diagnosis code pairs that are subject to an Excludes1 note.

Remittance Advice and Explanation of Payment

Closing Balance: .00

Insured Name:
Patient Name:
Service Provide
Memb
PCN:
NPI:
Carrier: FL

Serv	Dates	Procedure	Mod	Days Ct/Qty	Charge	Allowed	Mbr Cost Share	Disallow / Discount	Interest / Penalty	Med Allow/	TPP	Denied	Payment Codes	Payment
0100	082321	99204		1.00	250.00	162.94	0.00	.00	.00	.00	.00	250.00	wd	.00
0200	082321	97140		1.00	68.00	21.04	0.00	.00	.00	.00	.00	68.00	we	.00
			Sub-total		318.00	183.98	0.00	.00	.00	.00	.00	318.00		.00
										.00				
			TOTAL		318.00	183.98	0.00	.00	.00	.00	.00	318.00		.00

Payment Code Description

wd DIAGNOSIS CODE INCORRECTLY CODED PER ICD10 MANUAL
we PROCEDURE MISSING CORRECT/REQUIRED MODIFIER OR REVENUE CODE GP=ok

The member cost share amount represents the sum of the deductible, copay and/or coinsurance. If a claim line is fully denied, and the denial reason results in a member being liable for the denied charges, you may bill the member for the denied amount up to billed charges for a non-participating provider.

Dx codes;
m50.823
m54.6
m51.86
m79.18

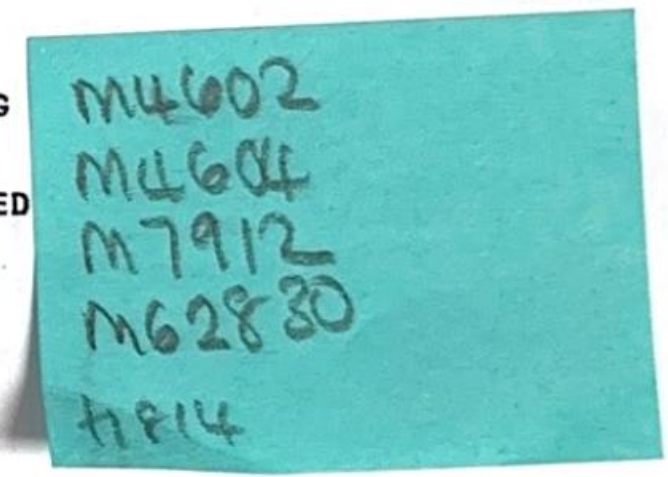
CONTINUED FROM PREVIOUS PAGE.

(6). PAYMENT CANNOT EXCEED THE ALLOWABLE CHARGE DETERMINED BY MEDICARE.

(7). THE MEMBER/PATIENT MAY HAVE HEALTH COVERAGE THROUGH ANOTHER CARRIER/MEDICARE. EXPENSES MAY BE ELIGIBLE FOR PAYMENT BY THAT CARRIER.

(8). THE DIAGNOSIS CODE(S) SUBMITTED IS INCONSISTENT WITH ICD-10-CM CODING GUIDELINES. NO MEDICAL RECORDS ARE NECESSARY AT THIS TIME. PLEASE SUBMIT A CORRECTED CLAIM. PATIENT CANNOT BE BILLED FOR THE DISALLOWED CODE.

(9). CHARGES EXCEED BLUECHOICE SCHEDULE OF MAXIMUM ALLOWANCE. SERVICES WERE PROVIDED BY A CONTRACTING PROVIDER. PATIENT IS NOT RESPONSIBLE FOR CHARGES OVER THE ALLOWANCE.

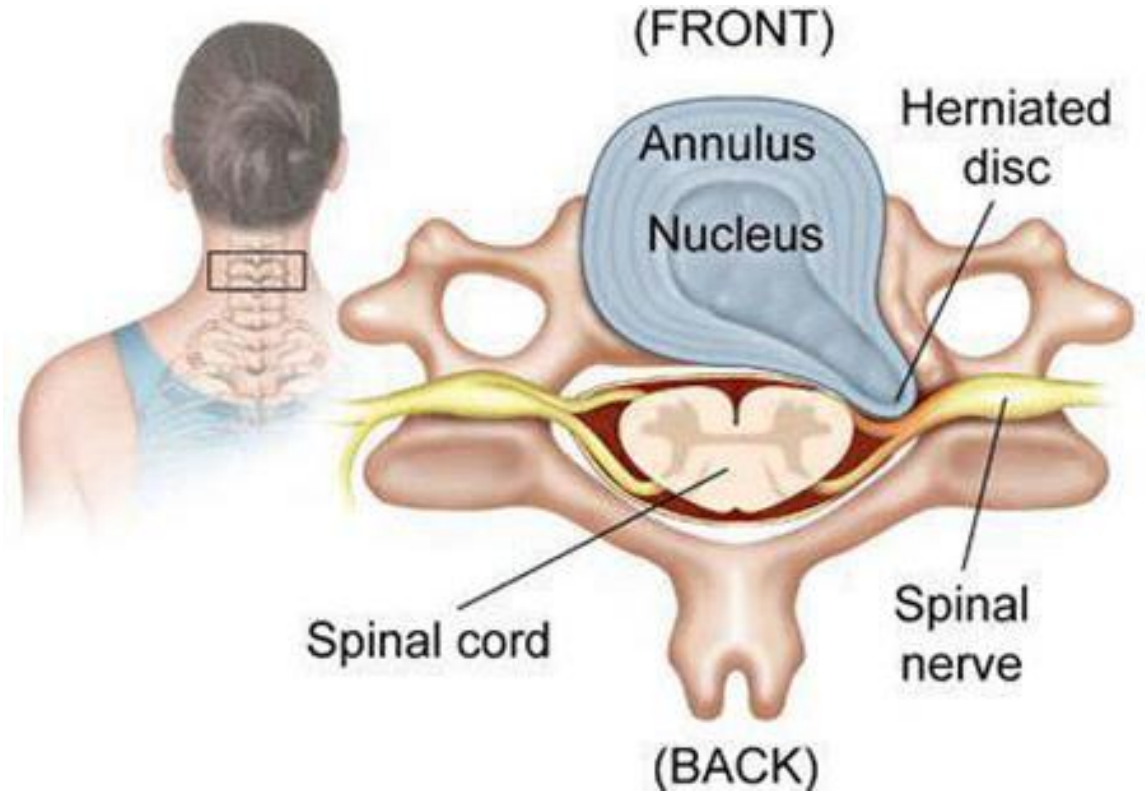


Diagnosis Excludes
Codes that cannot be coded together
On the same claim
Exclude 1

Code	Type 1 Code Exclusion – These codes cannot be coded together on the same claim
M54.2	- cervicalgia due to intervertebral cervical disc disorder (M50.-)
M54.50, M54.51, or M54.59	- low back strain (S39.012) lumbago due to intervertebral disc displacement (M51.2-) lumbago with sciatica (M54.4-)
M54.6	- pain in thoracic spine due to intervertebral disc disorder (M51.- S23.- S33-)
M54.4-	- lumbago with sciatica due to intervertebral disc disorder (M51.1-) M54.3, M54.5, M79.2
M54.81	- dorsalgia in thoracic region (M54.6) low back pain (M54.5)
M54.89	- dorsalgia in thoracic region (M54.6) low back pain (M54.5x)
M54.1-	- neuralgia and neuritis NOS (M79.2) radiculopathy with cervical disc disorder (M50.1) radiculopathy with lumbar and other intervertebral disc disorder (M51.1) radiculopathy with spondylosis (M47.2) Nerve root and plexus disorders (G50-59)
M50. -	- cervicalgia (M54.2), traumatic rupture of cervical intervertebral disc (S13.0-)
M51.-	- lumbar dislocation and sprain (S33.-), traumatic rupture of lumbar intervertebral disc (S33.0-), thoracic pain (M54.6), dislocation and sprain of thoracic S23.-) M54.- M54.3- and M54.4-
M53.-	nerve root plexus compressions in diseases classified elsewhere (G55.)
S33.-	- nontraumatic rupture or displacement of lumbar intervertebral disc NOS (M51) obstetric damage to pelvic joints and ligaments (O71.6)
S39.012-	low back pain (M54.5)
S23.-	- rupture or displacement (nontraumatic) of thoracic intervertebral disc NOS (M51)
M79.1-	- fibromyalgia (M79.7) myositis (M60.-) disorders of muscles (spasm, cramp) (M62.-)
M79.7	- myalgia (M79.1-)
M62-	- myalgia (M79.1-), cramp spasm (R25.82) stiff man syndrome (G25.82)
M47.-	- nerve root plexus disorders (G54.-)
G54.-	- intervertebral disc disorders (M50, M51), neuralgia or neuritis NOS (M79.2), neuritis or radiculitis brachial NOS (M54.13), neuritis or radiculitis lumbar NOS (M54.16), neuritis or radiculitis lumbosacral NOS (M54.17), neuritis or radiculitis thoracic NOS (M54.14), radiculitis NOS, radiculopathy (M54.10), . spondylosis (M47.-)
G55.-	ankylosing spondylitis (F45.-), dorsopathies (M53.- M54.-)., disc disorders (M50.1- M51.1-), spondylosis (M47.0- M47.2-), spondylopathies M46.-, M48.-)
M40.-	- congenital kyphosis and lordosis (Q76.4), kyphoscoliosis (M41), postprocedural kyphosis and lordosis (M96.)
M41.-	-congenital scoliosis NOS (Q67.5), congenital scoliosis due to bony malformation (Q76.3), postural congenital scoliosis (Q67.5), kyphoscoliotic heart disease (I27.1), postprocedural scoliosis (M96.)
M43.-	-congenital spondylolysis and spondylolisthesis (Q76.2), hemivertebra (Q76.3, Q76.4-), Klippel-Feil syndrome. M43.01 to M43.0x may not be coded with M43.1x (Q76.1), lumbarization and sacralization (Q76.4), spina bifida occulta (Q76.0), spinal curvature in osteoporosis (M80.), spinal curvature in Paget's disease of bone [osteitis deformans] (M88.)
M46.-	-nerve root and plexus compressions in diseases not classified elsewhere (G55.-)

MADE SIMPLE

- No spine pain or M54 codes with disc
- No myalgia with spasm – or only one muscle code
- Do not use multiple codes for radicular issues



	Shoulder Upper Arm
M99.07	Segmental and somatic dysfunction, upper extremity
M99.17	Subluxation complex (vertebral), upper extremity
M25.511	Pain in right shoulder
M25.512	Pain in left shoulder
M65.811	Other synovitis and tenosynovitis, right shoulder
M65.812	Other synovitis and tenosynovitis, left shoulder
M65.821	Other synovitis and tenosynovitis, right upper arm
M65.822	Other synovitis and tenosynovitis, left upper arm
M65.911	Unspecified synovitis and tenosynovitis, right shoulder (new 10-1-2024)
M65.912	Unspecified synovitis and tenosynovitis, left shoulder (new 10-1-2024)
M65.921	Unspecified synovitis and tenosynovitis, right upper arm (new 10-1-2024)
M65.922	Unspecified synovitis and tenosynovitis, left upper arm (new 10-1-2024)
M75.01	Adhesive capsulitis of the right shoulder (frozen shoulder)
M75.02	Adhesive capsulitis of the left shoulder (frozen shoulder)
M75.51	Bursitis of right shoulder
M75.52	Bursitis of left shoulder
M75.101	Unspecified rotator cuff tear or rupture of right shoulder , not specified as traumatic
M75.102	Unspecified rotator cuff tear or rupture of left shoulder , not specified as traumatic
S43.421A	Sprain of right rotator cuff capsule, initial encounter
S43.422A	Sprain of left rotator cuff capsule, initial encounter
S43.411A	Sprain of right coracohumeral (ligament), initial encounter
S43.412A	Sprain of left coracohumeral (ligament), initial encounter
S43.81XA	Sprain of other specified parts of right shoulder girdle, initial encounter
S43.82XA	Sprain of other specified parts of left shoulder girdle, initial encounter
S43.491A	Other sprain of right shoulder joint, initial encounter (active treatment)
S43.492A	Other sprain of left shoulder joint, initial encounter (active treatment)
S46.811A	Strain of other muscles, fascia and tendons at shoulder and upper arm level, right arm
S46.812A	Strain of other muscles, fascia and tendons at shoulder and upper arm level, left arm
S43.431A	Superior glenoid labrum lesion of right shoulder, initial encounter
S43.432A	Superior glenoid labrum lesion of left shoulder, initial encounter
	Elbow
M99.07	Segmental and somatic dysfunction, upper extremity
M99.17	Subluxation complex (vertebral), upper extremity
M77.01	Medial epicondylitis, right elbow (golfer's elbow)
M77.02	Medial epicondylitis, left elbow (golfer's elbow)
M77.11	Lateral epicondylitis, right elbow (tennis elbow)
M77.12	Lateral epicondylitis, left elbow (tennis elbow)
M65.831	Other synovitis and tenosynovitis, right forearm
M65.832	Other synovitis and tenosynovitis, left forearm
M65.931	Unspecified synovitis and tenosynovitis, right forearm (new 10-1-2024)
M65.932	Unspecified synovitis and tenosynovitis, left forearm (new 10-1-2024)
S53.431A	Radial collateral ligament sprain of right elbow, initial encounter
S53.432A	Radial collateral ligament sprain of left elbow, initial encounter
S53.441A	Ulnar collateral ligament sprain of right elbow, initial encounter
S53.442A	Ulnar collateral ligament sprain of left elbow, initial encounter

S53.411A	Radiohumeral (joint) sprain of right elbow, initial encounter
S53.412A	Radiohumeral (joint) sprain of left elbow, initial encounter
S53.421A	Ulnohumeral (joint) sprain of right elbow, initial encounter
S53.422A	Ulnohumeral (joint) sprain of left elbow, initial encounter
S53.491A	Other sprain of right elbow, initial encounter
S53.492A	Other sprain of left elbow, initial encounter
S53.401A	Unspecified sprain of right elbow, initial encounter (active care)
S53.402A	Unspecified sprain of left elbow, initial encounter (active care)
S56.211A	Strain of other flexor muscle, fascia and tendon at forearm level, right arm
S56.212A	Strain of other flexor muscle, fascia and tendon at forearm level, left arm
S56.511A	Strain of other extensor muscle, fascia and tendon at forearm level, right arm
S56.512A	Strain of other extensor muscle, fascia and tendon at forearm level, left arm
	Wrist
M99.07	Segmental and somatic dysfunction, upper extremity
M99.17	Subluxation complex (vertebral), upper extremity
G56.01	Carpal tunnel syndrome, right upper limb
G56.02	Carpal tunnel syndrome, left upper limb
G56.03	Carpal tunnel syndrome, bilateral upper limb
G56.11	Median nerve neuritis (lesion), right upper limb
G56.12	Median nerve neuritis (lesion), left upper limb
G56.13	Median nerve neuritis (lesion), bilateral upper limb
G56.21	Lesion of ulnar nerve, right upper limb
G56.22	Lesion of ulnar nerve, left upper limb
G56.23	Lesion of ulnar nerve, bilateral upper limb
G56.31	Lesion of radial nerve, right upper limb
G56.32	Lesion of radial nerve, left upper limb
G56.33	Lesion of radial nerve, bilateral upper limb
S63.501A	Unspecified sprain of right wrist, initial encounter
S63.502A	Unspecified sprain of left wrist, initial encounter
S63.511A	Sprain of carpal joint of right wrist, initial encounter
S63.512A	Sprain of carpal joint of left wrist, initial encounter
S63.521A	Sprain of radiocarpal joint of right wrist, initial encounter
S63.522A	Sprain of radiocarpal joint of left wrist, initial encounter
S63.591A	Other sprain of right wrist, initial encounter (active care)
S66.011A	Strain of long flexor muscle, fascia and tendon of right thumb at wrist and hand level, initial encounter
S66.012A	Strain of long flexor muscle, fascia and tendon of left thumb at wrist and hand level, initial encounter
S66.211A	Strain of extensor muscle, fascia and tendon of right thumb at wrist and hand level, initial encounter
S66.212A	Strain of extensor muscle, fascia and tendon of left thumb at wrist and hand level, initial encounter
S66.811A	Strain of other specified muscles, fascia and tendons at wrist and hand level, right hand
S66.812A	Strain of other specified muscles, fascia and tendons at wrist and hand level, left hand
M65.941	Unspecified synovitis and tenosynovitis, right hand (new 10-1-2024)
M65.942	Unspecified synovitis and tenosynovitis, left hand (new 10-1-2024)
	Hip and Thigh
M99.06	Segmental and somatic dysfunction, lower extremity
M99.16	Subluxation complex (vertebral), lower extremity
M76.01	Gluteal tendinitis, right hip

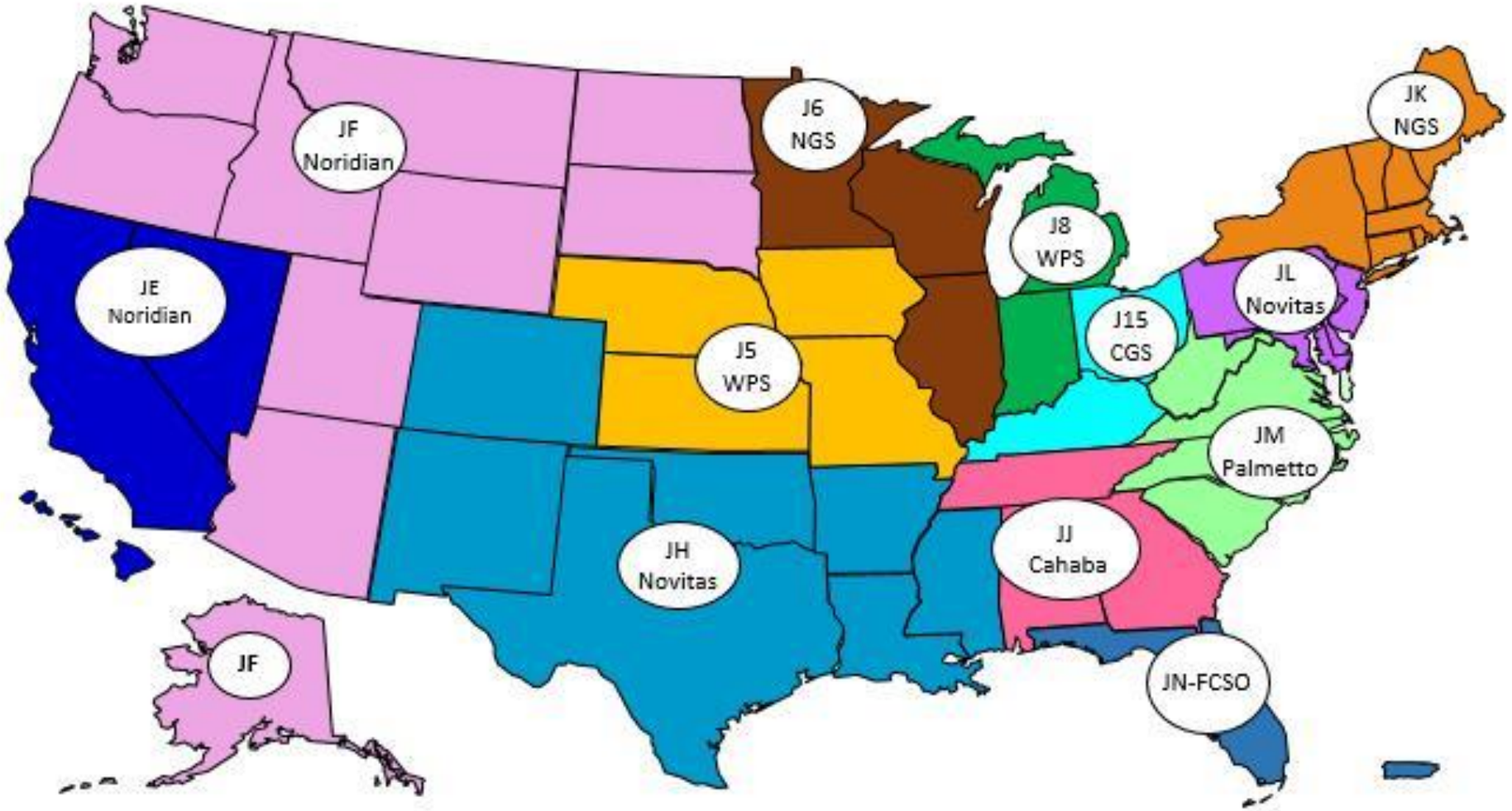
M76.02	Gluteal tendinitis, left hip
M76.11	Psoas tendinitis, right hip
M76.12	Psoas tendinitis, left hip
M76.31	Iliotibial band syndrome, right leg
M76.32	Iliotibial band syndrome, left leg
M70.71	Other bursitis of hip, right hip
M70.72	Other bursitis of hip, left hip
M70.70	Other bursitis of hip unspecified hip
M70.60	Trochanteric bursitis, unspecified hip
M65.951	Unspecified synovitis and tenosynovitis, right thigh (new 10-1-2024)
M65.952	Unspecified synovitis and tenosynovitis, left thigh (new 10-1-2024)
M65.851	Other synovitis and tenosynovitis, right thigh
M65.852	Other synovitis and tenosynovitis, left thigh
S73.111A	Iliofemoral ligament sprain of right hip, initial encounter
S73.112A	Iliofemoral ligament sprain of left hip, initial encounter
S73.121A	Ischiocapsular ligament sprain of right hip, initial encounter
S73.122A	Ischiocapsular ligament sprain of left hip, initial encounter
S73.191A	Other sprain of right hip, initial encounter
S73.192A	Other sprain of left hip, initial encounter
S76.311A	Strain of muscle, fascia and tendon of the posterior muscle group (hamstring) at thigh level, right thigh
S76.312A	Strain of muscle, fascia and tendon of the posterior muscle group (hamstring) at thigh level, left thigh
S76.111A	Strain of right quadriceps muscle, fascia and tendon, initial encounter
S76.112A	Strain of left quadriceps muscle, fascia and tendon, initial encounter
S76.211A	Strain of adductor muscle, fascia and tendon of right thigh, initial encounter
S76.212A	Strain of adductor muscle, fascia and tendon of left thigh, initial encounter
S76.811A	Strain of other specified muscles, fascia and tendons at thigh level, right thigh, initial encounter
S76.812A	Strain of other specified muscles, fascia and tendons at thigh level, left thigh, initial encounter
S76.011A	Strain of muscle, fascia and tendon of right hip, initial encounter
S76.012A	Strain of muscle, fascia and tendon of left hip, initial encounter
S76.911A	Strain of unspecified muscles, fascia and tendons at thigh level, right thigh, initial encounter
S76.912A	Strain of unspecified muscles, fascia and tendons at thigh level, left thigh, initial encounter
	Knee
M99.06	Segmental and somatic dysfunction, lower extremity
M99.16	Subluxation complex (vertebral), lower extremity
M25.561	Pain in the right knee (joint)
M25.562	Pain in the left knee (joint)
M70.51	Bursitis of knee not otherwise specified, right knee (enthesopathy)
M70.52	Bursitis of knee not otherwise specified, left knee (enthesopathy)
M65.961	Unspecified synovitis and tenosynovitis, right lower leg (new 10-1-2024)
M65.962	Unspecified synovitis and tenosynovitis, left lower leg (new 10-1-2024)
M76.51	Patellar tendinitis, right knee
M76.52	Patellar tendinitis, left knee

M22.41	Chondromalacia patella, right knee
M22.42	Chondromalacia patella, left knee
S83.421A	Sprain of lateral collateral ligament of right knee, initial encounter
S83.422A	Sprain of lateral collateral ligament of left knee, initial encounter
S83.411A	Sprain of medial collateral ligament of right knee, initial encounter
S83.412A	Sprain of medial collateral ligament of left knee, initial encounter
S83.511A	Sprain of anterior cruciate ligament of right knee, initial encounter
S83.512A	Sprain of anterior cruciate ligament of left knee, initial encounte
S83.521A	Sprain of posterior cruciate ligament of right knee, initial encounter
S83.522A	Sprain of posterior cruciate ligament of left knee, initial encounter
S83.61XA	Sprain of the superior tibiofibular joint and ligament, right knee, initial encounter
S83.62XA	Sprain of the superior tibiofibular joint and ligament, left knee, initial encounter
S83.8X1A	Sprain of other specified parts of right knee
S83.8X2A	Sprain of other specified parts of left knee
S86.111A	Strain of other muscle(s) and tendon(s) of posterior muscle group at lower leg level, right leg
S86.112A	Strain of other muscle(s) and tendon(s) of posterior muscle group at lower leg level, left leg,
S86.211A	Strain of muscle(s) and tendon(s) of anterior muscle group at lower leg level, right leg,
S86.212A	Strain of muscle(s) and tendon(s) of anterior muscle group at lower leg level, left leg,
M65.861	Other synovitis and tenosynovitis, right lower leg
M65.862	Other synovitis and tenosynovitis, left lower leg

	Ankle & Foot
M99.06	Segmental and somatic dysfunction, lower extremity
M99.16	Subluxation complex (vertebral), lower extremity
M25.571	Pain in unspecified ankle and joints of right foot
M25.572	Pain in unspecified ankle and joints of left foot
M76.61	Achilles tendinitis, right leg
M76.62	Achilles tendinitis, left leg
M72.2	Plantar fascial fibramatosis (plantar fasciitis)
M76.811	Anterior tibial syndrome, right leg (tibialis tendinitis)
M76.812	Anterior tibial syndrome, left leg (tibialis tendinitis)
M76.821	Posterior tibial tendinitis, right leg (tibialis tendinitis)
M76.822	Posterior tibial tendinitis, left leg (tibialis tendinitis)
S93.421A	Sprain of deltoid ligament of right ankle, initial encounter
S93.422A	Sprain of deltoid ligament of left ankle, initial encounter
S93.411A	Sprain of calcaneofibular ligament of right ankle, initial encounter
S93.412A	Sprain of calcaneofibular ligament of left ankle, initial encounter
S93.431A	Sprain of tibiofibular ligament of right ankle, initial encounter
S93.432A	Sprain of tibiofibular ligament of left ankle, initial encounter
S93.491A	Sprain of other ligament of right ankle, initial encounter
S93.492A	Sprain of other ligament of left ankle, initial encounter
S96.811A	Strain of other specified muscles and tendons at ankle and foot level, right foot
S96.812A	Strain of other specified muscles and tendons at ankle and foot level, left foot
S86.011A	Strain of right Achilles tendon, initial encounter

S86.012A	Strain of left Achilles tendon, initial encounter
G57.51	Tarsal tunnel syndrome, right lower limb
G57.52	Tarsal tunnel syndrome, left lower limb
G57.53	Tarsal tunnel syndrome, bilateral lower limb
G57.61	Lesion of plantar nerve, right lower limb
G57.62	Lesion of plantar nerve, left lower limb
G57.63	Lesion of plantar nerve, bilateral lower limb
M65.871	Other synovitis and tenosynovitis, right ankle and foot
M65.872	Other synovitis and tenosynovitis, left ankle and foot
M65.971	Unspecified synovitis and tenosynovitis, right ankle and foot (new 10-1-2024)
M65.972	Unspecified synovitis and tenosynovitis, left ankle and foot (new 10-1-2024)

Medicare Administrative Carriers MAC



Noridian MAC

Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, North Dakota, Oregon, South Dakota, Washington, Utah, & Wyoming

M99.00-M99.05

M99.10-M9915

Novitas MAC

Arkansas, Colorado Delaware, District of Columbia, Louisiana, Maryland, Mississippi, New Jersey, New Mexico, Pennsylvania, Oklahoma, & Texas (includes Indian Health and Veterans Affairs)

M99.00-M99.05

M99.10-M9915

First Coast MAC

Florida, Puerto Rico, & U.S. Virgin Islands

M99.00-M99.05

M99.10-M9915

CAHABA MAC & Palmetto MAC

Alabama, Georgia and Tennessee

North Carolina, Railroad, South Carolina, Virginia, & West Virginia

M99.01 to M99.05 only

Wisconsin Physician Services (WPS) MAC

Indiana, Iowa, Kansas, Michigan, Missouri, & Nebraska

M99.00 to M99.05

National Government Services NGS

Connecticut, Illinois, Maine, Massachusetts, Minnesota, New Hampshire, New York, Rhode Island Vermont & Wisconsin

M99.01 to M99.05

CGS Celerian Group Company

Kentucky and Ohio

M99.01 to M99.05

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.	**The following diagnoses are published by The following Medicare Administrative carriers but not publish lists currently but they will follow the same protocol of primary subluxation with a secondary neuromusculoskeletal diagnosis**
WPS MEDICARE	Indiana, Iowa, Kansas, Michigan, Missouri, & Nebraska
ICD-10-CM CODE	**DESCRIPTION**
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

SHORT-TERM TREATMENT

G43.009	Migraine without aura, not intractable, without status migrainosus
G43.019	Migraine without aura, intractable, without status migrainosus
G43.109	Migraine with aura, not intractable, without status migrainosus
G43.119	Migraine with aura, intractable, without status migrainosus
G43.A0	Cyclical vomiting, in migraine, not intractable
G43.A1	Cyclical vomiting, in migraine, intractable
G43.B0	Ophthalmoplegic migraine, not intractable
G43.B1	Ophthalmoplegic migraine, intractable
G43.C0	Periodic headache syndromes in child or adult, not intractable
G43.C1	Periodic headache syndromes in child or adult, intractable
G43.D0	Abdominal migraine, not intractable
G43.D1	Abdominal migraine, intractable
G43.909	Migraine, unspecified, not intractable, without status migrainosus
G43.919	Migraine, unspecified, intractable, without status migrainosus
G44.1	Vascular headache, not elsewhere classified
G44.209	Tension-type headache, unspecified, not intractable
M47.24	Other spondylosis with radiculopathy, thoracic region
M47.25	Other spondylosis with radiculopathy, thoracolumbar region

M47.26	Other spondylosis with radiculopathy, lumbar region
M47.27	Other spondylosis with radiculopathy, lumbosacral region
M47.28	Other spondylosis with radiculopathy, sacral and sacrococcygeal region
M47.811	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M48.11	Ankylosing hyperostosis [Forestier], occipito-atlanto-axial region
M48.12	Ankylosing hyperostosis [Forestier], cervical region
M48.13	Ankylosing hyperostosis [Forestier], cervicothoracic region
M48.14	Ankylosing hyperostosis [Forestier], thoracic region
M48.15	Ankylosing hyperostosis [Forestier], thoracolumbar region
M48.16	Ankylosing hyperostosis [Forestier], lumbar region
M48.17	Ankylosing hyperostosis [Forestier], lumbosacral region
M48.18	Ankylosing hyperostosis [Forestier], sacral and sacrococcygeal region
M48.19	Ankylosing hyperostosis [Forestier], multiple sites in spine
M54.2	Cervicalgia
M54.50	Low back pain, unspecified
M54.51	Vertebrogenic low back pain
M54.59	Other low back pain
M54.6	Pain in thoracic spine
M62.49	Contracture of muscle, multiple sites
M62.838	Other muscle spasm
R51.0	Headache with orthostatic component, not elsewhere classified
R51.9	Headache, unspecified
G43.009	Migraine without aura, not intractable, without status migrainosus

Moderate-Term Treatment

G54.0	Brachial plexus disorders
G54.1	Lumbosacral plexus disorders
G54.2	Cervical root disorders, not elsewhere classified
G54.3	Thoracic root disorders, not elsewhere classified
G54.4	Lumbosacral root disorders, not elsewhere classified
G54.8	Other nerve root and plexus disorders
G55	Nerve root and plexus compressions in diseases classified elsewhere

G57.01	Lesion of sciatic nerve, right lower limb
G57.02	Lesion of sciatic nerve, left lower limb
G57.03	Lesion of sciatic nerve, bilateral lower limbs
G57.21	Lesion of femoral nerve, right lower limb
G57.22	Lesion of femoral nerve, left lower limb
G57.23	Lesion of femoral nerve, bilateral lower limbs
G57.91	Unspecified mononeuropathy of right lower limb
G57.92	Unspecified mononeuropathy of left lower limb
G57.93	Unspecified mononeuropathy of bilateral lower limbs
M12.311	Palindromic rheumatism, right shoulder
M12.312	Palindromic rheumatism, left shoulder
M12.351	Palindromic rheumatism, right hip
M12.352	Palindromic rheumatism, left hip
M12.361	Palindromic rheumatism, right knee
M12.362	Palindromic rheumatism, left knee
M12.371	Palindromic rheumatism, right ankle and foot
M12.372	Palindromic rheumatism, left ankle and foot
M12.38	Palindromic rheumatism, other specified site
M12.39	Palindromic rheumatism, multiple sites
M12.411	Intermittent hydrarthrosis, right shoulder
M12.412	Intermittent hydrarthrosis, left shoulder
M12.451	Intermittent hydrarthrosis, right hip
M12.452	Intermittent hydrarthrosis, left hip
M12.461	Intermittent hydrarthrosis, right knee
M12.462	Intermittent hydrarthrosis, left knee
M12.471	Intermittent hydrarthrosis, right ankle and foot
M12.472	Intermittent hydrarthrosis, left ankle and foot
M12.48	Intermittent hydrarthrosis, other site
M12.49	Intermittent hydrarthrosis, multiple sites
M15.4	Erosive (osteo)arthritis
M15.8	Other polyosteoarthritis
M16.0	Bilateral primary osteoarthritis of hip
M16.11	Unilateral primary osteoarthritis, right hip
M16.12	Unilateral primary osteoarthritis, left hip
M25.011	Hemarthrosis, right shoulder
M25.012	Hemarthrosis, left shoulder
M25.051	Hemarthrosis, right hip
M25.052	Hemarthrosis, left hip
M25.061	Hemarthrosis, right knee
M25.062	Hemarthrosis, left knee

M43.02	Spondylolysis, cervical region
M43.03	Spondylolysis, cervicothoracic region
M43.04	Spondylolysis, thoracic region
M43.05	Spondylolysis, thoracolumbar region
M43.06	Spondylolysis, lumbar region
M43.07	Spondylolysis, lumbosacral region
M43.08	Spondylolysis, sacral and sacrococcygeal region
M43.09	Spondylolysis, multiple sites in spine
M43.11	Spondylolisthesis, occipito-atlanto-axial region
M43.12	Spondylolisthesis, cervical region
M43.13	Spondylolisthesis, cervicothoracic region
M43.14	Spondylolisthesis, thoracic region
M43.15	Spondylolisthesis, thoracolumbar region
M43.16	Spondylolisthesis, lumbar region
M43.17	Spondylolisthesis, lumbosacral region
M43.18	Spondylolisthesis, sacral and sacrococcygeal region
M43.19	Spondylolisthesis, multiple sites in spine
M43.27	Fusion of spine, lumbosacral region
M43.28	Fusion of spine, sacral and sacrococcygeal region
M43.6	Torticollis
M46.01	Spinal enthesopathy, occipito-atlanto-axial region
M46.02	Spinal enthesopathy, cervical region
M46.03	Spinal enthesopathy, cervicothoracic region
M46.04	Spinal enthesopathy, thoracic region
M46.05	Spinal enthesopathy, thoracolumbar region
M46.06	Spinal enthesopathy, lumbar region
M46.07	Spinal enthesopathy, lumbosacral region
M46.08	Spinal enthesopathy, sacral and sacrococcygeal region
M46.09	Spinal enthesopathy, multiple sites in spine
M46.41	Discitis, unspecified, occipito-atlanto-axial region
M46.42	Discitis, unspecified, cervical region
M46.43	Discitis, unspecified, cervicothoracic region
M46.44	Discitis, unspecified, thoracic region
M46.45	Discitis, unspecified, thoracolumbar region
M46.46	Discitis, unspecified, lumbar region
M46.47	Discitis, unspecified, lumbosacral region
M50.11	Cervical disc disorder with radiculopathy, high cervical region
M50.120	Mid-cervical disc disorder, unspecified level
M50.121	Cervical disc disorder at C4-C5 level with radiculopathy
M50.122	Cervical disc disorder at C5-C6 level with radiculopathy

M50.123	Cervical disc disorder at C6-C7 level with radiculopathy
M50.13	Cervical disc disorder with radiculopathy, cervicothoracic region
M50.81	Other cervical disc disorders, high cervical region
M50.820	Other cervical disc disorders, mid-cervical region, unspecified level
M50.821	Other cervical disc disorders at C4-C5 level
M50.822	Other cervical disc disorders at C5-C6 level
M50.823	Other cervical disc disorders at C6-C7 level
M50.83	Other cervical disc disorders, cervicothoracic region
M50.91	Cervical disc disorder, unspecified, high cervical region
M50.920	Unspecified cervical disc disorder, mid-cervical region, unspecified level
M50.921	Unspecified cervical disc disorder at C4-C5 level
M50.922	Unspecified cervical disc disorder at C5-C6 level
M50.923	Unspecified cervical disc disorder at C6-C7 level
M50.93	Cervical disc disorder, unspecified, cervicothoracic region
M51.14	Intervertebral disc disorders with radiculopathy, thoracic region
M51.15	Intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.84	Other intervertebral disc disorders, thoracic region
M51.85	Other intervertebral disc disorders, thoracolumbar region
M51.86	Other intervertebral disc disorders, lumbar region
M51.87	Other intervertebral disc disorders, lumbosacral region
M53.0	Cervicocranial syndrome
M53.1	Cervicobrachial syndrome
M53.2X7	Spinal instabilities, lumbosacral region
M53.2X8	Spinal instabilities, sacral and sacrococcygeal region
M53.86	Other specified dorsopathies, lumbar region
M53.87	Other specified dorsopathies, lumbosacral region
M53.88	Other specified dorsopathies, sacral and sacrococcygeal region
M54.11	Radiculopathy, occipito-atlanto-axial region
M54.12	Radiculopathy, cervical region
M54.13	Radiculopathy, cervicothoracic region
M54.14	Radiculopathy, thoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M60.811	Other myositis, right shoulder
M60.812	Other myositis, left shoulder
M60.851	Other myositis, right thigh
M60.852	Other myositis, left thigh

M60.861	Other myositis, right lower leg
M60.862	Other myositis, left lower leg
M60.871	Other myositis, right ankle and foot
M60.872	Other myositis, left ankle and foot
M60.88	Other myositis, other site
M60.89	Other myositis, multiple sites
M62.830	Muscle spasm of back
M79.11	Myalgia of mastication muscle
M79.12	Myalgia of auxiliary muscles, head and neck
M79.18	Myalgia, other site
M79.7	Fibromyalgia
Q76.2	Congenital spondylolisthesis
R26.2	Difficulty in walking, not elsewhere classified
R29.4	Clicking hip
S13.4XXA	Sprain of ligaments of cervical spine, initial encounter
S13.8XXA	Sprain of joints and ligaments of other parts of neck, initial encounter
S16.1XXA	Strain of muscle, fascia and tendon at neck level, initial encounter
S23.3XXA	Sprain of ligaments of thoracic spine, initial encounter
S23.8XXA	Sprain of other specified parts of thorax, initial encounter
S29.012A	Strain of muscle and tendon of back wall of thorax, initial encounter
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
S33.6XXA	Sprain of sacroiliac joint, initial encounter
S33.8XXA	Sprain of other parts of lumbar spine and pelvis, initial encounter
S39.012A	Strain of muscle, fascia and tendon of lower back, initial encounter
S39.013A	Strain of muscle, fascia and tendon of pelvis, initial encounter

Long-Term Treatment

M48.01	Spinal stenosis, occipito-atlanto-axial region
M48.02	Spinal stenosis, cervical region
M48.03	Spinal stenosis, cervicothoracic region
M48.04	Spinal stenosis, thoracic region
M48.05	Spinal stenosis, thoracolumbar region
M48.061	Spinal stenosis, lumbar region without neurogenic claudication
M48.062	Spinal stenosis, lumbar region with neurogenic claudication
M48.07	Spinal stenosis, lumbosacral region
M48.31	Traumatic spondylopathy, occipito-atlanto-axial region
M48.32	Traumatic spondylopathy, cervical region
M48.33	Traumatic spondylopathy, cervicothoracic region
M48.34	Traumatic spondylopathy, thoracic region

M48.35	Traumatic spondylopathy, thoracolumbar region
M48.36	Traumatic spondylopathy, lumbar region
M48.37	Traumatic spondylopathy, lumbosacral region
M48.38	Traumatic spondylopathy, sacral and sacrococcygeal region
M50.21	Other cervical disc displacement, high cervical region
M50.220	Other cervical disc displacement, mid-cervical region, unspecified level
M50.221	Other cervical disc displacement at C4-C5 level
M50.222	Other cervical disc displacement at C5-C6 level
M50.223	Other cervical disc displacement at C6-C7 level
M50.23	Other cervical disc displacement, cervicothoracic region
M50.31	Other cervical disc degeneration, high cervical region
M50.320	Other cervical disc degeneration, mid-cervical region, unspecified level
M50.321	Other cervical disc degeneration at C4-C5 level
M50.322	Other cervical disc degeneration at C5-C6 level
M50.323	Other cervical disc degeneration at C6-C7 level
M50.33	Other cervical disc degeneration, cervicothoracic region
M51.24	Other intervertebral disc displacement, thoracic region
M51.25	Other intervertebral disc displacement, thoracolumbar region
M51.26	Other intervertebral disc displacement, lumbar region
M51.27	Other intervertebral disc displacement, lumbosacral region
M51.34	Other intervertebral disc degeneration, thoracic region
M51.35	Other intervertebral disc degeneration, thoracolumbar region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M96.1	Postlaminectomy syndrome, not elsewhere classified
M99.20	Subluxation stenosis of neural canal of head region
M99.21	Subluxation stenosis of neural canal of cervical region
M99.22	Subluxation stenosis of neural canal of thoracic region
M99.23	Subluxation stenosis of neural canal of lumbar region
M99.30	Osseous stenosis of neural canal of head region
M99.31	Osseous stenosis of neural canal of cervical region
M99.32	Osseous stenosis of neural canal of thoracic region
M99.33	Osseous stenosis of neural canal of lumbar region
M99.40	Connective tissue stenosis of neural canal of head region
M99.41	Connective tissue stenosis of neural canal of cervical region
M99.42	Connective tissue stenosis of neural canal of thoracic region

M99.43	Connective tissue stenosis of neural canal of lumbar region
M99.50	Intervertebral disc stenosis of neural canal of head region
M99.51	Intervertebral disc stenosis of neural canal of cervical region
M99.52	Intervertebral disc stenosis of neural canal of thoracic region
M99.53	Intervertebral disc stenosis of neural canal of lumbar region
M99.60	Osseous and subluxation stenosis of intervertebral foramina of head region
M99.61	Osseous and subluxation stenosis of intervertebral foramina of cervical region
M99.62	Osseous and subluxation stenosis of intervertebral foramina of thoracic region
M99.63	Osseous and subluxation stenosis of intervertebral foramina of lumbar region
M99.70	Connective tissue and disc stenosis of intervertebral foramina of head region
M99.71	Connective tissue and disc stenosis of intervertebral foramina of cervical region
M99.72	Connective tissue and disc stenosis of intervertebral foramina of thoracic region
M99.73	Connective tissue and disc stenosis of intervertebral foramina of lumbar region
Q76.2	Congenital spondylolisthesis

Novitas Medicare Diagnosis

Arkansas, Colorado Delaware, District of Columbia, Louisiana, Maryland, Mississippi, New Jersey, New Mexico, Pennsylvania, Oklahoma, & Texas (includes Indian Health and Veterans Affairs)

Primary diagnosis must be category 1 segmental dysfunction and secondary must be Category A-D

Twelve (12) chiropractic manipulation treatments for **Group A diagnoses**.
Eighteen (18) chiropractic manipulation treatments for **Group B diagnoses**.
Twenty-four (24) chiropractic manipulation treatments for **Group C diagnoses**.
Thirty (30) chiropractic manipulation treatments for **Group D diagnoses**.

ICD-10 CODE	DESCRIPTION
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
M99.10	Subluxation complex (vertebral) of head region
M99.11	Subluxation complex (vertebral) of cervical region
M99.12	Subluxation complex (vertebral) of thoracic region
M99.13	Subluxation complex (vertebral) of lumbar region
M99.14	Subluxation complex (vertebral) of sacral region
M99.15	Subluxation complex (vertebral) of pelvic region

Group A Diagnoses

ICD-10 CODE	DESCRIPTION
G44.209	Tension-type headache, unspecified, not intractable
G44.86	Orthostatic Headache
M25.50	Pain in unspecified joint (specify as spine)
M54.03	Panniculitis affecting regions of neck and back, cervicothoracic region
M54.04	Panniculitis affecting regions of neck and back, thoracic region
M54.05	Panniculitis affecting regions of neck and back, thoracolumbar region
M54.06	Panniculitis affecting regions of neck and back, lumbar region
M54.07	Panniculitis affecting regions of neck and back, lumbosacral region
M54.08	Panniculitis affecting regions of neck and back, sacral and sacrococcygeal region
M54.09	Panniculitis affecting regions, neck and back, multiple sites in spine
M54.2	Cervicalgia
M54.50	Unspecified Low back pain
M54.51	Vertebrogenic low bak pain
M54.59	Other, low back pain
M54.6	Pain in thoracic spine
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified
M62.40	Contracture of muscle, unspecified site
M62.411	Contracture of muscle, right shoulder
M62.412	Contracture of muscle, left shoulder
M62.419	Contracture of muscle, unspecified shoulder
M62.421	Contracture of muscle, right upper arm
M62.422	Contracture of muscle, left upper arm
M62.429	Contracture of muscle, unspecified upper arm
M62.431	Contracture of muscle, right forearm
M62.432	Contracture of muscle, left forearm
M62.439	Contracture of muscle, unspecified forearm
M62.441	Contracture of muscle, right hand
M62.442	Contracture of muscle, left hand
M62.449	Contracture of muscle, unspecified hand
M62.451	Contracture of muscle, right thigh
M62.452	Contracture of muscle, left thigh
M62.459	Contracture of muscle, unspecified thigh
M62.461	Contracture of muscle, right lower leg
M62.462	Contracture of muscle, left lower leg
M62.469	Contracture of muscle, unspecified lower leg
M62.471	Contracture of muscle, right ankle and foot
M62.472	Contracture of muscle, left ankle and foot
M62.479	Contracture of muscle, unspecified ankle and foot
M62.48	Contracture of muscle, other site
M62.49	Contracture of muscle, multiple sites

M62.830	Muscle spasm of back
M62.831	Muscle spasm of calf
M62.838	Other muscle spasm
R51.0	Orthostatic Headache
R51.9	Headache

Group B Diagnosis

	DESCRIPTION
M46.00	Spinal enthesopathy, site unspecified
M46.01	Spinal enthesopathy, occipito-atlanto-axial region
M46.02	Spinal enthesopathy, cervical region
M46.03	Spinal enthesopathy, cervicothoracic region
M46.04	Spinal enthesopathy, thoracic region
M46.05	Spinal enthesopathy, thoracolumbar region
M46.06	Spinal enthesopathy, lumbar region
M46.07	Spinal enthesopathy, lumbosacral region
M46.08	Spinal enthesopathy, sacral and sacrococcygeal region
M46.09	Spinal enthesopathy, multiple sites in spine
M47.10	Other spondylosis with myelopathy, site unspecified
M47.11	Other spondylosis with myelopathy, occipito-atlanto-axial region
M47.12	Other spondylosis with myelopathy, cervical region
M47.13	Other spondylosis with myelopathy, cervicothoracic region
M47.20	Other spondylosis with radiculopathy, site unspecified
M47.21	Other spondylosis with radiculopathy, occipito-atlanto-axial region
M47.22	Other spondylosis with radiculopathy, cervical region
M47.23	Other spondylosis with radiculopathy, cervicothoracic region
M47.24	Other spondylosis with radiculopathy, thoracic region
M47.25	Other spondylosis with radiculopathy, thoracolumbar region
M47.811	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.819	Spondylosis without myelopathy or radiculopathy, site unspecified
M47.891	Other spondylosis, occipito-atlanto-axial region
M47.892	Other spondylosis, cervical region
M47.893	Other spondylosis, cervicothoracic region
M47.894	Other spondylosis, thoracic region
M47.895	Other spondylosis, thoracolumbar region
M47.899	Other spondylosis, site unspecified
M47.9	Spondylosis, unspecified

M48.10	Ankylosing hyperostosis [Forestier], site unspecified
M48.11	Ankylosing hyperostosis [Forestier], occipito-atlanto-axial region
M48.12	Ankylosing hyperostosis [Forestier], cervical region
M48.13	Ankylosing hyperostosis [Forestier], cervicothoracic region
M48.14	Ankylosing hyperostosis [Forestier], thoracic region
M48.15	Ankylosing hyperostosis [Forestier], thoracolumbar region
M48.16	Ankylosing hyperostosis [Forestier], lumbar region
M48.17	Ankylosing hyperostosis [Forestier], lumbosacral region
M48.18	Ankylosing hyperostosis [Forestier], sacral and sacrococcygeal region
M48.19	Ankylosing hyperostosis [Forestier], multiple sites in spine
M53.3	Sacrococcygeal disorders, not elsewhere classified
M60.80	Other myositis, unspecified site
M60.811	Other myositis, right shoulder
M60.812	Other myositis, left shoulder
M60.819	Other myositis, unspecified shoulder
M60.821	Other myositis, right upper arm
M60.822	Other myositis, left upper arm
M60.829	Other myositis, unspecified upper arm
M60.831	Other myositis, right forearm
M60.832	Other myositis, left forearm
M60.839	Other myositis, unspecified forearm
M60.841	Other myositis, right hand
M60.842	Other myositis, left hand
M60.849	Other myositis, unspecified hand
M60.851	Other myositis, right thigh
M60.852	Other myositis, left thigh
M60.859	Other myositis, unspecified thigh
M60.861	Other myositis, right lower leg
M60.862	Other myositis, left lower leg
M60.869	Other myositis, unspecified lower leg
M60.871	Other myositis, right ankle and foot
M60.872	Other myositis, left ankle and foot
M60.879	Other myositis, unspecified ankle and foot
M60.88	Other myositis, other site
M60.89	Other myositis, multiple sites
M60.9	Myositis, unspecified
M72.9	Fibroblastic disorder, unspecified
M79.12	Myalgia of auxiliary muscles, head and neck (new 10-1-2018)
M79.18	Myalgia, other site (new 10-1-2018)
M79.7	Fibromyalgia
S13.4XXA	Sprain of ligaments of cervical spine, initial encounter
S13.8XXA	Sprain of joints and ligaments of other parts of neck, initial encounter
S16.1XXA	Strain of muscle, fascia and tendon at neck level, initial encounter
S23.3XXA	Sprain of ligaments of thoracic spine, initial encounter

S23.8XXA	Sprain of other specified parts of thorax, initial encounter
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
S33.6XXA	Sprain of sacroiliac joint, initial encounter
S33.8XXA	Sprain of other parts of lumbar spine and pelvis, initial encounter

Group C Diagnoses

ICD-10 CODE	DESCRIPTION
G54.0	Brachial plexus disorders
G54.1	Lumbosacral plexus disorders
G54.2	Cervical root disorders, not elsewhere classified
G54.3	Thoracic root disorders, not elsewhere classified
G54.4	Lumbosacral root disorders, not elsewhere classified
G54.8	Other nerve root and plexus disorders
G55	Nerve root and plexus compressions in diseases classified elsewhere
M43.6	Torticollis
M46.41	Discitis, unspecified, occipito-atlanto-axial region
M46.42	Discitis, unspecified, cervical region
M46.43	Discitis, unspecified, cervicothoracic region
M46.44	Discitis, unspecified, thoracic region
M46.45	Discitis, unspecified, thoracolumbar region
M46.46	Discitis, unspecified, lumbar region
M46.47	Discitis, unspecified, lumbosacral region
M48.01	Spinal stenosis, occipito-atlanto-axial region
M48.02	Spinal stenosis, cervical region
M48.03	Spinal stenosis, cervicothoracic region
M50.10	Cervical disc disorder with radiculopathy, unspecified cervical region
M50.11	Cervical disc disorder with radiculopathy, high cervical region
M50.121	Cervical disc disorder at C4-C5 level with radiculopathy
M50.122	Cervical disc disorder at C5-C6 level with radiculopathy
M50.123	Cervical disc disorder at C6-C7 level with radiculopathy
M50.13	Cervical disc disorder with radiculopathy, cervicothoracic region
M50.80	Other cervical disc disorders, unspecified cervical region
M50.81	Other cervical disc disorders, high cervical region
M50.821	Other cervical disc disorders at C4-C5 level
M50.822	Other cervical disc disorders at C5-C6 level
M50.823	Other cervical disc disorders at C6-C7 level
M50.83	Other cervical disc disorders, cervicothoracic region
M50.90	Cervical disc disorder, unspecified, unspecified cervical region
M50.91	Cervical disc disorder, unspecified, high cervical region
M50.921	Unspecified cervical disc disorder at C4-C5 level
M50.922	Unspecified cervical disc disorder at C5-C6 level

M50.923	Unspecified cervical disc disorder at C6-C7 level
M50.93	Cervical disc disorder, unspecified, cervicothoracic region
M51.84	Other intervertebral disc disorders, thoracic region
M51.85	Other intervertebral disc disorders, thoracolumbar region
M51.86	Other intervertebral disc disorders, lumbar region
M51.87	Other intervertebral disc disorders, lumbosacral region
M53.0	Cervicocranial syndrome
M53.1	Cervicobrachial syndrome
M54.11	Radiculopathy, occipito-atlanto-axial region
M54.12	Radiculopathy, cervical region
M54.13	Radiculopathy, cervicothoracic region
M99.20	Subluxation stenosis of neural canal of head region
M99.21	Subluxation stenosis of neural canal of cervical region
M99.30	Osseous stenosis of neural canal of head region
M99.31	Osseous stenosis of neural canal of cervical region
M99.40	Connective tissue stenosis of neural canal of head region
M99.41	Connective tissue stenosis of neural canal of cervical region
M99.50	Intervertebral disc stenosis of neural canal of head region
M99.51	Intervertebral disc stenosis of neural canal of cervical region
M99.60	Osseous and subluxation stenosis of intervertebral foramina of head region
M99.61	Osseous and subluxation stenosis of intervertebral foramina of cervical region
M99.70	Connective tissue and disc stenosis of intervertebral foramina of head region
M99.71	Connective tissue and disc stenosis of intervertebral foramina of cervical region

Group D Diagnoses

ICD-10 CODE	DESCRIPTION
M43.00	Spondylolysis, site unspecified
M43.01	Spondylolysis, occipito-atlanto-axial region
M43.02	Spondylolysis, cervical region
M43.03	Spondylolysis, cervicothoracic region
M43.04	Spondylolysis, thoracic region
M43.05	Spondylolysis, thoracolumbar region
M43.06	Spondylolysis, lumbar region
M43.07	Spondylolysis, lumbosacral region
M43.08	Spondylolysis, sacral and sacrococcygeal region
M43.09	Spondylolysis, multiple sites in spine
M43.10	Spondylolisthesis, site unspecified
M43.11	Spondylolisthesis, occipito-atlanto-axial region
M43.12	Spondylolisthesis, cervical region
M43.13	Spondylolisthesis, cervicothoracic region
M43.14	Spondylolisthesis, thoracic region
M43.15	Spondylolisthesis, thoracolumbar region
M43.16	Spondylolisthesis, lumbar region

M43.17	Spondylolisthesis, lumbosacral region
M43.18	Spondylolisthesis, sacral and sacrococcygeal region
M43.19	Spondylolisthesis, multiple sites in spine
M43.27	Fusion of spine, lumbosacral region
M43.28	Fusion of spine, sacral and sacrococcygeal region
M47.14	Other spondylosis with myelopathy, thoracic region
M47.15	Other spondylosis with myelopathy, thoracolumbar region
M47.16	Other spondylosis with myelopathy, lumbar region
M47.26	Other spondylosis with radiculopathy, lumbar region
M47.27	Other spondylosis with radiculopathy, lumbosacral region
M47.28	Other spondylosis with radiculopathy, sacral and sacrococcygeal region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M47.896	Other spondylosis, lumbar region
M47.897	Other spondylosis, lumbosacral region
M47.898	Other spondylosis, sacral and sacrococcygeal region
M48.04	Spinal stenosis, thoracic region
M48.05	Spinal stenosis, thoracolumbar region
M48.061	Spinal stenosis, lumbar region without neurogenic claudication
M48.062	Spinal stenosis, lumbar region with neurogenic claudication
M48.07	Spinal stenosis, lumbosacral region
M48.30	Traumatic spondylopathy, site unspecified
M48.31	Traumatic spondylopathy, occipito-atlanto-axial region
M48.32	Traumatic spondylopathy, cervical region
M48.33	Traumatic spondylopathy, cervicothoracic region
M48.34	Traumatic spondylopathy, thoracic region
M48.35	Traumatic spondylopathy, thoracolumbar region
M48.36	Traumatic spondylopathy, lumbar region
M48.37	Traumatic spondylopathy, lumbosacral region
M48.38	Traumatic spondylopathy, sacral and sacrococcygeal region
M50.20	Other cervical disc displacement, unspecified cervical region
M50.21	Other cervical disc displacement, high cervical region
M50.221	Other cervical disc displacement at C4-C5 level
M50.222	Other cervical disc displacement at C5-C6 level
M50.223	Other cervical disc displacement at C6-C7 level
M50.23	Other cervical disc displacement, cervicothoracic region
M50.30	Other cervical disc degeneration, unspecified cervical region
M50.31	Other cervical disc degeneration, high cervical region
M50.321	Other cervical disc degeneration at C4-C5 level
M50.322	Other cervical disc degeneration at C5-C6 level
M50.323	Other cervical disc degeneration at C6-C7 level
M50.33	Other cervical disc degeneration, cervicothoracic region
M51.14	Intervertebral disc disorders with radiculopathy, thoracic region

M51.15	Intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.24	Other intervertebral disc displacement, thoracic region
M51.25	Other intervertebral disc displacement, thoracolumbar region
M51.26	Other intervertebral disc displacement, lumbar region
M51.27	Other intervertebral disc displacement, lumbosacral region
M51.34	Other intervertebral disc degeneration, thoracic region
M51.35	Other intervertebral disc degeneration, thoracolumbar region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M53.2X7	Spinal instabilities, lumbosacral region
M53.2X8	Spinal instabilities, sacral and sacrococcygeal region
M53.3	Sacrococcygeal disorders, not elsewhere classified
M53.86	Other specified dorsopathies, lumbar region
M53.87	Other specified dorsopathies, lumbosacral region
M53.88	Other specified dorsopathies, sacral and sacrococcygeal region
M54.14	Radiculopathy, thoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.30	Sciatica, unspecified side
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.40	Lumbago with sciatica, unspecified side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M96.1	Postlaminectomy syndrome, not elsewhere classified
M99.12	Subluxation complex (vertebral) of thoracic region
M99.13	Subluxation complex (vertebral) of lumbar region
M99.14	Subluxation complex (vertebral) of sacral region
M99.22	Subluxation stenosis of neural canal of thoracic region
M99.23	Subluxation stenosis of neural canal of lumbar region
M99.32	Osseous stenosis of neural canal of thoracic region
M99.33	Osseous stenosis of neural canal of lumbar region
M99.42	Connective tissue stenosis of neural canal of thoracic region
M99.43	Connective tissue stenosis of neural canal of lumbar region
M99.52	Intervertebral disc stenosis of neural canal of thoracic region
M99.53	Intervertebral disc stenosis of neural canal of lumbar region
M99.62	Osseous and subluxation stenosis of intervertebral foramina of thoracic region
M99.63	Osseous and subluxation stenosis of intervertebral foramina of lumbar region
M99.72	Connective tissue and disc stenosis of intervertebral foramina of thoracic region
M99.73	Connective tissue and disc stenosis of intervertebral foramina of lumbar region
Q76.2	Congenital spondylolisthesis

S13.100A	Subluxation of unspecified cervical vertebrae, initial encounter
S13.101A	Dislocation of unspecified cervical vertebrae, initial encounter
S13.110A	Subluxation of C0/C1 cervical vertebrae, initial encounter
S13.111A	Dislocation of C0/C1 cervical vertebrae, initial encounter
S13.120A	Subluxation of C1/C2 cervical vertebrae, initial encounter
S13.121A	Dislocation of C1/C2 cervical vertebrae, initial encounter
S13.130A	Subluxation of C2/C3 cervical vertebrae, initial encounter
S13.131A	Dislocation of C2/C3 cervical vertebrae, initial encounter
S13.140A	Subluxation of C3/C4 cervical vertebrae, initial encounter
S13.141A	Dislocation of C3/C4 cervical vertebrae, initial encounter
S13.150A	Subluxation of C4/C5 cervical vertebrae, initial encounter
S13.151A	Dislocation of C4/C5 cervical vertebrae, initial encounter
S13.160A	Subluxation of C5/C6 cervical vertebrae, initial encounter
S13.161A	Dislocation of C5/C6 cervical vertebrae, initial encounter
S13.170A	Subluxation of C6/C7 cervical vertebrae, initial encounter
S13.171A	Dislocation of C6/C7 cervical vertebrae, initial encounter
S13.180A	Subluxation of C7/T1 cervical vertebrae, initial encounter
S13.181A	Dislocation of C7/T1 cervical vertebrae, initial encounter
S14.2XXA	Injury of nerve root of cervical spine, initial encounter
S14.3XXA	Injury of brachial plexus, initial encounter
S23.0XXA	Traumatic rupture of thoracic intervertebral disc, initial encounter
S23.100A	Subluxation of unspecified thoracic vertebra, initial encounter
S23.101A	Dislocation of unspecified thoracic vertebra, initial encounter
S23.110A	Subluxation of T1/T2 thoracic vertebra, initial encounter
S23.111A	Dislocation of T1/T2 thoracic vertebra, initial encounter
S23.120A	Subluxation of T2/T3 thoracic vertebra, initial encounter
S23.121A	Dislocation of T2/T3 thoracic vertebra, initial encounter
S23.122A	Subluxation of T3/T4 thoracic vertebra, initial encounter
S23.123A	Dislocation of T3/T4 thoracic vertebra, initial encounter
S23.130A	Subluxation of T4/T5 thoracic vertebra, initial encounter
S23.131A	Dislocation of T4/T5 thoracic vertebra, initial encounter
S23.132A	Subluxation of T5/T6 thoracic vertebra, initial encounter
S23.133A	Dislocation of T5/T6 thoracic vertebra, initial encounter
S23.140A	Subluxation of T6/T7 thoracic vertebra, initial encounter
S23.141A	Dislocation of T6/T7 thoracic vertebra, initial encounter
S23.142A	Subluxation of T7/T8 thoracic vertebra, initial encounter
S23.143A	Dislocation of T7/T8 thoracic vertebra, initial encounter
S23.150A	Subluxation of T8/T9 thoracic vertebra, initial encounter
S23.151A	Dislocation of T8/T9 thoracic vertebra, initial encounter
S23.152A	Subluxation of T9/T10 thoracic vertebra, initial encounter
S23.153A	Dislocation of T9/T10 thoracic vertebra, initial encounter
S23.160A	Subluxation of T10/T11 thoracic vertebra, initial encounter
S23.161A	Dislocation of T10/T11 thoracic vertebra, initial encounter
S23.162A	Subluxation of T11/T12 thoracic vertebra, initial encounter

S23.163A	Dislocation of T11/T12 thoracic vertebra, initial encounter
S23.170A	Subluxation of T12/L1 thoracic vertebra, initial encounter
S23.171A	Dislocation of T12/L1 thoracic vertebra, initial encounter
S24.2XXA	Injury of nerve root of thoracic spine, initial encounter
S33.0XXA	Traumatic rupture of lumbar intervertebral disc, initial encounter
S33.100A	Subluxation of unspecified lumbar vertebra, initial encounter
S33.101A	Dislocation of unspecified lumbar vertebra, initial encounter
S33.110A	Subluxation of L1/L2 lumbar vertebra, initial encounter
S33.111A	Dislocation of L1/L2 lumbar vertebra, initial encounter
S33.120A	Subluxation of L2/L3 lumbar vertebra, initial encounter
S33.121A	Dislocation of L2/L3 lumbar vertebra, initial encounter
S33.130A	Subluxation of L3/L4 lumbar vertebra, initial encounter
S33.131A	Dislocation of L3/L4 lumbar vertebra, initial encounter
S33.140A	Subluxation of L4/L5 lumbar vertebra, initial encounter
S33.141A	Dislocation of L4/L5 lumbar vertebra, initial encounter
S33.2XXA	Dislocation of sacroiliac and sacrococcygeal joint, initial encounter
S34.21XA	Injury of nerve root of lumbar spine, initial encounter
S34.22XA	Injury of nerve root of sacral spine, initial encounter
S34.4XXA	Injury of lumbosacral plexus, initial encounter

Noridian Medicare

Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, North Dakota, Oregon, South Dakota, Washington, Utah, & Wyoming

	Primary Subluxation Diagnosis
M99.00	Segmental somatic dysfunction head region (occipital)
M99.01	Segmental somatic dysfunction cervical region
M99.02	Segmental somatic dysfunction thoracic region
M99.03	Segmental and somatic dysfunction, lumbar region
M99.04	Segmental and somatic dysfunction, sacral region
M99.05	Segmental and somatic dysfunction, pelvic region
M99.10	Subluxation complex (vertebral) of head region
M99.11	Subluxation complex (vertebral) of cervical region
M99.12	Subluxation complex (vertebral) of thoracic region
M99.13	Subluxation complex (vertebral) of Lumbar region
M99.14	Subluxation complex (vertebral) of sacral region
M99.15	Subluxation complex (vertebral) of pelvic region

G44.1	Vascular headache, not elsewhere classified
G44.209	Tension-type headache, unspecified, not intractable
G44.219	Episodic tension-type headache, not intractable
G44.229	Chronic tension-type headache, not intractable
M24.50	Contracture, unspecified joint
M47.10	Other spondylosis with myelopathy, site unspecified
M47.21	Other spondylosis with radiculopathy, occipito-atlanto-axial region
M47.22	Other spondylosis with radiculopathy, cervical region
M47.23	Other spondylosis with radiculopathy, cervicothoracic region
M47.24	Other spondylosis with radiculopathy, thoracic region
M47.25	Other spondylosis with radiculopathy, thoracolumbar region
M47.26	Other spondylosis with radiculopathy, lumbar region
M47.27	Other spondylosis with radiculopathy, lumbosacral region
M47.28	Other spondylosis with radiculopathy, sacral and sacrococcygeal region
M47.811	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M47.819	Spondylosis without myelopathy or radiculopathy, site unspecified
M47.891	Other spondylosis, occipito-atlanto-axial region
M47.892	Other spondylosis, cervical region
M47.893	Other spondylosis, cervicothoracic region
M47.894	Other spondylosis, thoracic region
M47.895	Other spondylosis, thoracolumbar region
M47.896	Other spondylosis, lumbar region
M47.897	Other spondylosis, lumbosacral region
M47.898	Other spondylosis, sacral and sacrococcygeal region
M48.10	Ankylosing hyperostosis [Forestier], site unspecified
M48.11	Ankylosing hyperostosis [Forestier], occipito-atlanto-axial region
M48.12	Ankylosing hyperostosis [Forestier], cervical region
M48.13	Ankylosing hyperostosis [Forestier], cervicothoracic region
M48.14	Ankylosing hyperostosis [Forestier], thoracic region
M48.15	Ankylosing hyperostosis [Forestier], thoracolumbar region
M48.16	Ankylosing hyperostosis [Forestier], lumbar region
M48.17	Ankylosing hyperostosis [Forestier], lumbosacral region
M48.18	Ankylosing hyperostosis [Forestier], sacral and sacrococcygeal region
M48.19	Ankylosing hyperostosis [Forestier], multiple sites in spine
M54.2	Cervicalgia

M54.50	Low back pain, unspecified
M54.51	Vertebrogenic low back pain
M54.59	Other Low back pain
M54.6	Pain in thoracic spine
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified
R51.0	Orthostatic Headache
R51.9	Headache

Category II Generally requires moderate term treatment

G54.0	Brachial plexus disorders
G54.1	Lumbosacral plexus disorders
G54.2	Cervical root disorders, not elsewhere classified
G54.3	Thoracic root disorders, not elsewhere classified
G54.4	Lumbosacral root disorders, not elsewhere classified
G54.8	Other nerve root and plexus disorders
G55	Nerve root and plexus compressions in diseases classified elsewhere
M25.50	Pain in unspecified joint (specify spine)
M43.01	Spondylolysis, occipito-atlanto-axial region
M43.02	Spondylolysis, cervical region
M43.03	Spondylolysis, cervicothoracic region
M43.04	Spondylolysis, thoracic region
M43.05	Spondylolysis, thoracolumbar region
M43.06	Spondylolysis, lumbar region
M43.07	Spondylolysis, lumbosacral region
M43.08	Spondylolysis, sacral and sacrococcygeal region
M43.09	Spondylolysis, multiple sites in spine
M43.11	Spondylolisthesis, occipito-atlanto-axial region
M43.12	Spondylolisthesis, cervical region
M43.13	Spondylolisthesis, cervicothoracic region
M43.14	Spondylolisthesis, thoracic region
M43.15	Spondylolisthesis, thoracolumbar region
M43.16	Spondylolisthesis, lumbar region
M43.17	Spondylolisthesis, lumbosacral region
M43.18	Spondylolisthesis, sacral and sacrococcygeal region
M43.19	Spondylolisthesis, multiple sites in spine
M43.27	Fusion of spine, lumbosacral region
M43.28	Fusion of spine, sacral and sacrococcygeal region
M43.6	Torticollis
M46.01	Spinal enthesopathy, occipito-atlanto-axial region
M46.02	Spinal enthesopathy, cervical region
M46.03	Spinal enthesopathy, cervicothoracic region
M46.04	Spinal enthesopathy, thoracic region
M46.05	Spinal enthesopathy, thoracolumbar region

M46.06	Spinal enthesopathy, lumbar region
M46.07	Spinal enthesopathy, lumbosacral region
M46.08	Spinal enthesopathy, sacral and sacrococcygeal region
M46.09	Spinal enthesopathy, multiple sites in spine
M48.01	Spinal stenosis, occipito-atlanto-axial region
M48.02	Spinal stenosis, cervical region
M48.03	Spinal stenosis, cervicothoracic region
M48.04	Spinal stenosis, thoracic region
M48.05	Spinal stenosis, thoracolumbar region
M48.061	Spinal stenosis, lumbar region without neurogenic claudication
M48.062	Spinal stenosis, lumbar region with neurogenic claudication
M48.07	Spinal stenosis, lumbosacral region
M50.11	Cervical disc disorder with radiculopathy, high cervical region C2-3 C3-4
M50.120	Mid-cervical disc disorder, unspecified
M50.121	Cervical disc disorder at C4-C5 level with radiculopathy
M50.122	Cervical disc disorder at C5-C6 level with radiculopathy
M50.123	Cervical disc disorder at C6-C7 level with radiculopathy
M50.13	Cervical disc disorder with radiculopathy, cervicothoracic region
M50.820	Other cervical disc disorders, mid-cervical region, unspecified level
M50.821	Other cervical disc disorders at C4-C5 level
M50.822	Other cervical disc disorders at C5-C6 level
M50.823	Other cervical disc disorders at C6-C7 level
M50.83	Other cervical disc disorders, cervicothoracic region
M50.90	Cervical disc disorder, unspecified, unspecified cervical region
M50.91	Cervical disc disorder, unspecified, high cervical region C2-3 C3-4
M50.920	Unspecified cervical disc disorder, mid-cervical region, unspecified level
M50.921	Unspecified cervical disc disorder at C4-C5 level
M50.922	Unspecified cervical disc disorder at C5-C6 level
M50.923	Unspecified cervical disc disorder at C6-C7 level
M50.93	Cervical disc disorder, unspecified, cervicothoracic region
M51.14	Intervertebral disc disorders with radiculopathy, thoracic region
M51.15	Intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.84	Other intervertebral disc disorders, thoracic region
M51.85	Other intervertebral disc disorders, thoracolumbar region
M51.86	Other intervertebral disc disorders, lumbar region
M51.87	Other intervertebral disc disorders, lumbosacral region
M53.0	Cervicocranial syndrome
M53.1	Cervicobrachial syndrome
M53.2X7	Spinal instabilities, lumbosacral region
M53.2X8	Spinal instabilities, sacral and sacrococcygeal region
M53.3	Sacrococcygeal disorders, not elsewhere classified
M53.86	Other specified dorsopathies, lumbar region
M53.87	Other specified dorsopathies, lumbosacral region

M53.88	Other specified dorsopathies, sacral and sacrococcygeal region
M54.11	Radiculopathy, occipito-atlanto-axial region
M54.12	Radiculopathy, cervical region
M54.13	Radiculopathy, cervicothoracic region
M54.14	Radiculopathy, thoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M60.811	Other myositis, right shoulder
M60.812	Other myositis, left shoulder
M60.821	Other myositis, right upper arm
M60.822	Other myositis, left upper arm
M60.831	Other myositis, right forearm
M60.832	Other myositis, left forearm
M60.841	Other myositis, right hand
M60.842	Other myositis, left hand
M60.851	Other myositis, right thigh
M60.852	Other myositis, left thigh
M60.861	Other myositis, right lower leg
M60.862	Other myositis, left lower leg
M60.871	Other myositis, right ankle and foot
M60.872	Other myositis, left ankle and foot
M60.89	Other myositis, multiple sites
M60.9	Myositis, unspecified
M62.830	Muscle spasm of back
M79.12	Myalgia auxiliary muscles of head and neck
M79.18	Myalgia, other region
M79.7	Fibromyalgia
M99.20	Subluxation stenosis of neural canal of head region
M99.21	Subluxation stenosis of neural canal of cervical region
M99.22	Subluxation stenosis of neural canal of thoracic region
M99.23	Subluxation stenosis of neural canal of lumbar region
M99.30	Osseous stenosis of neural canal of head region
M99.31	Osseous stenosis of neural canal of cervical region
M99.32	Osseous stenosis of neural canal of thoracic region
M99.33	Osseous stenosis of neural canal of lumbar region
M99.40	Connective tissue stenosis of neural canal of head region
M99.41	Connective tissue stenosis of neural canal of cervical region
M99.42	Connective tissue stenosis of neural canal of thoracic region
M99.43	Connective tissue stenosis of neural canal of lumbar region
M99.50	Intervertebral disc stenosis of neural canal of head region
M99.51	Intervertebral disc stenosis of neural canal of cervical region
M99.52	Intervertebral disc stenosis of neural canal of thoracic region
M99.53	Intervertebral disc stenosis of neural canal of lumbar region
M99.60	Osseous and subluxation stenosis of intervertebral foramina of head region

M99.61	Osseous and subluxation stenosis of intervertebral foramina of cervical region
M99.62	Osseous and subluxation stenosis of intervertebral foramina of thoracic region
M99.63	Osseous and subluxation stenosis of intervertebral foramina of lumbar region
M99.70	Connective tissue and disc stenosis of intervertebral foramina of head region
M99.71	Connective tissue and disc stenosis of intervertebral foramina of cervical region
M99.72	Connective tissue and disc stenosis of intervertebral foramina of thoracic region
M99.73	Connective tissue and disc stenosis of intervertebral foramina of lumbar region
Q76.2	Congenital spondylolisthesis
S13.4XXA	Sprain of ligaments of cervical spine, initial encounter
S13.4XXD	Sprain of ligaments of cervical spine, subsequent encounter
S13.4XXS	Sprain of ligaments of cervical spine, sequelae
S13.8XXA	Sprain of joints and ligaments of other parts of neck, initial encounter
S13.8XXD	Sprain of joints and ligaments of other parts of neck, subsequent encounter
S13.8.XXS	Sprain of joints and ligaments of other parts of neck, sequelae
S16.1XXA	Strain of muscle, fascia and tendon at neck level, initial encounter
S16.1XXD	Strain of muscle, fascia and tendon at neck level, subsequent encounter
S16.1XXS	Strain of muscle, fascia and tendon at neck level, sequelae
S23.3XXA	Sprain of ligaments of thoracic spine, initial encounter
S23.3XXD	Sprain of ligaments of thoracic spine, subsequent encounter
S23.3XXS	Sprain of ligaments of thoracic spine, sequelae
S23.8XXA	Sprain of other specified parts of thorax, initial encounter
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
S33.5XXD	Sprain of ligaments of lumbar spine, subsequent encounter
S33.5XXS	Sprain of ligaments of lumbar spine, sequelae
S33.6XXA	Sprain of sacroiliac joint, initial encounter
S33.6XXD	Sprain of sacroiliac joint, subsequent encounter
S33.6XXS	Sprain of sacroiliac joint, sequelae
S33.8XXA	Sprain of other parts of lumbar spine and pelvis, initial encounter
S33.8XXD	Sprain of other parts of lumbar spine and pelvis, subsequent encounter
S33.8XXS	Sprain of other parts of lumbar spine and pelvis, sequelae
S39.012A	Strain of muscle, tendon, fascia of lower back, initial encounter
S39.012D	Strain of muscle, tendon, fascia of lower back, subsequent encounter
S39.012S	Strain of muscle, tendon, fascia of lower back, sequelae

Category III May require long term treatment

M48.31	Traumatic spondylopathy, occipito-atlanto-axial region
M48.32	Traumatic spondylopathy, cervical region
M48.33	Traumatic spondylopathy, cervicothoracic region
M48.34	Traumatic spondylopathy, thoracic region
M48.35	Traumatic spondylopathy, thoracolumbar region
M48.36	Traumatic spondylopathy, lumbar region

M48.37	Traumatic spondylopathy, lumbosacral region
M48.38	Traumatic spondylopathy, sacral and sacrococcygeal region
M50.20	Other cervical disc displacement, unspecified cervical region
M50.21	Other cervical disc displacement, high cervical C2-C3, C3-C4
M50.220	Other cervical disc displacement, mid-cervical region, unspecified level
M50.221	Other cervical disc displacement at C4-C5 level
M50.222	Other cervical disc displacement at C5-C6 level
M50.223	Other cervical disc displacement at C6-C7 level
M50.23	Other cervical disc displacement, cervicothoracic region
M50.30	Other cervical disc degeneration, unspecified cervical region
M50.31	Other cervical disc degeneration, high cervical region C2-3 C3-4
M50.320	Other cervical disc degeneration, mid-cervical region, unspecified level
M50.321	Other cervical disc degeneration at C4-C5 level
M50.322	Other cervical disc degeneration at C5-C6 level
M50.323	Other cervical disc degeneration at C6-C7 level
M50.33	Other cervical disc degeneration, cervicothoracic region
M51.24	Other intervertebral disc displacement, thoracic region
M51.25	Other intervertebral disc displacement, thoracolumbar region
M51.26	Other intervertebral disc displacement, lumbar region
M51.27	Other intervertebral disc displacement, lumbosacral region
M51.34	Other intervertebral disc degeneration, thoracic region
M51.35	Other intervertebral disc degeneration, thoracolumbar region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M96.1	Postlaminectomy syndrome, not elsewhere classified

Note the differences based on 0-3 years of age and 4 and up

Aetna 0107 Clinical Policy Bulletin 04/09/2024 next review 1/23/2025

This Clinical Policy Bulletin addresses chiropractic services.

Medical Necessity

A. Aetna considers chiropractic services medically necessary when *all* of the following criteria are met:

1. The member has a neuromusculoskeletal disorder; *and*
2. The medical necessity for treatment is clearly documented; *and*
3. Improvement is documented within the initial 2 weeks of chiropractic care.

If no improvement is documented within the initial 2 weeks, additional chiropractic treatment is considered not medically necessary unless the chiropractic treatment is modified.

If no improvement is documented within 30 days despite modification of chiropractic treatment, continued chiropractic treatment is considered *not* medically necessary.

Once the maximum therapeutic benefit has been achieved, continuing chiropractic care is considered not medically necessary.

B. Home-based chiropractic service is considered medically necessary in selected cases based upon the member's needs (i.e., the member must be homebound). This may be considered medically necessary in the transition of the member from hospital to home, and may be an extension of case management services.

C. Chiropractic manipulation in asymptomatic persons or in persons without an identifiable clinical condition is considered not medically necessary.

D. Chiropractic care in persons, whose condition is neither regressing nor improving, is considered not medically necessary.

Chiropractic manipulation has no proven value for treatment of idiopathic scoliosis or for treatment of scoliosis beyond early adolescence, unless the member is exhibiting pain or spasm, or some other medically necessary indications for chiropractic manipulation are present.

Aetna Chiropractic Diagnosis

ICD-10 codes covered if selection criteria are met (0-3 years of age):

G24.3	Spasmodic torticollis
G54.0 - G55	Nerve root and plexus disorders
G71.0 - G72.9	Primary disorders of muscles and other myopthies
G80.0 - G80.9	Cerebral palsy
M05.00 - M08.99	Rheumatoid arthritis and other inflammatory polyarthropathies
M40.00-M40.51, M42.00-M54.9	Deforming dorsopathies, spondylitis and other dorsopathies [excluding scoliosis]
M91.10 - M94.9	Chondropathies
Q65.00 - Q68.8	Congenital musculoskeletal deformities
Q72.70 - Q72.73, Q74.1 - Q74.2	Congenital malformations of lower limb, including pelvic girdle
Q74.0, Q74.9, Q74.89	Congenital malformations of upper limb, including shoulder girdle
Q76.0 - Q76.49	Congenital malformations of spine
Q77.0 -Q77.1 Q77.4 - Q77.5 Q77.7 - Q77.9, Q78.9	Osteochrondrodysplasia
S03.4xx+	Sprain of jaw
S13.0xx+ - S13.9xx+, S23.0xx+ - S23.9xx+, S33.0xx+ - S33.9xx+, S43.001+ - S43.92X+, S53.001+ - S53.499, S63.001+ - S63.92X+, S73.001+ - S73.199+, S83.001 - S83.92X+, S93.01X+ - S93.699+	Dislocation and sprains of joint and ligaments
S14.2xx+ - S14.9xx+, S24.2xx+ - S24.9XX+, S34.21x+ -hS34.9XX+	Injury to nerve roots, spinal plexus and other nerves
S16.1xx+	Strain of muscle, fascia and tendon at neck level
S23.41x+ - S23.429+, S33.4xx+ S33.8xx+ -S33.9xx+	Sprain of other ribs, sternum, and pelvis
S13.0xx+ - S13.9xx+, S23.0xx+ - S23.9xx+, S33.0xx+ - S33.9xx+, S43.001+ - S43.92X+, S53.001+ - S53.499, S63.001+ - S63.92X+, S73.001+ - S73.199+, S83.001 - S83.92X+,	Dislocation and sprains of joint and ligaments

S93.01X+ - S93.699+	
S14.2xx+ - S14.9xx+, S24.2xx+ - S24.9XX+, S34.21x+ -S34.9XX+ S76.811+-S786.919+ S76.911+ - S76.919+	Sprain of other ribs, sternum, and pelvis
S84.00x+ - S84.92x+ S86.001+ - S86.019+, S86.111+ - S86.119+, S86.211+ - S86.219+, S86.311+ - S86.319+, S86.811+ - S86.819+, S86.911+ - S86.919+	Injury of muscle, fascia and tendon at lower leg level
S94.00x+ - S94.92x+	Injury of nerves at ankle and foot level
S96.001+ - S96.019+, S96.111+ - S96.119+, S96.211+ - S96.219+, S96.811+ - S96.819+, S96.911+ - S96.919+	Injury of muscle, fascia and tendon at ankle and foot level

ICD-10 codes for adults and children (4 years of age and older)

G24.3	Spasmodic torticollis
G43.001 - G43.919	Migraine
G44.001 -G44.89	Tension and other headaches
G54.0 - G55	Nerve root and plexus disorders
G56.00 - G56.93	Mononeuritis of upper limb
G71.00 - G72.9	Muscular dystrophies and other myopathies
G80.0 - G80.9	Cerebral palsy
M05.00 - M08.99	Rheumatoid arthritis and other inflammatory polyarthropathies
M12.00 - M13.89	Other and unspecified arthropathies
M15.0 - M19.93	Osteoarthritis and allied disorders
M20.001 - M25.9	Other joint disorders
M26.601 - M26.69	Temporomandibular joint disorders
M35.3, M75.00 - M79.9	Rheumatism, shoulder lesions and enthesopathies [excludes back]
M40.00 - M40.51 M42.00 - M54.9	Deforming dorsopathies, spondylitis and other dorsopathies [excluding scoliosis]
M85.30 - M85.39	Osteitis condensans
M89.00 - M89.09	Algoneurodystrophy
M91.10 - M94.9	Osteochondropathies
M95.3	Acquired deformity of neck
M95.5	Acquired deformity of pelvis
M95.8	Other specified acquired deformities of musculoskeletal system
M95.9	Acquired deformities of musculoskeletal system, unspecified

M99.00 - M99.09	Segmental and somatic dysfunction [allowed by CMS]
M99.10 - M99.19	Subluxation complex (vertebral)
M99.83 - M99.84	Other acquired deformity of back or spine
Many Options	Other, multiple, and ill- defined dislocations [including vertebra]
Q65.00 - Q68.8	Congenital musculoskeletal deformities
Q74.1 - Q74.2	Congenital malformations of lower limb, including pelvic girdle
Q74.0, Q74.9, Q87.89	Congenital malformations of upper limb, including shoulder girdle
Q76.0 - Q76.49	Congenital malformations of spine
Q77.0 -Q77.1 Q77.4 - Q77.5 Q77.7 - Q77.9 Q78.9	Osteochrondrodysplasia
R51.x	Headache
S03.4xx+	Sprain of jaw
S13.0xx+ - S13.9xx+, S23.0xx+ - S23.9xx+, S33.0xx+ - S33.9xx+, S43.001+ - S43.92X+, S53.001+ - S53.499, S63.001+ - S63.92X+, S73.001+ - S73.199+, S83.001 - S83.92X+, S93.01X+ - S93.699+	Dislocation and sprains of joint and ligaments
S14.2xx+ - S14.9xx+, S24.2xx+ - S24.9XX+, S34.21x+ -hS34.9XX+	Injury to nerve roots, spinal plexus and other nerves
S16.1xx+	Strain of muscle, fascia and tendon at neck level
S23.41x+ - S23.429+, S33.4xx+ S33.8xx+ -S33.9xx+	Sprain of other ribs, sternum, and pelvis
S39.002+, S39.012+, S39.092+	Injury or strain of muscle, fascia and tendon of lower back
S44.00x+ - S44.92x+ S46.011+ - S46.019+, S46.111+ - S46.119+, S46.211+ - S46.219+, S46.311+ - S46.319+, S46.811+ - S46.819+, S46.911+ - S46.919	Injury of nerves at shoulder and upper arm level
S74.00x+ - S74.92x+	Injury of nerves at hip and thigh level
S76.011+ - S76.019+, S76.111+ - S76.119+, S76.211+ - S76.219+, S76.311+ - S76.319+,	Injury and strain of muscle, fascia and tendon at hip and thigh level

S76.811+ - S76.819+, S76.911+ - S76.919+	
S84.00x+ - S84.92x+	Injury of nerves at lower leg level
S86.001+ - S86.019+, S86.111+ - S86.119+, S86.211+ - S86.219+, S86.311+ - S86.319+, S86.811+ - S86.819+, S86.911+ -n S86.919+	Injury of muscle, fascia and tendon at lower leg level
S94.011+ - S94.019+,	
S94.111+ - S94.119+, S94.211+ - S94.219+, S94.311+ - S94.319+, S94.811+ - S94.819+, S94.911+ - S94.919+ S96.911+ - S96.919+	Injury of muscle, fascia

aetna®

P.O. BOX 14079
LEXINGTON KY 40512-4079
USA

Explanation Of Benefits

Please Retain for Future Reference

Printed: 01/10/2024
Page:

CHIROPRACTIC INC

PIN:
TIN:
Trace Number:
Trace Amount:

Patient Name: *(son)*

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
01/02/24	11	98943	1.0	60.00	22.00				22.00		22.00	0.00
01/02/24	11	98940	1.0	60.00	24.00				24.00		24.00	0.00
01/02/24	11	9714059	1.0	60.00	13.00				13.00		13.00	0.00
01/02/24	11	97014	1.0	40.00	14.40				14.40		14.40	0.00
TOTALS				**220.00**	**73.40**				**73.40**		**73.40**	**0.00**

ISSUED AMT: **NO PAY**

Remarks:

The member's plan covers services or supplies needed (medically necessary) to treat a disease or injury. To determine whether future claims meet this requirement of the member's plan, we may request additional information from you.

Future claims for this type of service may not be covered if this requirement is not met. A medical necessity determination based on the specific plan of benefits and medical records will be conducted at a specified point in time during the course of therapy for physical & occupational therapy, acupuncture, osteopathic therapy and chiropractic treatment. Depending on the member's plan of benefits, the review may occur following the 10th and 25th visit. Claims for therapy services may be subject to medical review, even if the plan has unlimited benefits, and even if the services are provided by a participating provider. Coverage of benefits is dependent upon the timely submission of records. [ICTR - 903]

For Questions Regarding This Claim P.O. BOX 14079 LEXINGTON, KY 40512-4079
CALL (888) 632-3862 FOR ASSISTANCE
Note: All inquiries should reference the ID number above for prompt response.

Total Patient Responsibility:	$73.40
Claim Payment:	$0.00

Cigna Medical Coverage Policy- Therapy Services
Chiropractic Care

Effective Date: 4/15/2024
Next Review Date: 12/15/2024

INSTRUCTIONS FOR USE

Cigna / ASH Medical Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document may differ significantly from the standard benefit plans upon which these Cigna / ASH Medical Coverage Policies are based. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Cigna / ASH Medical Coverage Policy. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Determinations in each specific instance may require consideration of:

1) the terms of the applicable benefit plan document in effect on the date of service
2) any applicable laws/regulations
3) any relevant collateral source materials including Cigna-ASH Medical Coverage Policies and
4) the specific facts of the particular situation

Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant guidelines and criteria outlined in this policy, including covered diagnosis and/or procedure code(s) outlined in the Coding Information section of this policy. Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this policy. When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under this policy will be denied as not covered.

Cigna / ASH Medical Coverage Policies relate exclusively to the administration of health benefit plans.

Cigna / ASH Medical Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines.

Some information in these Coverage Policies may not apply to all benefit plans administered by Cigna. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make benefit determinations. References to standard benefit plan language and benefit determinations do not apply to those clients.

Coverage for chiropractic care varies across plans. Refer to the customer's benefit plan document for coverage details.

When covered, chiropractic care may be subject to the terms, conditions and limitations of the applicable benefit plan's Short-Term Rehabilitative Therapy or Chiropractic Care Services benefit and schedule of copayments. A chiropractic treatment visit is defined as up to a one-hour session of treatment on any given day. Inclusive of this, each date of service is limited to a maximum of 4 timed codes.

Chiropractic care provided to treat an injury or condition that is work-related or was sustained in the workplace may require coordination of benefits (COB). Please refer to the applicable benefit plan document to determine the terms, conditions and limitations of coverage.

If coverage for chiropractic care is available, the following conditions of coverage apply.

GUIDELINES

Medically Necessary

I. **Chiropractic services are considered medically necessary when ALL of the following conditions are met:**

- The service is aimed at diagnosis, and treatment of musculoskeletal and related disorders and the effects of these on the nervous system and general health
- The service is for conditions that require the unique knowledge, skills, and judgment of a chiropractor for education and training that is part of an active skilled plan of treatment
- The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.
- The individual's condition has the potential to improve or is improving (and has not reached maximum improvement).
- Improvement is evidenced by successive objective measurements over a defined time frame.
- The services are delivered by a qualified provider of chiropractic services

II. **Upper extremity manipulation/mobilization is considered medically necessary as part of a multimodal treatment program for shoulder complaints, dysfunction, disorders and/or pain. If examination/evaluation of any other UE condition indicate restricted joint play, addition of manipulation/mobilization with standard care is reasonable.**

III. **Use of lower extremity manipulation/mobilization is considered medically necessary as part of a multimodal treatment of ankle inversion sprains. If examination/evaluation of any other LE condition indicate restricted joint play, addition of manipulation/mobilization with standard care is reasonable.**

IV. **Supportive care, also referred to as ongoing care, or long-term treatment or care, may be necessary as a treatment for individuals who have reached a maximum benefit but fail to sustain the benefit and progressively deteriorate when removed from treatment programs. The potential for the individual to develop dependency on ongoing care should be considered in treatment planning. Once a maximum benefit has been reached, continuing chiropractic care is considered not medically necessary.**

Not Medically Necessary

I. **Chiropractic services are considered not medically necessary if any of the following is determined:**

- Chiropractic services are considered maintenance /preventive:
  - Maintenance/preventive care is defined as elective healthcare that is typically long-term, by definition not therapeutically necessary, but provided at intervals (preferably regular) to prevent disease, promote health and enhance the quality of life.
  - Ongoing preventive/maintenance care may include patient education, screening procedures to identify risk, a home exercise program (HEP), and lifestyle modifications in the hope of promoting optimal health.
- The service is not aimed at diagnosis, and/or treatment of disorders of the musculoskeletal system, and the effects of these disorders on the nervous system and general health.
- The service is for conditions for which therapy would be considered routine educational, training, conditioning, or fitness. This includes treatments or activities that require only routine supervision.
- The service(s) are not expected to result in a practical improvement in the level of functioning within a reasonable and predictable period of time.

II. **The following treatments are considered not medically necessary because they are nonmedical, educational or training in nature. In addition, these treatments/programs are specifically excluded under many benefit plans:**

- back school
- vocational rehabilitation programs and any program with the primary goal of returning an individual to work
- work hardening programs

III. **Duplicative or redundant services expected to achieve the same therapeutic goal are considered not medically necessary. For example:**

- Multiple modalities procedures that have similar or overlapping physiologic effects (e.g., multiple forms of superficial or deep heating modalities)
- Same or similar rehabilitative services provided as part of an authorized therapy program through another therapy discipline.
  - When an individual receives rehabilitation from a physical therapist, occupational therapist, chiropractor or other rehabilitation professional, each practitioner should provide different treatments that reflect each discipline's unique perspective on the individual's impairments and functional deficits and not duplicate the same treatment. They must also have separate evaluations, treatment plans, and goals. When an individual receives manual therapy services from a physical therapist and chiropractic or osteopathic manipulation, the services must be documented as separate and distinct and must be justified as non-duplicative.
  - The medical necessity of neuromuscular reeducation, therapeutic exercises, and/or therapeutic activities, performed on the same day, must be documented in the medical record.

IV. **Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) for treatment of non-musculoskeletal conditions are considered not medically necessary.**

Not Covered or Reimbursable

I. **The following chiropractic service is not covered or reimbursable:**

- The treatment visit extends beyond 4 timed unit services per date of service per provider (equivalent to one hour).

Experimental, Investigational, Unproven

I. Use of any of the following treatments are considered experimental, investigational, and/or unproven:

- Cybex back system/Biodex
- Digital postural analysis
- Digital radiographic mensuration
- Dry hydrotherapy/aquamassage/hydromassage
- Dry Needling
- Elastic therapeutic tape/taping (e.g., Kinesio™ tape, KT TAPE/KT TAPE PRO™, Spidertech™ tape)
- H-WAVE ®
- Iontophoresis or phonophoresis
- MedX lumbar/cervical machines
- Microcurrent Electrical Nerve Stimulation (MENS)
- Non-invasive Interactive Neurostimulation (e.g., InterX®)
- Spinal/paraspinal ultrasound
- Surface electromyography /paraspinal electromyography
- Thermography

- When an individual receives rehabilitation from a physical therapist, occupational therapist, chiropractor or other rehabilitation professional, each practitioner should provide different treatments that reflect each discipline's unique perspective on the individual's impairments and functional deficits and not duplicate the same treatment. They must also have separate evaluations, treatment plans, and goals. When an individual receives manual therapy services from a physical therapist and chiropractic or osteopathic manipulation, the services must be documented as separate and distinct and must be justified as non-duplicative.
- The medical necessity of neuromuscular reeducation, therapeutic exercises, and/or therapeutic activities, performed on the same day, must be documented in the medical record.

Experimental, Investigational, Unproven

Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) for treatment of non-musculoskeletal conditions are considered experimental, investigational or unproven.

Use of any of the following treatments are considered experimental, investigational or unproven:

- Dry hydrotherapy/aquamassage/hydromassage
- Non-invasive Interactive Neurostimulation (e.g., InterX®)
- Microcurrent Electrical Nerve Stimulation (MENS)
- H-WAVE ®
- Elastic therapeutic tape/taping (e.g., Kinesio™ tape, KT TAPE/KT TAPE PRO™, Spidertech™ tape)
- Dry Needling
- Vertebral axial decompression therapy and devices (e.g., VAX-D, DRX, DRX2000, DRX3000, DRX5000, DRX9000, DRS, Dynapro™ DX2, Accu-SPINA™ System, IDD Therapy® [Intervertebral Differential Dynamics Therapy], Tru Tac 401, Lordex Power Traction device, Spinerx LDM)
- MedX lumbar/cervical machines
- Cybex back system/Biodex
- Digital radiographic mensuration
- Digital postural analysis
- Thermography
- Spinal/paraspinal ultrasound
- Surface electromyography /paraspinal electromyography
- Iontophoresis or phonophoresis

Massage Therapy

Massage therapy is considered NOT medically necessary when it is provided in the absence of other covered chiropractic modalities or physical therapy/occupational therapy. It must be provided as part of a multi-modal rehabilitation program.

Note: Massage therapy may be provided by several types of providers. To qualify for coverage, the provider must meet the definition of provider contained in the benefit plan. Please refer to the applicable plan language to determine benefit coverage for the rendering provider.

DESCRIPTION

Chiropractic is a health care profession that focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. Chiropractic services are used most often to treat musculoskeletal and related conditions. Chiropractic services are intended to improve, adapt or restore functions which have been impaired or permanently lost as a result of illness, injury, loss of a body part, or congenital abnormality involving goals an individual can reach in a reasonable period of time Benefits will end when treatment is no longer medically necessary and the individual stops progressing toward those goals. The specific time frames for which one would expect practical functional improvement is dependent on various

with planned procedures/modalities (frequency and duration), measurable and attainable short- and long-term goals, and anticipated duration of care. At a minimum, documentation is required for every treatment day and for each area or spinal segment treated and for each therapy performed. Each daily record should include: the date of service, the total treatment time for each date of service, and the identity of the person(s) providing the services; the type and specific location of CMT including segment(s) adjusted, subluxation listings/dynamic restrictions, direction(s) of corrective thrust(s), and specific technique(s) used; the name of each modality and/or procedure performed, the parameters for each modality (e.g., amperage/voltage, location of pads/electrodes), area of treatment, and total treatment time spent for each therapy (mandatory for timed services). Failure to properly identify and sufficiently document the parameters for each therapy on a daily progress note may result in an adverse determination (partial approval or denial).There should be a reasonable expectation that the identified goals will be met. The following are recommended:

- If conservative care is appropriate, a short course (not to extend beyond eight weeks) is warranted. If the patient demonstrates objective evidence of improvement, additional care may be appropriate.
- The provider should attempt to integrate some form of active care as early as possible. Continued use of passive care modalities may lead to patient dependency and should be avoided.
- Passive modalities may be helpful for short term relief of the acute signs of inflammation (e.g., pain, muscle spasm, swelling, loss of function). The utilization of passive modalities is not considered medically necessary once the acute phase of care is over.
- The utilization of more than 2 passive modalities per office visit is typically considered excessive and is not supported as medically necessary. Use of more than 2 modalities on each visit date should be justified in the documentation.
- These rules hold true for acute, chronic and postsurgical cases. No matter what specific treatment is chosen, it must yield identifiable, objective outcomes to establish the necessity of care.

Duplicated / Insufficient Information

(1) Entries in the medical record should be contemporaneous, individualized, appropriately comprehensive, and made in a chronological, systematic, and organized manner. Duplicated/nearly duplicated medical records (a.k.a. cloned records) are not acceptable. It is not clinically reasonable or physiologically feasible that a patient's condition will be identical on multiple encounters. (Should the findings be identical for multiple encounters, it would be expected that treatment would end because the patient is not making progress toward current goals.)

This includes, but not limited to:

- duplication of information from one treatment session to another (for the same or different patient[s]);
- duplication of information from one evaluation to another (for the same or different patient[s]).

Duplicated medical records do not meet professional standards of medical record keeping and may result in an adverse determination (partial approval or denial) of those services.

a short course of treatment (i.e., 1-6 visits per episode) may be necessary (Farabaugh, et al., 2010 [Council of Chiropractic Guidelines and Practice Parameters [CCGPP]).

The evaluation and documentation of the need for chiropractic services for exacerbation or re-injury should include detail surrounding the individuals response to previous and current modalities of treatment, response to absence of treatment, that maximum therapeutic benefit was reached and documented, analgesic pattern use, patient-centered outcome assessment tools, and any other health care services that have been used to manage symptoms (Farabaugh, et al., 2010). Clinical documentation should clearly describe the condition that requires additional treatment sessions, and that the condition is an exacerbation or re-injury.

DOCUMENTATION GUIDELINES

Evaluation

An initial evaluation service is essential to determine whether any services are medically necessary, to gather baseline data, establish a treatment plan, and develop goals based on the data. The initial evaluation is usually completed in a single session. An evaluation is needed before implementing any chiropractic treatment. Initial evaluations include an Evaluation and Management (New Patient or Established Patient E/M) service and may include, as necessary, imaging, laboratory studies, and other diagnostic tests and measures. The initial evaluation service must include: A level of clinical history, examination, and medical decision-making relevant and appropriate to the individual's complaint(s) and presentation;

- Prior functional level, if acquired condition;
- Specific standardized and non-standardized tests, assessments, and tools;
- Analytic interpretation and synthesis of all data, including imaging studies, special tests, lab reports, and/or reports/records from other healthcare providers;
- Objective, measurable, and functional descriptions of an individual's deficits using comparable and consistent methods;
- Summary of clinical reasoning and consideration of contextual factors with recommendations;
- The establishment of a working diagnosis;
- Plan of care with specific treatment techniques or activities to be used in treatment sessions that should be updated as the individual's condition changes;
- Frequency and duration of treatment (treatment dose);
- Functional, measurable, and time-framed long-term and short-term goals based on appropriate and relevant evaluation data;
- Rehabilitation prognosis and discharge plan.

Note: Appropriate range of motion (ROM) testing (CPT codes 95851- 95852), including digital wireless inclinometers or other such electronic device that measures ROM using a handheld device are integral within Evaluation/Reevaluation codes. Computerized isokinetic muscle strength and endurance testing using a machine, such as a Biodex, would be considered a physical performance test or measurement using CPT code 97750 – "Physical performance test or measurement (e.g. musculoskeletal, functional capacity), with written report, each 15 minutes."

Treatment Sessions

Chiropractic treatment can vary from Chiropractic Manipulative Therapy alone (CMT CPT codes 98940-98943) to the use of a variety of physical medicine and rehabilitation modalities and procedures depending on the patient's condition, response to care, and treatment tolerance. A chiropractic treatment session lasts up to one-hour on any given day and all services must be supported in the treatment plan and be based on an individual's medical condition. Consistent with Centers for Medicare & Medicaid Services (CMS) Local Coverage Determinations (LCDs), up to a maximum of 4 timed codes (modalities and procedures) will be allowed. Chiropractic services in excess of 60 minutes per day are generally not demonstrated to have additional medical benefit in an outpatient setting. A chiropractic treatment session may include:

- Chiropractic Manipulative Therapy (CMT). A brief evaluation of the patient's progress and response to previous treatment(s) is included in the work value of a CMT.
- Passive physical medicine modalities such as electrotherapeutic and mechanical modalities preparatory to other skilled services

- Active physical medicine procedures such as therapeutic exercise, including neuromuscular reeducation, coordination, and balance;
- Functional training in self-care and home management;
- Functional training in and modification of environments (home, work, school, or community), including biomechanics and ergonomics;
- Manual therapy techniques, including soft tissue mobilization, joint mobilization, and manual lymphatic drainage;
- Assessment, design, fabrication, application, fitting, and training in assistive technology, adaptive devices, and orthotic devices;
- Training in the use of prosthetic devices;
- Skilled reassessment of the individual's problems, plan, and goals as part of the treatment session;
- Coordination, communication, and documentation;
- Reevaluation, if there is a significant change in the individual's condition or there is as need to update and modify the treatment plan.

Documentation of treatment sessions should include at a minimum:

- Date of treatment;
- Specific treatment(s) provided that match the procedure codes billed;
- Total treatment time;
- The individual's response to treatment;
- Skilled ongoing reassessment of the individual's progress toward the goals;
- Any progress toward the goals in objective, measurable terms using consistent and comparable methods;
- Any problems or changes to the plan of care;
- Name and credentials of the treating clinician.

Progress Reports

In order to reflect that continued chiropractic services are medically necessary, intermittent progress reports must demonstrate that the individual is making functional progress. Progress reports may be in the form of an expanded treatment session note (e.g. S.O.A.P. note format) or a more formal report. Progress reports should include at a minimum:

- Start of care date;
- Time period covered by the report;
- Working diagnoses;
- Statement of the individual's functional level at the beginning of the progress report period;
- Statement of the individual's current status as compared to evaluation baseline data and the prior progress report, including objective measures of the individual's function that relate to the treatment goals;
- Changes in prognosis and why;
- Changes in plan of care and why;
- Changes in goals and why;
- Consultations with other professionals or coordination of services, if applicable;
- Signature and title of qualified professional responsible for the therapy services.

Reevaluation

The Chiropractic Manipulative Therapy (CMT) service includes a brief reevaluation of the patient's condition, as well as documentation of the patient's response to the treatment. Routine use of E/M services is not medically necessary. A reevaluation (an Established Patient E/M service) is indicated when there are new clinical findings, a rapid change in the individual's status, or failure to respond to treatment interventions. There are several routine reassessments that are not considered reevaluations. These include ongoing reassessments that are part of each skilled treatment session, progress reports, and discharge summaries.
The E/M services may include all or some of the components of the initial evaluation, such as:

- Data collection with objective measurements taken based on appropriate and relevant assessment tests and tools using comparable and consistent methods;
- Determining effectiveness of intervention(s) and whether chiropractic care is still warranted;;
- Organizing the composite of current problem areas and deciding a priority/focus of treatment;
- Identifying the appropriate intervention(s) for new or ongoing goal achievement;
- Modification of intervention(s);

- Revision in plan of care if needed;
- Correlation to meaningful change in function; and
- Updating the discharge plan as appropriate.

Standardized Tests and Measures/Functional Outcome Measures (FOMs)
Measuring outcomes is an important component of chiropractors' practice. Outcome measures are important in direct management of individual patient care and for the opportunity they provide the profession in collectively comparing care and determining effectiveness.

The use of standardized tests and measures early in an episode of care establishes the baseline status of the patient, providing a means to quantify change in the patient's functioning. Outcome measures, along with other standardized tests and measures used throughout the episode of care, as part of periodic reexamination/reevaluation, provide information about whether predicted outcomes are being realized. As the patient reaches the termination of chiropractic services and the end of the episode of care, the chiropractor measures the outcomes of the chiropractic services. Standardized outcome measures provide a common language with which to evaluate the success of chiropractic interventions, thereby providing a basis for comparing outcomes related to different intervention approaches. Measuring outcomes of care within the relevant components of function (including body functions and structures), activity, and participation, among patients with the same diagnosis, is the foundation for determining which intervention approaches comprise best clinical practice.

LITERATURE REVIEW

Chiropractic care is most often employed as a treatment for spinal conditions including low-back pain, cervical pain, and thoracic spine disorders. Chiropractic care may be used as treatment for extremity joint dysfunction and temporomandibular joint (TMJ) dysfunction. Most studies involving the long-term safety and effectiveness of spinal manipulation have been done on adult populations. Thus, no generalizations can be made regarding the long-term safety and effectiveness of spinal manipulation for other populations. Evidence in the published, peer-reviewed, scientific literature has not shown that preventive chiropractic services are effective and improve long-term clinical outcomes.

Massage Therapy
Few clinical trials have been undertaken to assess the effect of this modality alone in the treatment of specific medical conditions. Rehabilitation programs frequently combine massage therapy with one or more other treatment interventions. While there is scant literature regarding the efficacy of this treatment when used as the sole modality, massage therapy has been a part of physical therapy or chiropractic treatment plans for the management of musculoskeletal pain. As an example, for mechanical low back pain, the greatest effects of massage therapy are seen in short term relief of pain. The effects on function were less clear. These therapeutic effects tend to diminish in the longer term (Chou et al., 2016). Massage therapy was also noted as an effective treatment of acute post-operative pain (Chou et al., 2020) and chronic low back pain in the intermediate term (Skelly et al., 2018). Slight functional improvements were noted in the intermediate term for fibromyalgia using myofascial release massage (Skelly et al., 2018; Kundakci et al., 2022).

blue of california

Payment Policy

Chiropractic Care	
Original effect date:	Revision date:
04/08/2015	01/01/2023

IMPORTANT INFORMATION

Blue Shield of California payment policy may follow industry standard recommendations from various sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT) and/or other professional organizations and societies for individual provider scope of practice or other coding guidelines. The above referenced payment policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms or their electronic equivalent. This payment policy is intended to serve as a general overview and does not address every aspect of the claims reimbursement methodology. This information is intended to serve only as a general reference regarding Blue Shield's payment policy and is not intended to address every facet of a reimbursement situation. Blue Shield of California may use sound discretion in interpreting and applying this policy to health care services provided in a particular case. Furthermore, the policy does not address all payment attributes related to reimbursement for health care services provided to a member. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy such as coding methodology, industry-standard reimbursement logic, regulatory/legislative requirements, benefit design, medical and drug policies. Coverage is subject to the terms, conditions and limitation of an individual member's programs benefits.

Application

Blue Shield of California's Chiropractic Care Payment Policy will apply to professional services performed by a Chiropractor that are within her/his scope of license as defined by the State of California.

Policy

This payment policy shall apply to the following services, when allowable:

- Effective 12/01/2017, Blue Shield of California will pay the Evaluation and Management Services (99050-99499) that are within the scope of licensure, as per the updated Fee Schedule Rates.
- 100% of the Blue Shield of California published Physician Fee Schedule for radiology services within scope of licensure, except for radiology services that are subject to the Multiple Procedure Reduction for Radiology policy.

- 100% of the Blue Shield of California published Physician Fee Schedule for medical supplies within scope of licensure.
- 75% of the Blue Shield of California published Physician Fee Schedule for the initial service of: strapping[1,2], splinting, or other procedures, and 37.5% for the subsequent strapping, splinting and/or other procedures performed on a different body area on the same day within the scope of licensure.
- For Physical Therapy, Electrical Stimulation, and Chiropractic Manipulation, please refer to the Physical Medicine Payment Policy[3].

Note:

1. When the purpose of strapping or splinting is immobilization, then the strapping codes (29200, 29240, 29260, 29280, 29520, 29530, 29540, 29550, 29580, or 29799) may be appropriate; as those codes describe the use of a strap or other reinforced material applied post-fracture or other injury to immobilize the joint.
2. The strapping codes when used for Kinesiology Taping to increase mobility (for improving strength, range of motion, and coordination); are considered bundled, as they are inclusive to the therapy codes.
3. Physical Medicine Multiple Procedure Payment Reduction Payment Policy – Multiple Procedure Payment Reduction (MPPR) will apply as published for all physical therapy, electrical stimulation, and chiropractic manipulation services.

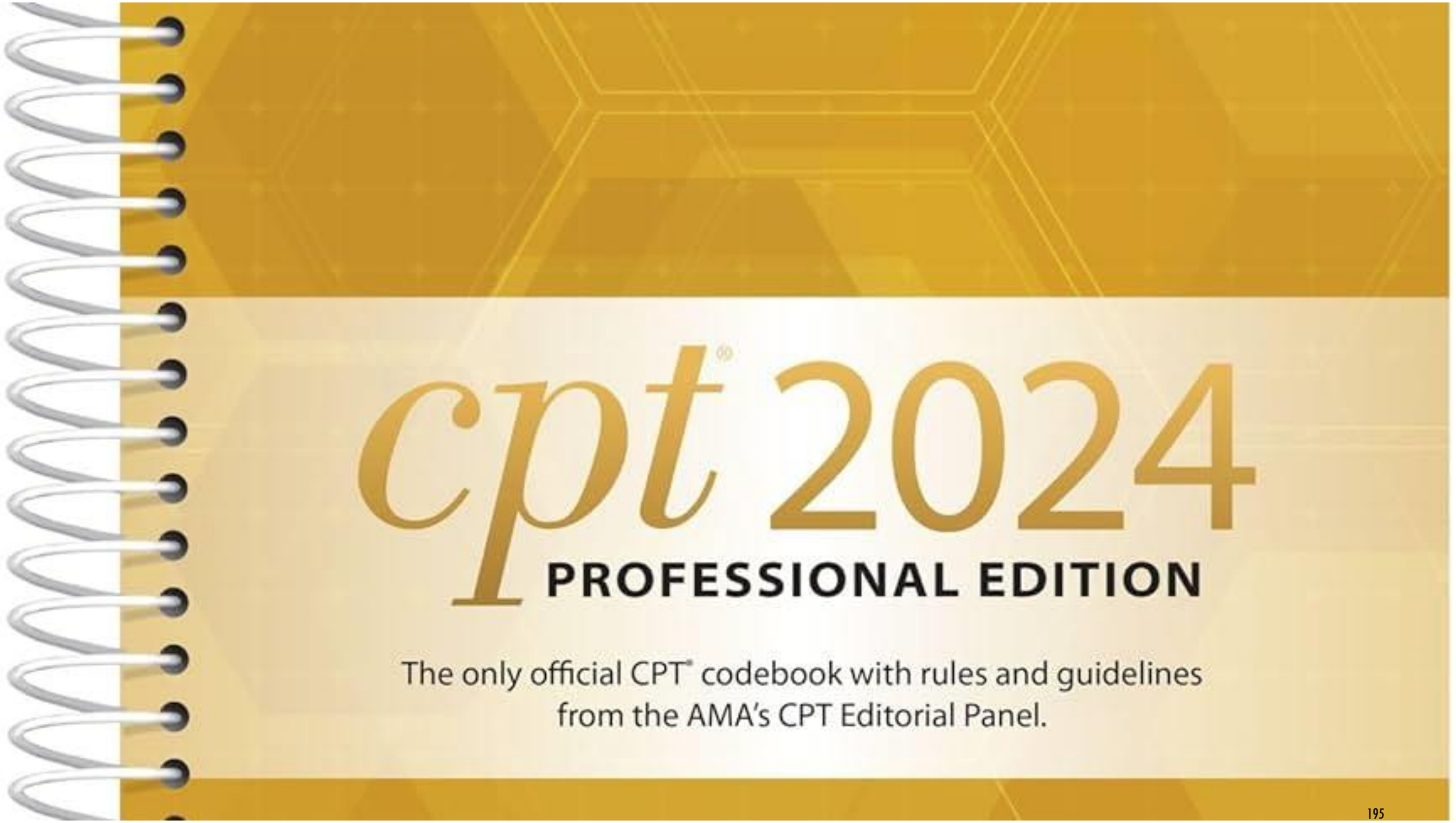
Procedure Unit	Percentage of Reimbursement
First unit with highest Relative Value Units (RVUs)	100% of allowed amount
Second unit with the next highest RVUs	85% of allowed amount
Third unit with the next highest RVUs	40% of allowed amount
Fourth unit with the next highest RVUs	40% of allowed amount
Fifth and subsequent procedure units	10% of allowed amount

Rationale

Blue Shield Multiple Procedure Payment Reduction policy applies to all the codes in the Physical Medicine section of the Current Procedural Terminology - AMA code book. Additionally, subsequent services do not require the same relative effort and are therefore paid as a percentage of the Blue Shield of California Physician Fee Schedule.

Reimbursement Guideline

Blue Shield of California will reference national or regional industry standards, such as Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and MUE (Medically Unlikely Edits) rules, and American Medical Association's (AMA) CPT guidelines, as coding standards and as guidance for payment policy. In


cpt 2024
PROFESSIONAL EDITION
The only official CPT® codebook with rules and guidelines
from the AMA's CPT Editorial Panel.

2024 CHIROPRACTIC MANIPULATION (98940-98943)
PHYSICAL MEDICINE & REHABILITATION
(97010 - 97799)

CHIROPRACTIC MANIPULATION

98940 Chiropractic manipulative treatment, spinal one or two regions
98941 Chiropractic manipulative treatment, spinal three or four regions
98942 Chiropractic manipulative treatment, spinal five regions
98943 Chiropractic manipulative treatment, extraspinal one or more regions

MODALITIES
Any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.

SUPERVISED
The application of a modality that *does not* require direct (one one-on-one) patient contact by the provider.

Application of a modality to one or more areas;

97010 Hot or cold packs
97012 Traction, mechanical
97014 Electrical stimulation, (unattended)
G0283 Electrical stimulation, (**VA,MC, UHC**)
97016 Vasopneumatic devices
97018 Paraffin bath
97022 Whirlpool
97024 Diathermy (Includes Microwave)
97026 Infrared
97028 Ultraviolet

CONSTANT ATTENDANCE
The application of a modality that requires direct (one on one) patient contact by the provider.

Application of a modality to one or more areas;

97032 Electrical Stimulation (manual), 15 min.
97033 Iontophoresis, each 15 minutes
97034 Contrast baths, each 15 minutes
97035 Ultrasound, each 15 minutes
97036 Hubbard tank, each 15 minutes
97039 Unlisted modality (specify type and time if constant attendance)

LASER
S8948 Application of a modality with constant attendance to one or more areas; Low-level laser; each 15-minute
0552T Low-level laser therapy dynamic photonic and dynamic thermokinetic energies, provided by physician or other qualified health professional

THERAPEUTIC PROCEDURES
A manner of effecting change through the application of clinical skills and or services that attempt to improve function.

Physician or therapist required to have direct (one one-on-one) patient contact.

Therapeutic procedure, one or more areas, 15 min.

97110 Therapeutic exercises to develop strength and endurance, range of motion, and flexibility.
97112 Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception.
97113 Aquatic therapy with therapeutic exercises
97116 Gait training (includes stair climbing)
97124 Massage, including effleurage, petrissage, tapotement (stroking, compression, percussion)
97139 Unlisted therapeutic procedure (specify)
97140 Manual therapy techniques, one or more regions.(for example, mobilization, manipulation, manual traction, manual lymphatic drainage)

Additional Procedures

97150 Therapeutic procedure(s), group (2 or more)
97530 Therapeutic activities, direct (one one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 min.

2024 CHIROPRACTIC MANIPULATION (98940-98943)
PHYSICAL MEDICINE & REHABILITATION
(97010 - 97799)

97535 Self-care/home management training (e.g. activities of daily living (ADL) and compensatory training, safety procedures, and instructions in use of adaptive equipment) direct one one-on-one contact by provider, each 15 minutes.
97537 Community/work reintegration training (eg. avocational activities and/or work environment/modification analysis, work task analysis), direct one one-on-one contact by provider, each 15 minutes.
97542 Wheelchair management/propulsion training, each 15 min.
97545 Work hardening/conditioning; initial 2 hours.
97546 *each additional hour*
97799 Unlisted physical medicine/rehabilitation service.

ORTHOTIC FITTING AND TRAINING

97760 Orthotics management and training (including assessment and fitting when not otherwise reported) upper and lower extremities or trunk each 15 min.
97763 Orthotic(s)/Prosthetic(s) management and or training upper and lower extremity(ties) and or trunk, subsequent encounter each 15 minutes

TESTS & MEASUREMENTS

97750 Physical performance test / measurement(e.g., musculoskeletal functional capacity) with written report, each 15 minutes

MAINTENANCE CARE

S8990 Physical or manipulative therapy performed for maintenance rather than restoration.

ACUPUNCTURE

97810 Acupuncture, one or more needles: without electrical stimulation, initial 15 minutes of personal one-on-one contact with patient
97811 Each additional 15 minutes of personal one-on-one with patient, with re-insertion of needles
97813 Acupuncture, one or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with patient
97814 Each additional 15 minutes of personal one-on-one with patient, with re-insertion of needles

DRY NEEDLING

20560 Needle insertion without injection 1-2 muscle(s)
20561 3 or more muscles

CMT

98940 1-2 regions

98941 3-4 regions

98942 5 regions

98943 Extraspinal regions (one or more)

Code is determined by diagnosis and regions manipulated not the technique or style of manipulation alone

Spinal regions not vertebra

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.

The chiropractic manipulative treatment codes include a pre-manipulation patient assessment. Additional evaluation and management (E/M) services, including office or other outpatient services (99202-99215), subsequent hospital inpatient or observation care (99231-99233), office or other outpatient consultations (99242, 99243, 99244, 99245), subsequent nursing facility services (99307-99310), and home or residence services (99341-99350), may be reported separately using modifier 25 if the patient's condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and postservice work associated with the procedure. The E/M service may be caused or prompted by the same symptoms or condition for which the CMT service was provided. As such, different diagnoses are not required for the reporting of the CMT and E/M service on the same date.

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; and pelvic (sacro-iliac joint) region. The five extraspinal regions referred to are: head (including temporomandibular joint, excluding atlanto-occipital) region; lower extremities; upper extremities; rib cage (excluding costotransverse and costovertebral joints) and abdomen.

98940 Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
→ *CPT Assistant* Jan 97:7, 11, Feb 99:10, Dec 00:15, Mar 06:15, Dec 07:16-17, Oct 09:10, May 10:9, Dec 13:15, Nov 18:12

98941 spinal, 3-4 regions
→ *CPT Assistant* Jan 97:7, 11, Mar 97:10, Feb 99:10, Dec 00:15, Mar 06:15, Dec 07:16-17, Oct 09:10, May 10:9, Nov 18:12

98942 spinal, 5 regions
→ *CPT Assistant* Jan 97:7, 11, Feb 99:10, Dec 00:15, Mar 06:15, Dec 07:16-17, Oct 09:10, May 10:9, Nov 18:12

98943 extraspinal, 1 or more regions
→ *CPT Assistant* Jan 97:7, 11, Mar 97:10, Feb 99:10, Dec 00:15, Mar 06:15, Dec 07:16-17, Oct 09:10, May 10:9, Dec 13:15, Nov 18:12

98940 Chiropractic manipulative treatment (CMT); spinal, one to two regions. Documentation must include a validated diagnosis for one or two spinal regions and support that manipulative treatment occurred in one to two regions of the spine (region as defined by CPT).

98941 Chiropractic manipulative treatment (CMT); spinal, three to four regions. Documentation must support that manipulative treatment occurred in three to four regions of the spine (region as defined by CPT) and one of the following:

1. validated diagnoses for three or four spinal regions

2. validated diagnoses for two spinal regions, plus one or two adjacent spinal regions with documented soft tissue and segmental findings

98942 Chiropractic manipulative treatment (CMT); spinal, five regions. Documentation must support that manipulative treatment occurred in five regions of the spine (region as defined by CPT) and one of the following:

1. validated diagnoses for five spinal regions

2. validated diagnoses for three spinal regions, plus two adjacent spinal regions with documented soft tissue and segmental findings

3. validated diagnoses for four spinal regions, plus one adjacent spinal region with documented soft tissue and segmental findings

98943 Chiropractic manipulative treatment (CMT); extraspinal, one to five regions. Documentation must support that manipulative treatment occurred in one or more extraspinal regions (as defined by CPT), and there is a validated diagnosis for one or more extraspinal regions for which manipulation has been shown to be both safe and efficacious

Anthem

California | Commercial

July 11, 2024

[redacted]

Subject: Claims data analysis of Chiropractic Manipulative Treatments

[redacted]

Thank you for the care you provide to our members. We value our business relationship with our Anthem Blue Cross (Anthem) care provider partners and seek educational opportunities to further foster collaboration to help ensure proper coding and payment of claims. We regularly review submitted claims data in an effort to observe coding trends and billing patterns for providers in the same geographic area and peer group.

We reviewed the use of Chiropractic Manipulative Treatments as part of our ongoing claims data review. Paid claims data for Anthem members for dates of service between 01/01/2023 and 12/31/2023 was analyzed for the purpose of identifying those providers who appear to fall outside of the expected utilization.

The review indicated your utilization of code(s) 98941 is outside the expected billing distribution determined by the billing behavior of other providers within your peer group.

We recognize that many factors may impact the coding of your Chiropractic Manipulative Treatments. Our goal is to partner with you to further understand your coding methodologies and billing practices and to assist providers with understanding documentation and reporting guidelines to support the level of care billed for each service.

We appreciate the services you provide and your commitment to the healthcare needs of our members. The intent of this letter is to serve as an educational resource. If you need further information about the data analysis referenced in this letter, please reach out to the Provider Education team via *email* (PEducationZ4@Anthem.com) (please include your National Provider Identifier or NPI) at your earliest convenience.

Anthem

Medicare Advantage

June 14, 2024

[redacted]

Subject: Claims data analysis of Chiropractic Manipulative Treatments

Dear Dr. [redacted]

Thank you for the care you provide to our members. We value our partnership with Anthem Blue Cross and Blue Shield providers and seek educational opportunities to foster collaboration efforts to help ensure proper coding and payment of claims. We regularly review submitted claims data to observe coding trends and billing patterns for providers in the same geographic area and peer group.

We reviewed the use of Chiropractic Manipulative Treatments as part of our ongoing claims data review. Paid claims data for Anthem Blue Cross and Blue Shield members for dates of service between 01/01/2023 and 12/31/2023 was analyzed for the purpose of identifying those providers who appear to fall outside of the expected utilization.

The review indicated your utilization of code(s) 98941 is outside the expected billing distribution determined by the billing behavior of other providers within your peer group.

We recognize that many factors may impact the coding of your Chiropractic Manipulative Treatments. Our goal is to partner with you to further understand your coding methodologies and billing practices and to assist providers with understanding documentation and reporting guidelines to support the level of care billed for each service.

We appreciate the services you provide and your commitment to the healthcare needs of our members. The intent of this letter is to serve as an educational resource. If you need further information about the data analysis referenced in this letter, reach out to the Provider Education team via email at PEducationZ3@Anthem.com at your earliest convenience. Please include your NPI.

Counting Time as a Function of Work

Pre-service time includes assessment and management time - medical record review, physician contact while the patient is present, assessment of the patient's progress since the previous visit, and time required to establish clinical judgment for the treatment session. Pre-service time is not the time required to get the patient ready to receive the treatment.

Intra-service time includes the hands-on treatment time.

Post-service time includes the assessment of treatment effectiveness, communication with the patient/caregiver to include education/instruction/counseling/advising, professional communications, clinical judgment required for treatment planning for the next treatment session, and documentation while the patient is present.

Counting Minutes for Timed Codes in 15 Minute Units

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15-minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:

Units Number of Minutes

1 unit: ≥ 8 minutes through 22 minutes
2 units: ≥ 23 minutes through 37 minutes
3 units: ≥ 38 minutes through 52 minutes
4 units: ≥ 53 minutes through 67 minutes
5 units: ≥ 68 minutes through 82 minutes
6 units: ≥ 83 minutes through 97 minutes
7 units: ≥ 98 minutes through 112 minutes
8 units: ≥ 113 minutes through 127 minutes

The pattern remains the same for treatment times in excess of 2 hours.

Only one time-based code may be performed at a time.

If more than one procedure code is billed for the same date of service, then in order to fully support all of the billed services the time must be separately documented for each specific procedure or time-based service. This will clearly document what portion of the total visit was spent performing each of the billed codes.

Methods and examples for time documentation:

Acceptable:

- A specific number of minutes. Example: "Manual therapy to lumbar spine x 15 minutes."
- Listing begin-time and end-time for service. Example: "E-stim to the cervical spine, 09:30 – 09:45."

Unacceptable:

- Documenting time in terms of "units". Examples: "One unit of pulsed ultrasound was administered." or "Ther Ex 1 unit."
- Documenting time using a range. Example: "Therapeutic activities x 6 – 12 minutes as appropriate per assessment and symptoms."
- Documenting a quantity but not specifying the measurement or increment used. Example: "97110 Exercises x 2"
- No time mentioned at all. Example: Checking or circling "NMR" or "TE" with no additional information documented.

For time-based service(s), ensure that the documentation contains the duration (e.g. start and stop times – preferred by the Plan), the issues addressed, and the service provider's signature.

- **Time-Based Codes**
  - For any time-based procedure codes, the duration of the service must clearly be documented in the medical record. If the duration of the time-based service is not clearly and properly documented in the medical record, then the service is not supported due to incomplete documentation; the procedure code will be denied as not documented.
  - If more than one procedure code is billed for the same date of service, in order to fully support all of the billed services, the time must be separately documented for each specific procedure or time-based service. This will clearly document what portion of the total visit was spent performing each of the billed codes.
    - Unacceptable documentation of time-based codes:
    - Documenting time in terms of "units"
    - Documenting time using a range
    - Documenting a quantity but not specifying the measurement or increment used
    - No time mentioned at all

UnitedHealthcare

USE MODIFIER –GP ON ALL PHYSICAL MEDICINE CODES 97010-97799

- GP is appended on the following plans-
- United Health Care (including Optum Health)
- VA claims
- Anthem (BCBS)
- **Blue Cross of CA (not Blue Shield)**
- Medicare (Medicare does not pay but is necessary for a denial so a secondary may make payment
- Do not blanket for plans other than these as it may cause denial for plans that do not require

MODALITIES

- Type and intensity if applicable
- Area(s) applied
- Time of application (timed services 8-minute rule)

Documentation-

97012 Cervical spine distraction with harness intermittent 30 pounds of force for 15 minutes. Supine with roll support.

97026 Infra-red heat lumbar spine 15 minutes

97014 E stim bilateral trapezius 4 pads to patient tolerance 50hz 15 minutes

97035 Ultrasound left patellar tendon 8 minutes 0.5 intensity

MECHANICAL TRACTION 97012

Current Procedural Terminology (CPT) code 97012 describes the “application of a modality to 1 or more areas; traction, mechanical”.

Third-party payer policies may differ regarding what constitutes mechanical traction, the CPT Assistant defines mechanical traction as follows: “The force used to create a degree of tension of soft tissues and/or to allow for separation between joint surfaces. The degree of traction is controlled through the amount of force (pounds) allowed, duration (time), and angle of pull (degrees) using mechanical means. Terms often used in describing pelvic/cervical traction are intermittent or static (describing the length of time traction is applied) or auto traction (use of the body’s own weight to create the force).”

The goals of mechanical traction typically include one or more of the following: re-establishing normal ranges of motion, reducing pain and/or muscle spasm, enhancing muscle relaxation, and improving blood flow to soft tissue.

ROLLER TABLES IST

The American Medical Association (AMA) currently has no specific CPT or HCPCS code that reflects the act of a patient lying recumbent on massage or roller tables.

Roller tables do not meet the definition of auto-traction according to the AMA CPT Assistant. They do not create a sufficient force to allow for the separation of joint surfaces.

The appropriate reportable code would be CPT code 97039 (unlisted modality; specify type and time if used under constant attendance).

acatoday.org

Coding Guidance

Flexion Distraction Technique

Introduction:

The American Chiropractic Association fields number requests from members asking for the proper coding of the technique known as "Flexion Distraction". The following information should clarify the proper coding for this technique.

Definition:

Flexion distraction is a Chiropractic Manipulative Technique. Per the preamble of the CMT code set (98940-98943) it is a procedure that is a form of manual treatment to influence joint and neurophysiological function.

Application:

The physician work included in the CMT codes was laid out in a work value survey of the chiropractic profession conducted in the spring of 1996 and included the work of flexion distraction. The procedure is taught in the curriculum in accredited chiropractic programs and institutions. Therefore, the appropriate coding for this technique is 98940, 98941, or 98942, depending on the number of body regions treated.[1]

VERTEBRAL AXIAL DECOMPRESSION

Vertebral axial decompression therapy is described as an alternative, noninvasive, nonsurgical procedure of applying axial (Y-axis) traction to the spine. Vertebral axial decompression is performed for symptomatic relief of pain associated with lumbar disk problems. The treatment combines pelvic and/or cervical traction connected to a special table that permits the traction application.

S9090 Vertebral axial decompression, per session

Aetna Currently, there is no adequate scientific evidence that proves that vertebral axial decompression is an effective adjunct to conservative therapy for back pain. In addition, vertebral axial decompression devices have not been adequately studied as alternatives to back surgery.

Blue FEP Benefit Application BlueCard/National Account Issues State or federal mandates (e.g., FEP) may dictate that all FDA-approved devices may not be considered investigational, and thus these devices may be assessed only on the basis of their medical necessity.

Insurance Co

LIBERTY MUTUAL | SAFECO - DE -
Insurance Co: LM GENERAL INSURANCE COMPANY
PO BOX 5014
SCRANTON, PA 18505-5014

Provider

[redacted]

Bill:

Patient

[redacted]

Tax ID: [redacted] **Type:** DC
License:
Rendering Provider:
External ID:
Invoice No:

Claim Number: [redacted]
DOI/DOL:
CR Date / BR Date:

Policyholder/Insured:
Policyholder/Insured Address:

Bill Details

Dates of Service: 01-25-2024 to 02-27-2024
Post Date: 03-07-2024

Reviewer: B//
Pay Auth: 99
Client Type of Bill: MT
Adjuster: n0303201

CR Seq: [redacted]

Bill ICD Version: 10

Dx A: M99.01	SEGMENTAL AND SOMATIC DYSFUNCT ION OF CERVICAL REGION	**Dx B:** S13.8XXD	SPRAIN OF JOINTS AND LIGAMENTS OF OTH PRT NECK, SUBS ENCNTR	**Dx C:** M50.220	OTHER CERV DISC DISPLACMNT, MI D-CERVICAL REGION, UNSP LEVEL
Dx D: M53.1	CERVICOBRACHIAL SYNDROME	**Dx E:** M99.02	SEGMENTAL AND SOMATIC DYSFUNCT ION OF THORACIC REGION	**Dx F:** M54.6	PAIN IN THORACIC SPINE
Dx G: M99.03	SEGMENTAL AND SOMATIC DYSFUNCT ION OF LUMBAR REGION	**Dx H:** S33.5XXD	SPRAIN OF LIGAMENTS OF LUMBAR SPINE, SUBSEQUENT ENCOUNTER	**Dx I:** S34.21XA	INJURY OF NERVE ROOT OF LUMBAR SPINE, INITIAL ENCOUNTER
Dx J: M51.26	OTHER INTERVERTEBRAL DISC DISP LACEMENT, LUMBAR REGION	**Dx K:** M99.04	SEGMENTAL AND SOMATIC DYSFUNCT ION OF SACRAL REGION	**Dx L:** M99.05	SEGMENTAL AND SOMATIC DYSFUNCT ION OF PELVIC REGION

Messages

873	PER CPT AMA GUIDELINES, THE APPROPRIATE CODE FOR REPORTING VAX-D IS 97012.
898	BENEFITS ARE EXHAUSTED

97124 MASSAGE VS 97140 MANUAL THERAPY

- A massage is the use of rhythmically applied pressure to the skin and soft tissues of the body. Effleurage, petrissage, tapotement (stroking, compression, percussion).
- Some manual therapy techniques include soft tissue mobilization, myofascial release, strain-counter strain, muscle energy techniques, joint mobilizations and manipulations, and mobilization with movement.

97124 MASSAGE

Massage (CPT® code 97124), is a patterned and purposeful soft-tissue manipulation accomplished by use of digits, hands, forearms, elbows, knees and/or feet, with or without the use of emollients, liniments, heat and cold, hand-held tools or other external apparatus, for the intent of therapeutic change.

Techniques may include and are not limited to:

- Compression
- Friction
- Gliding/Stroking (effleurage)
- Holding
- Kneading (petrissage)
- Lifting
- Movement and mobilization(stretching, traction, range of motion and gymnastics)
- Percussion (tapotement)
- Vibration

Massage describes a service that is separate and distinct than those services described by Chiropractic Manipulative Treatment, Osteopathic Manipulative Treatment, and Manual Therapy Techniques and typically lacks a joint mobilization component.

Massage is applied to a large area often crossing over several types and several areas of soft tissue and is used primarily for its restorative effects. In some cases, massage may be used for stimulating soft tissue (tapotement).

The expected outcomes of massage are also more general in nature and may be what the patient can tolerate at the more acute stage of their treatment plans. This would include such goals as increasing circulation and decreasing muscle soreness and spasm.

Reduce tension, anxiety, stress and promote overall circulation

ILWU DENIAL OF MASSAGE

Principle Reason Not Authorized: Literature supports massage therapy of 1 unit per affected area; 1 unit of massage therapy is noted and supported by subjective complaints. Additional 3 units of massage therapy are not supported by clinical record and not medically necessary. All services for submitted date(s) of service have been reviewed. This is a partial denial of services for medical necessity. Once the claim is fully adjudicated, you will receive an Explanation of Benefits (EOB) with more details. All services for submitted date(s) of service have been reviewed. This is a partial denial of services for medical necessity. Once the claim is fully adjudicated, you will receive an Explanation of Benefits (EOB) with more details.

A copy of this denial letter will be sent to your chiropractor and to the Coastwise Claims Office.

Payment of massage will require that a CMT must be performed the same date of service

MANUAL THERAPY

Manual Therapy Techniques, (CPT® code 97140) consist of, but are not limited to, connective tissue massage, joint mobilization and manipulation, manual traction, passive range of motion, soft tissue mobilization and manipulation, and therapeutic massage. As the code descriptor states, 'manual' providers use their hands to administer these techniques. Therefore, procedure code 97140 describes 'hands-on' therapy techniques.

Typically, the goals of manual therapy are to modulate pain, increase joint range of motion, and reduce or eliminate soft tissue swelling, inflammation, or restriction. These techniques also induce relaxation and improve contractile and noncontractile tissue extensibility. Manual therapy techniques may be performed on individuals with symptoms that may include a limited range of motion, muscle spasm, pain, scar tissue or contracted tissue and/or soft tissue swelling, inflammation or restriction... and often involve joint function

APTA – MANUAL THERAPY- 97140

Manual therapy techniques are skilled hand movements and skilled passive movements of joints and soft tissue and are intended to improve tissue extensibility; increase range of motion; induce relaxation; mobilize or manipulate soft tissue and joints; modulate pain; and reduce soft tissue swelling, inflammation, or restriction. Techniques may include manual lymphatic drainage, manual traction, massage, mobilization/manipulation, and passive range of motion.

97124 relaxation versus 97140 muscle rehabilitation

CCI Edits

Chiropractic manipulative treatment (CMT) of five spinal regions. Physical medicine and rehabilitation services described by CPT codes 97112, 97124, and 97140 are not separately reportable when performed in a spinal region undergoing CMT. If these physical medicine and rehabilitation services are performed in a different region than CMT and the provider is eligible to report physical medicine and rehabilitation codes under the Medicare program, the provider may report CMT and the above codes using modifier 59 or XS.

Manipulation + Manual Therapy

CPT codes 97124 (Massage) & 97140 (Manual therapy techniques) may be billed on the same date of service as a CMT code when the manual therapy service is provided to a different body region than the CMT.

When these procedures are billed together, modifier -59 or -XS modifier must be appended to CPT code 97140 to delineate that an independent procedure was performed.

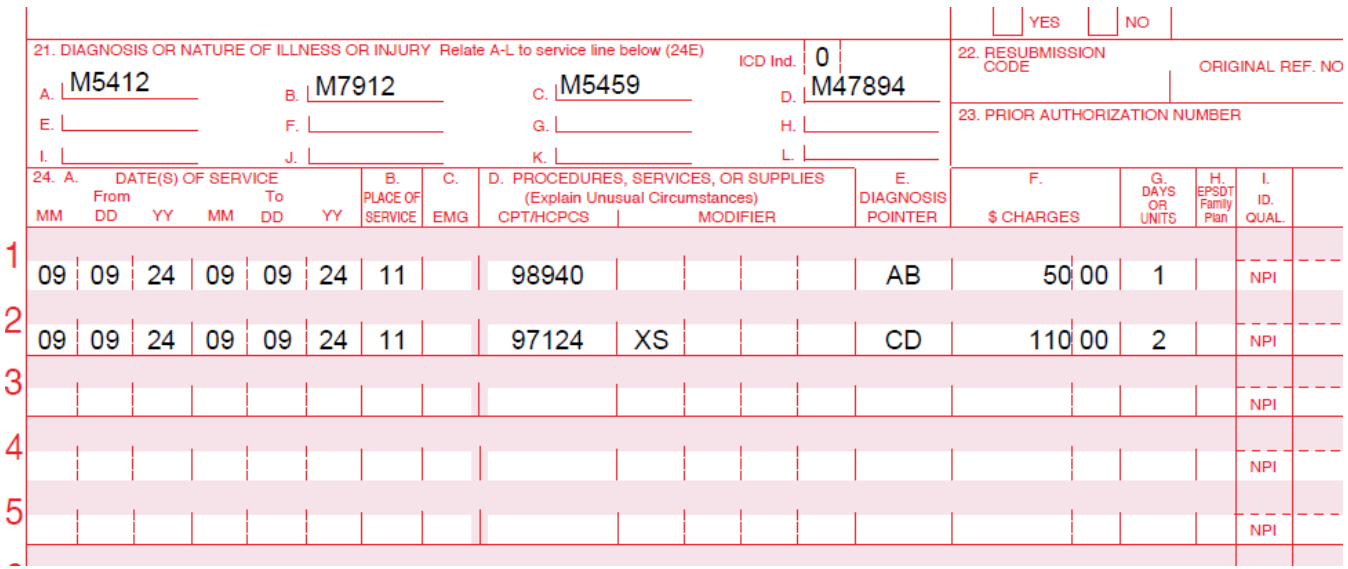
- 59 "Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances.
- XS Separate Structure, a Distinct Service Because It Was Performed On A Separate Organ/Structure

Current Procedural Terminology (CPT) instructions state that modifier 59 should not be used when a more descriptive modifier is available. Providers should utilize the more specific –X modifier when appropriate.

97124 & 97140: Massage or Manual therapy techniques (e.g. mobilization, manipulation, manual lymphatic drainage, manual traction) in one or more regions, each 15 minutes.

When reporting the CPT code 97124 or 97140 in conjunction with CMT codes, six criteria must be documented to validate the service:

1. Manipulation was not performed on the same anatomic region
2. The clinical rationale for a separate and identifiable service must be documented e.g., contraindication to CMT is present
3. Description of the massage or manual therapy technique(s) e.g., manual traction, myofascial release, mobilization, etc.
4. Location e.g., spinal region(s), shoulder, thigh, etc.
5. Time i.e., the number of minutes spent in performing the services associated with this procedure meets the timed-therapy services requirement
6. CPT code 97124 & 97140 is appended with the modifier -59 or -XS modifier



YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M5412 B. M7912 C. M5459 D. M47894

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.
1	09	09	24	09	09	24	11		98940		AB	50 00	1		NPI
2	09	09	24	09	09	24	11		97124	XS	CD	110 00	2		NPI
3															NPI
4															NPI
5															NPI

CHANGE HEALTHCARE

September 29, 2023

[redacted]

[redacted]

Dear Dr. [redacted]

Regence BlueCross BlueShield of Oregon has contracted with Change Healthcare to implement the Coding Advisor Program in order to review the billing of reported physical therapy and/or occupational therapy services with modifier 59. Claim data was analyzed between July 2022 and June 2023 for the purpose of identifying providers who are billing physical therapy and/or occupational therapy services that unbundle components from the comprehensive procedures. The following comprehensive procedures have been reported with component services: 97012 and 97140. In most cases, these component services should not be reported as a separate line item.

It is important that your practice understands and abides by the applicable documentation and reporting guidelines to ensure that the medical records support the services provided. The Change Healthcare Coding Advisor Program is intended to be informative in nature and is not intended to question a provider's treatment methods or clinical judgement.

Continuous Monitoring
Change Healthcare will continue to review your billing trends. We will periodically send you updates. If subsequent analysis reveals a continued use of physical therapy and/or occupational therapy services with modifier 59, Change Healthcare may contact your practice to request medical records for the purpose of further validation and education. At any time, we offer the opportunity for you to engage with Change Healthcare's mastery-level professional coders for further education and information on your claim submission practices.

Coding guidelines for reporting physical therapy and occupational therapy services:

- If a diagnostic procedure is inherent to a therapeutic procedure, the diagnostic procedure should not be reported separately.
- When reporting manual therapy and any of its paired codes for the same session or date, only report both services if they are performed in distinctly different 15-minutes intervals.
- Documentation for physical therapy and occupational therapy services require but are not limited to the following components:
  - Physical therapy: history, examination, clinical decision making, and plan of care (initial or revised).
  - Occupational therapy: occupational profile and history, assessments of performance, clinical decision making, and plan of care (initial or revised).

Source: American Medical Association CPT® Codebook Instructional Notes

Taking an Active Role
Change Healthcare is aware many factors may impact the coding of services rendered. We welcome the opportunity to collaborate with your practice. We encourage you to reach out to the Change Healthcare Coding Advisor Customer Service Support team, with your reference number, by phone at 844-592-7009, Option 3, or by fax at 615-238-0834, or email CodingAdvisorSupport@changehealthcare.com to learn more about the Coding Advisor Program and how we can help with documentation and coding practices.

Sincerely,

C. Hall

Aetna®

3 Independence Way
Princeton, NJ 08540

Phyllis Heller
Investigator
Special Investigations Unit, F071
(609) 452-0896
Fax: (860) 975-1769

[redacted]

Re: Our Case [redacted]

Dear Dr. [redacted]

We completed a review of claims submitted by your office to Aetna under Tax Identification Number [redacted] for claims adjudicated [redacted] We have identified an overpayment of $60,039.55.

After an analysis of your records, we identified an issue with your billing of CPT code 97140-59, Manual Therapy. We found you bill CPT code 97140 (Manual Therapy) with modifier -59 on the same day as a Chiropractic Manipulation Therapy (CMT). By appending modifier -59, you are indicating to Aetna that the services represented by 97140 were performed in an area separate and distinct from the area addressed by the CMT. The chart documentation submitted does not indicate a separate and distinct region was addressed or there was no documentation that this service was performed, therefore, Aetna considers CPT code 97140 to be overpaid in the amount of $35,769.68. This figure represents the total amount released for CPT code 97140 for the time period noted above, for all patients for whom you billed CPT code 97140, not just the files that we reviewed.

Our consultant also expressed concern with your billing of CPT code 99212-25, Evaluation & Management. During the process of this review, it was determined that the claims submitted with E&M codes were actually visits for continued care. It was also noted that modifier 25 was billed with all E&M codes; however the documentation did not support a separately identifiable service or there was no documentation that this service was performed. Based on the lack of documentation to support the use of this code, especially with modifier 25, we consider CPT code 99212-25 overpaid in the amount of $24,269.87. Allowing one E&M service a month, this figure represents the total amount released for this CPT code for the time period noted above, for all patients for whom you billed this code, not just the files that we reviewed.

I would like to address some other concerns we have in regards to your documentation. We will not request additional reimbursement but would like you to be aware of our position.

One issue involves your use of CPT code 98941 – Manipulation, 3-4 regions. The review by our chiropractic consultant noted that this code was misrepresented and CPT code 98940, 1-2 regions, should have been billed in all instances reviewed. We ask that you bill the appropriate code based on the service you perform.

An additional issue involves your billing of CPT code 97112 – Neuromuscular Re-education. Our chiropractic consultant noted that there was no documentation to indicate that this service was performed. Please be sure your documentation substantiates the use of this code and the techniques utilized are specified, along with the time spent.

Mobilizations

Muscle release

Modalities

These interventions fall under the category of **passive care**. While these techniques can be useful in providing relief of symptoms, they don't often solve the problem.

ARE YOU STUCK ON THE 3M'S OF CARE?

The provider should attempt to integrate some form of active care as early as possible. Continued use of passive care modalities may lead to patient dependency and should be avoided.

The utilization of passive modalities is not considered medically necessary once the acute phase of care is over

Passive modalities are most effective during the acute phase of treatment, since they are typically directed at reducing pain, inflammation, and swelling.

CIGNA Policy CPG 278

Requirements for Chiropractic Visits

- The following findings must be present to establish the medical necessity of chiropractic treatment:
  - Significant Functional Limitation (e.g. Activities of daily living, vocational activities) - Practitioners are strongly encouraged to utilize validated, standardized assessment tools to quantify functional limitations. These include the **Oswestry Disability Index (ODI)** with a score of 20% or higher (minimal clinically important difference of 12.8% or 6.4 raw points)[15] or the **Patient Specific Functional Scale (PSFS)** with combined average score of 7/10 or less for 3 items (minimum detectable change (90% CI) for average score = 2 points)[30].
  - Pain: limiting function and at least 3/10.
- Treatment frequency and duration must be based on the:
  - Severity of clinical findings,
  - Presence of complicating factors,
  - Natural history of the condition, and
  - Expectation for functional improvement.

Chiropractic Management[1,5,46]

- Chiropractic management should include appropriate patient education and reassurance, reactivation advice, and the promotion of self-efficacy.
- Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program.
- Passive care may be clinically indicated in the acute/subacute phase of treatment or during an acute exacerbation. However, the exclusive use of "passive modalities" (e.g., palliative care) has not demonstrated clinical efficacy in achieving functional restoration.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency. The use of self-directed home therapy will facilitate the fading of treatment frequency. This should include a home exercise program.
- Manage the condition for two weeks at a treatment frequency commensurate with the severity of the condition.[22,4]
- If there is measurable improvement in function and subjective complaints after two weeks, continue treatment for up to two additional weeks at a decreased frequency that is commensurate with the severity of the condition. [22,4]
- If there is no measurable improvement after two weeks, reassess for other possible causes or complicating factors. Consider a different adjustive/manipulative technique and/or referral for co-management. [22,4]
- Attempt a return to normal activity within four weeks.If significant and measurable improvement in levels of function and subjective complaints are demonstrated following the initial four weeks, continue for up to an additional month at a decreasing frequency commensurate with improvement in patient's condition. [22,4]

Lumbosacral Conditions (Non-Specific)

ROM and muscle re-education exercise to restore appropriate muscle control and support to the cervical region in patients with WAD should be implemented immediately.

There are five new RCTs (level II) and six systematic reviews (level I) reporting an active physical regime including exercise results in enhanced pain reduction and shortening of post-injury disability. The primary RCTs utilized a range of exercise approaches including range of motion, cervical muscle endurance, stabilization, co-ordination, cervical muscle strengthening, McKenzie method and functional capacity exercises.

State Insurance Regulatory Authority: Guidelines for the management of acute whiplash-associated disorders – for health professionals. Sydney: third edition 2014.

Passive v Active Care

It has been recommended that passive modalities not be employed except when necessary to facilitate participation in an active treatment program.

A general conclusion about the treatment of chronic, noncancer pain is that the results from traditional, passive modalities are disheartening. Perhaps this may be due to the propensity of patients to seek out passive versus active treatments. In pain management, active treatments should be the primary focus, with passive interventions as an adjunct.

It doesn't mean that active treatment is better than passive treatment (or vice versa) – the truth is **there's a role for both of those types of treatments** done at the proper timing.

Role of Active Versus Passive Complementary and Integrative Health Approaches in Pain Management
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5896844

The provider should attempt to integrate some form of active care as early as possible. Continued use of passive care modalities may lead to patient dependency and should be avoided.

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- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency. The use of self-directed home therapy will facilitate the fading of treatment frequency. This should include a home exercise program.
- Manage the condition for two weeks at a treatment frequency commensurate with the severity of the condition.[22,4]
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- If there is no measurable improvement after two weeks, reassess for other possible causes or complicating factors. Consider a different adjustive/manipulative technique and/or referral for co-management. [22,4]
- Attempt a return to normal activity within four weeks.If significant and measurable improvement in levels of function and subjective complaints are demonstrated following the initial four weeks, continue for up to an additional month at a decreasing frequency commensurate with improvement in patient's condition. [22,4]

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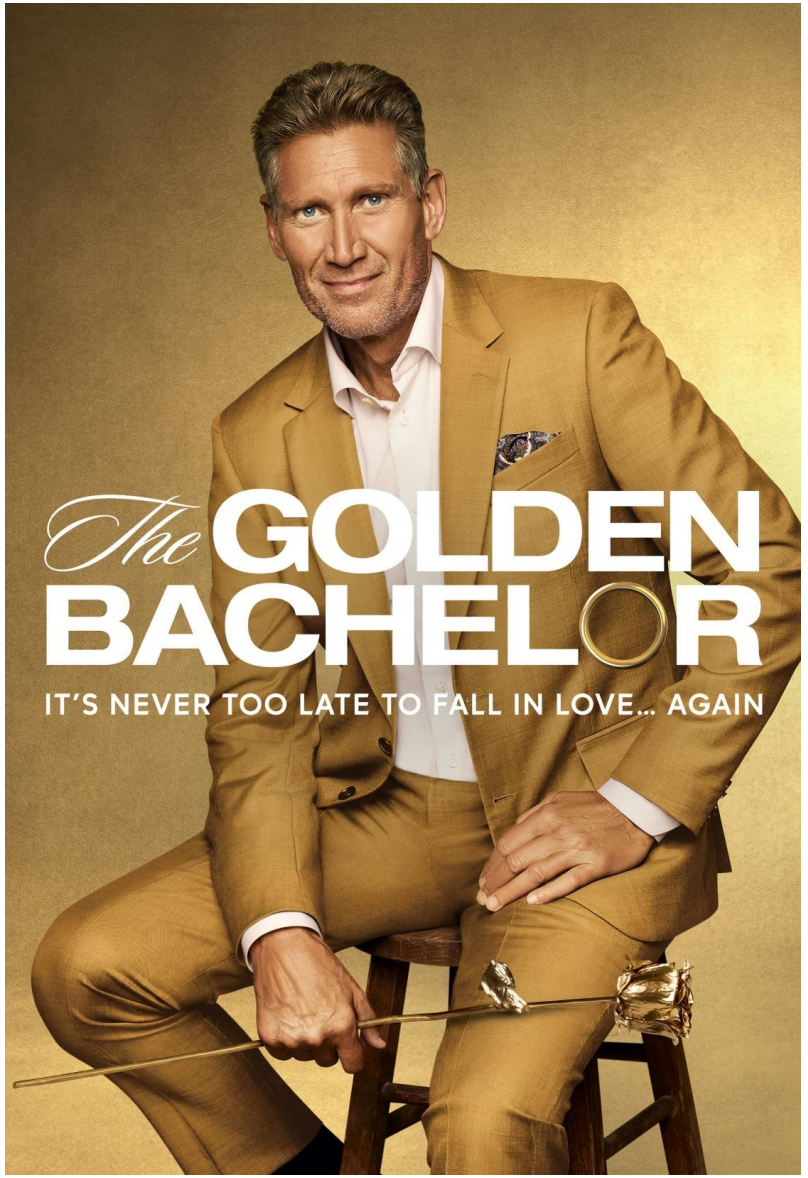
State Insurance Regulatory Authority: Guidelines for the management of acute whiplash-associated disorders – for health professionals. Sydney: third edition 2014.

The Bachelor reminds me of the CPT codes. They tend to be ambiguous, overlapping and not clear as to what his intent is



THERAPEUTIC PROCEDURES

What is this service?

TA, TE, or NMR?

97110 Therapeutic Exercises are movements and physical activities designed to restore function and flexibility, improve strength and decrease pain

Includes instruction, feedback, and supervision of a person in an exercise program for their condition. The purpose is to increase/maintain flexibility and muscle strength. May be performed with a patient either actively, active-assisted, or passively. It is considered medically necessary for loss or restriction of joint motion, strength, functional capacity or mobility which has resulted from disease or injury.

97110 THERAPEUTIC EXERCISES

One or more areas

Strength

Endurance

ROM

- Examples
  - Bike/Treadmill
  - Gym Equipment
  - Isotonic, Isokinetic, and Isometric Exercise
  - Stretching

EXERCISE REHABILITATION

EXERCISES TO STRENGTHEN YOUR NECK AND IMPROVE POSTURE

PATIENT NAME: .....

DATE: .....

1. BRÜGGER'S EXERCISE

Stand up straight with your hands at your sides. Begin by bending your elbows slightly as you rotate your arms outward. Slowly pull your shoulders back and down as you gently retract your head. Perform 2 sets of 10 repetitions.

2. HEAD RETRACTION

Begin by tucking your chin slightly then draw head upward toward the ceiling in a straight-line movement. Pause at end range for 4 seconds before returning to starting position. Perform 2 sets of 10 repetitions. This can also be performed in the seated position.

3. FLOOR ANGELS

Begin lying face up on floor with knees bent. Place arms with elbows bent comfortably on the floor with palms facing up. Slide arms upward above your head while maintaining forearm contact with floor. Do not let your back arch upward. Slowly return to start position and repeat. Perform 2 sets of 10 repetitions.

4. CRANIO-CERVICAL FLEXION

Begin by lying face up with knees bent. Slowly lower chin down in a head-nodding motion as you simultaneously lift head approximating the chin towards chest. Pause and hold for 5-10 seconds before returning to the starting position. Perform 2 sets of 10 repetitions.

5. BLACKBURN T

Begin lying face down. Arms should be extended shoulder level with thumbs pointing up. A pillow, or rolled towel, may be placed under forehead for comfort. Lift arms upward squeezing shoulder blades together. Neck muscles should remain relaxed. Hold for 5 seconds. Perform 2 sets of 10 repetitions.

6. BLACKBURN Y

Begin lying face down. Arms should be extended above shoulder level with thumbs pointing up. A pillow, or rolled towel, may be placed under forehead for comfort. Lift arms upward squeezing shoulder blades together. Neck muscles should remain relaxed. Hold for 4 seconds. Perform 2 sets of 10 repetitions.

GENERAL SHOULDER STRENGTHENING

PATIENT NAME: ---------- DATE: ----------


1. Sleeper Stretch at 90°

Begin lying on side, directly on shoulder. Head may be supported by pillow. Position arm with elbow at shoulder level and bend elbow to 90°. Grasp back of wrist with opposite hand and slowly lower forearm downward, towards floor, until stretch is felt in back of shoulder. Hold for 20 – 30 sec. Repeat 2-3 times.


2. Cross Body Stretch

Begin seated or standing. Extend one arm in front, and across body, at shoulder level. With opposite arm grasp arm above elbow and gently pull towards chest until a stretch is felt in the back of shoulder. Hold for 20 – 30 sec. Repeat 2-3 times.


3. Scapular Protraction with Resistance Band

Begin standing with resistance band in both hands and around the upper back. Protract the shoulders against resistance, keeping the arms straight. Pause momentarily before returning to neutral shoulder position. Hold for 2-4 seconds before slowly return to starting


4. Rotator Cuff External Rotation

Begin standing. Place towel between elbow and body. Grasp end of resistance band in hand while opposite end is anchored in door at elbow level. Bend elbow to 90°. While maintaining a 90° elbow bend, externally rotate arm, keeping towel trapped against body. Perform 2 sets of 10 repetitions.


5. Rotator Cuff Internal Rotation

Begin standing. Place towel between elbow and body. Grasp end of resistance band in hand while opposite end is anchored in door at elbow level. Bend elbow to 90°. While maintaining a 90° elbow bend, internally rotate arm, keeping towel trapped against body. Perform 2 sets of 10 repetitions.


6. Seated High Rows

Begin sitting upright with good posture. Grasp ends of resistance band with each hand. Arms are extended in front, shoulder width apart. Draw elbows back, maintaining distance between hands while squeezing shoulder blades together. Resistance should be felt during entire exercise. Perform 2 sets of 10 repetitions.

GENERAL HIP STRENGTHENING

NAME: ---------- DATE: ----------


1. Seated Inner Thigh Stretch

Begin seated on floor in an upright position. Bend your knees and pull the feet inward until the soles of shoes meet. Maintain a good upright sitting posture. Gently press your knees toward the floor using your hands and forearms until you feel a stretch in the inner thighs. Hold for 20-30 seconds and repeat 2-3 times.


2. Hip Flexor Stretch

Begin standing. Use a chair or a wall with one hand for support while flexing same side knee by grasping your foot or ankle. Maintain a neutral pelvis position. Keep knees side by side not allowing the bent knee to move forward. Gently pull your heel toward the buttocks until you feel a gentle stretch in the front of the thigh. Hold for 20-30 seconds and repeat 2-3 times.


3. Supine Hip Flexion

Begin in a supine position. Lift one leg until the foot is 12 inches off floor. Slowly lower the leg to starting position. Perform 3 sets of 10 repetitions.


4. Side Lying Leg Lift

Begin lying on the side with legs extended. Your top leg should attain a straight line through hip and shoulder while the bottom leg may be bent for added stability. Lift your top leg upward, abducting legs. Perform 3 sets of 10 repetitions.


5. Side Lying Hip Adduction

Begin lying on the side with one hand supporting the head. The bottom leg is straight, the top leg knee is bent and placed behind the straight leg with your foot flat on floor. Lift the straight leg upward six inches and slowly return to start position. Perform 3 sets of 10 repetitions.


6. Hip Bridge

Begin in a supine position. Bend your knees so the feet are firmly on floor with arms extended to sides. Lift your hips off floor to attain a bridge position with knees, hips, and shoulders in alignment. Slowly return to start position. Perform 3 sets of 10 repetitions.

Source: Safran, Marc et al. Instructions for Sports Medicine Patients. 2nd Edition. Saunders, 2012

EXERCISES TO STRENGTHEN YOUR CORE AND LOW BACK

PATIENT NAME: ----------

DATE: ----------

1. CAT - CAMEL

Begin by rounding your back upward until you feel a gentle stretch in the mid and low back. Pause for 3-5 seconds then relax and let your stomach fall downward as you gently arch your back. Perform 2 sets of 10 repetitions to warm up prior to strengthening exercises.

2. BIRD DOG

Begin by gently tightening your stomach muscles to activate your core. Raise one arm to shoulder level as the opposite leg lifts simultaneously off the floor extending to hip level. Hold for 4 seconds and return to the start position and alternate sides. Perform 2 sets of 10 repetitions.

3. MCGILL CURL UP

Begin lying on your back with one knee bent and one leg straight- with both hands placed underneath low back. Lift yourshoulders off floor trying not to round your low back. Let your elbows assist you if needed. Hold for 2-4 seconds before slowly return to starting position. Perform 2 sets of 10 repetitions.

4. HIP BRIDGE

Begin lying down with both knees bent. Gently tighten your stomach muscles to activate your core. Squeeze your glutes and lift the hips off the floor to until knees, hips and shoulders are in alignment. Hold for 2-4 seconds before slowly returning to start position. Perform 2 sets of 10 repetitions.

5. PLANK

Begin lying face down with elbows under shoulders and legs extended. Gently tighten your stomach muscles to activate your core. Lift knees and hips off the floor so that forearms and toes are supporting your body weight. Hold for 20 – 30 sec. Repeat 2 times.

6. SIDE PLANK

Begin lying on your side with your elbow underneath your shoulder and knees bent. Gently tighten your stomach muscles to activate your core. Lift hips off the floor so thatknees and elbow are supporting your body weight. Hold for 20 – 30 sec. Repeat 2 times and repeat on opposite side.

97530 THERAPEUTIC ACTIVITIES

- The CPT definition of 97530 is “Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes.”

This procedure involves the use of functional activities (e.g., bending, lifting, carrying, reaching, catching and overhead activities) to improve functional performance in a progressive manner.

Choosing 97530 or 97110 depends on the intent of the task. For example, abdominal curls can be used for strengthening a weak abdominal muscles and billed as therapeutic exercise; however, if the patient is performing abdominal curls to improve and perform getting from a lying position it would be considered a therapeutic activity.

Best practice is to determine what functional outcome is expected from the task. Is it simply a strength or flexibility outcome or one with a functional performance outcome?

In differentiating between the two, it helps to think of therapeutic exercises as a path to therapeutic activities.

97112 NEUROMUSCULAR REEDUCATION

Balance

Proprioception

Coordination

Kinesthetic sense

Activities that facilitate re-education
of movement, balance, posture, coordination,
and proprioception/kinesthetic sense.

recovery or require prolonged treatment beyond the natural history of recovery. The natural history of recovery is the anticipated recovery either with conservative treatment/care or without conservative treatment/care. The lack of continued functional improvement with continued treatment and complicating factors indicates a stable condition. Although the patient's condition may continue to change over time, the continuation of treatment is no longer necessary in order to affect those further changes. Furthermore, according to the evidence-based literature, the continuation of treatment after a patient has stabilized promotes patient/treatment dependence and feelings of unresolvable disability and may delay a return to normal function. The scientific literature supports a therapeutic withdrawal after the patient has stabilized which focuses more on home-based stretches and exercises and promotes a more active role of the patient.

CPT code 97112 is intended to identify therapeutic exercise that is used for the treatment of upper motor neuron lesions (i.e. stroke, paralysis). Neuromuscular re-education may also be considered medically necessary if at least one of the following conditions is present and documented: the patient has the loss of deep tendon reflexes and vibration sense accompanied by paresthesia, burning, or diffuse pain of the feet, lower legs, and/or fingers; the patient has nerve palsy, such as peroneal nerve injury causing foot drop; or the patient has muscular weakness or flaccidity as a result of a cerebral dysfunction, a nerve injury or disease, or has had a spinal cord disease or trauma. According the records provided for review, the patient did not exhibit any of the necessary signs or symptoms needed in order to initiate this type of therapy. Therefore, the dates of service in question are not medically necessary in relation to the motor vehicle accident.

In conclusion, I do not recommend reimbursement for treatment rendered on 02/14/19, 03/05/19 or 04/01/19

To predict mortality, you need a leg to stand on

10-second test

Stork position with foot placed on the weight-bearing leg

Lower risk of death in the next 7 years

Middle age (51) or older who could not perform a 10 second one leg stand were 84% greater to die of causes such as heart attacks, strokes, and cancer

British Journal of Sports Medicine

June 21, 2022

KINESIOTAPING = 97110 / 97112 IF ACTIVE THERAPY DONE IN CONJUNCTION

CPT® Assistant, March 2012, states that "Kinesio taping is a supply and therefore is included in the time spent in direct contact with the patient to provide either re-education of a muscle and movement or to stabilize one body area to enable improved strength or range of motion. This includes the application of Kinesio tape or McConnell taping techniques.

97150 GROUP THERAPEUTIC EXERCISE

Report 97150 for each member of the group.

Group therapy consists of therapy treatment provided simultaneously to two or more patients who may or may not be doing the same activities. If the therapist is dividing attention among the patients, providing only brief, intermittent personal contact, or giving the same instructions to two or more patients at the same time, one unit of CPT code 97150 is appropriate per patient.

97150

The individuals can be but need not be performing the same activity.

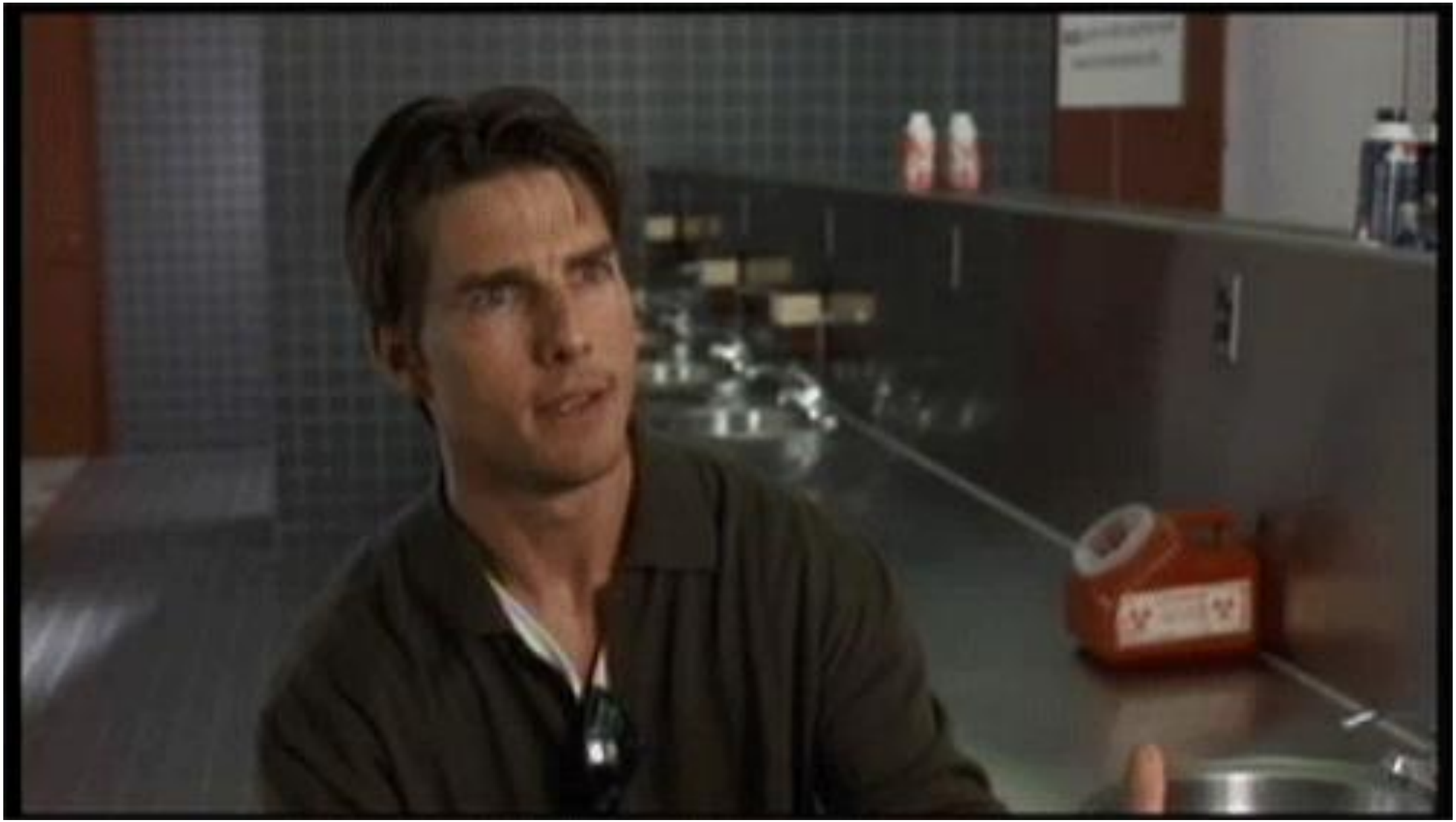
The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.

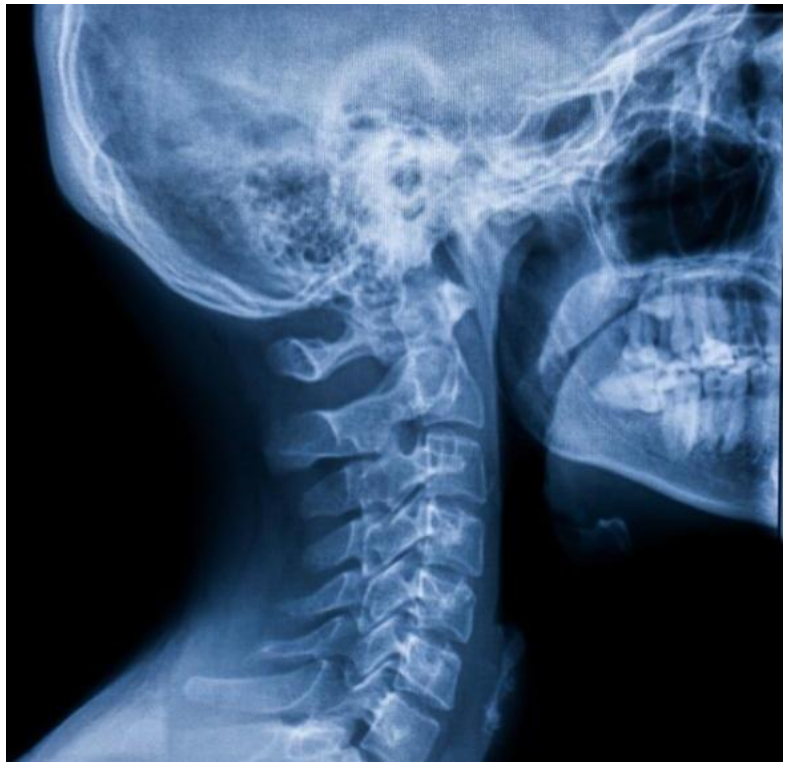
Service Dates	Rev	Procedure Code	DX Codes	Modifier	Quantity	Reason/Remark Codes	Billed Amount	Allowed Amount	Coinsurance Amount	Cop Amo
05/08/2023 05/08/2023		97112	M54.2 M54.50 M54.6	GY GP	1.000	W55	$45.00	$0.00	$0.00	$0.(
05/08/2023 05/08/2023		97012	M54.2 M54.50 M54.6	GY GP	1.000	K25	$25.00	$11.55	$0.00	$0.(

Previous Page 1 of 1 10 Ro… Next

Codes

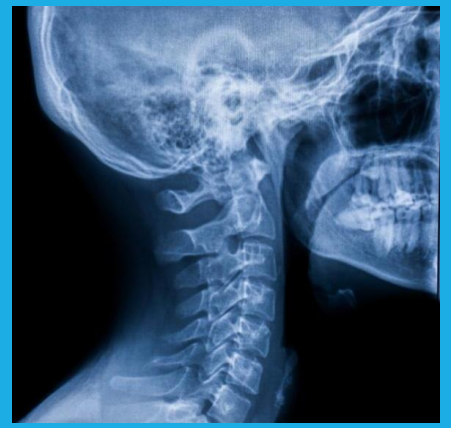
Type	Code	Description
Category	F1	Finalized/Payment-The claim/line has been paid.
Remark	K25	We reduce our rate when more than one procedure is done on the same day. The member does not owe this amount. [K25]
Remark	U62	The member's plan provides coverage for charges that are reasonable and appropriate. The charge for this service does not meet this requirement of th Show more...
Remark	W55	More than four interventions during the same treatment session are not considered a reasonable charge. No benefits are payable for the additional moda Show more...
Status	107	Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)





X-RAYS

	X-Ray Common Codes for Chiropractic
CPT Code	Description
	Head and Neck Soft Tissue
70140	Facial bones, less than 3 views
70160	Nasal bones, min 3 views
70328	Temporomandibular joint, unilateral
70330	Temporomandibular joint, bilateral
70360	Neck, soft tissue
	Chest
71045	Chest, single view
71046	Chest, 2 views
71047	Chest, 3 views
71048	Chest, 4 or more views
71100	Ribs, unilateral, 2 views
71110	Ribs, bilateral, 3 views
	Spine
72020	Spine, single view, specify level. Use 72081 if view includes entire thoracic spine.
72040	Cervical spine, 2 or 3 views
72050	Cervical spine, minimum 4 or 5 views
72052	Cervical spine, 6 or more views
72070	Thoracic spine, 2 views
72072	Thoracic spine 3 views
72074	Thoracic spine, 4 views
72080	Thoracolumbar, 2 views
72081	Spine entire thoracic and lumbar including skull 1 view
72082	Spine entire thoracic and lumbar including skull 2-3 views
72083	Spine entire thoracic and lumbar including skull 4-5 views
72084	Spine entire thoracic and lumbar including skull 6 views
72100	Lumbosacral spine, 2 or 3 views
72110	Lumbosacral spine, minimum 4 views
72114	Lumbosacral spine, minimum 6 views
72120	Lumbosacral spine, bending only 2 or 3 views
	Pelvis
72170	Pelvis, 1 or 2 views
72190	Pelvis complete, minimum 3 views
72200	Sacroiliac joints, less than 3 views
72202	Sacroiliac joints, 3 or more views
72220	Sacrum and coccyx, minimum 2 views
	Upper Extremities
73000	Clavicle, Complete
73010	Scapula, Complete
73020	Shoulder, 1 view
73030	Shoulder, complete, minimum 2 views
73050	Acromioclavicular joints bilateral with or without weighted distraction
73060	Humerus, minimum 2 views
73070	Elbow, 2 views
73080	Elbow, complete, minimum 3 views



X-RAYS

73090	Forearm, 2 views
73092	Upper extremities, infant, minimum 2 views
73100	Wrist, 2 views
73110	Wrist, complete, minimum 3 views
73120	Hand, 2 views
73130	Hand, minimum 3 views
73140	Fingers, minimum 2 views
	Lower Extremities
73501	Radiologic exam hip, unilateral with pelvis when performed 1 view
73502	Radiologic exam hip, unilateral with pelvis when performed 2-3 views
73503	Radiologic exam hip, unilateral with pelvis when performed 4 views
73521	Radiologic exam, hips bilateral with pelvis when performed 2 views
73522	Radiologic exam, hips bilateral with pelvis when performed 3-4 views
73523	Radiologic exam, hips bilateral with pelvis when performed minimum 5 views
73525	Radiologic examination, hip, arthography, supervision and interpretation
73551	Radiologic examination, femur, 1 view
73552	Radiologic examination, femur, 2 views
73560	Knee, 1 or 2 views
73562	Knee, 3 views
73564	Knee, complete 4 or more views
73565	Knees, both standing anteroposterior
73590	Tibia and Fibula, 2 views
73600	Ankle, 2 views
73610	Ankle, complete, minimum 3 views
73620	Foot, 2 views
73630	Foot, complete, minimum 3 views
73650	Calcaneus, minimum 2 views
73660	Toes, minimum 2 views
	Consultation & other
76140	Consultation on x-ray made elsewhere, 2nd opinion and report
76499	Unlisted radiogrpahic procedure

1. Diagnosis
2. Past medical history (traumatic, repetitive, acute, subacute, chronic, exacerbation, recurrent, chronic)
3. Comorbid factors and complications
4. ROM (quantify)
5. Palpation (quantify)
6. Ortho testing (quantify)
7. Neurologic testing (quantify)
8. Functional limitations (validated outcome assessments)
9. Therapeutic goals

MEDICAL NECESSITY

American Specialty Health

Reviewed for your plan by AUMSI UM Services, Inc.

Dear [redacted]

Recently, we received a claim for the service listed in the table. The service was reviewed and it's not approved. We'd like to explain why.

Physical therapy (PT) has been requested for you. PT is care that aims to help you function, move and live better. PT can be done if you are making progress that helps you with your daily tasks. Your progress must be objectively measured. This means that your provider should check your progress using special tests and tools. We reviewed the records we have. The records do not show that you made objective progress. The notes that your provider sent are not legible. As a result, PT is not medically necessary. We used Carelon Medical Benefits Management Clinical Guideline titled Outpatient

ANTHEM BLUE CROSS AND BLUE SHIELD
4241 IRWIN SIMPSON ROAD
MAILPOINT: OH0204-A102
MASON, OH 45040

Anthem

July 17, 2024

[redacted]

[redacted] we've reviewed your request

An experienced healthcare professional has reviewed the request for care that you or your doctor recently sent us.

Your request is important and personal to you and to us. Our decisions affect you. Because of that, our review included more than clinical guidelines and scientific data alone. Information about your health and your health plan were a part of it, too.

Results of the review
Our review showed that the care you've requested is Not Medically Necessary. We can't approve your request because your plan doesn't cover care that is Not Medically Necessary.

Details from the review (consider discussing with your doctor)
We have reviewed the request for special treatment (therapeutic procedures). For this service to be approved information must show that therapy has produced meaningful improvement. We do not find this type of information provided. We have not been given measurements of functional improvement. We also need treatment goals and a plan of care. Progress with goals is not identified. For this reason, the services are found not to be medically necessary. We used Carelon Medical Benefits Management Clinical Guideline titled Outpatient Rehabilitative and Habilitative Services, Physical Therapy to make this decision. You may view this guideline at www.carelon.com/mbm-guidelines-rehabilitation.

Details about the review

Reference number
[redacted]

Care location
Office

Doctor
[redacted]

Reason for denying your request
Not Medically Necessary

Do you have questions?

If you have questions about the information in this letter, please call (877) 814-4803

If you have questions about your benefits, please call the Member Services number on your ID card.

Would you like to appeal?

By phone
Call the Member Services number on your ID card.

In writing
Review the enclosed appeals information for details.

You have the right to appeal
You can appeal our decision if you or your doctor disagree with it. Please read the **Rights Available to Members** guide we've included with this letter. It explains your options, tells you how much time you have to appeal, and lists the information you'll need to send us.

- Your Care Management team

Your Rights as a Member

We've told your doctor about our decision. Your doctor can provide more information about your case by calling our clinical reviewer at (877) 814-4803.

Questions? Give us a call at the Member Services number on your ID card.

Get a free copy of the clinical criteria and MCG Guidelines
You or your doctor, or another person you choose, can get a free copy of the clinical criteria used in your review by logging in at www.anthem.com or calling Medical Care Management at (877) 814-4803. You can only get a free copy of the MCG Guidelines by calling Medical Care Management at (877) 814-4803.

Your plan uses these clinical criteria and guidelines when deciding to approve, change, or

DATA DRIVEN CARE

Tracking changes in restrictions of activities of daily living

Quality based care model

CHIRO-2.1: Recommended Standardized Assessments

Standardized assessment tools are used to assess and track changes in restrictions in Activities of Daily Living. Recommended standardized assessment tools are listed below:

Measure of Function	Reference
Disabilities of Arm, Shoulder, Hand (DASH and QuickDASH)	Franchignoni 2014; Angst 2011; Rysstad 2020
Hip Disability and Osteoarthritis Outcome Score (HOOS)	Ornetti 2009
Knee Injury and Osteoarthritis Outcome Score (KOOS)	Roos 2003; Ornetti 2009
Lower Extremity Functional Scale (LEFS)	Williams 2012; Binkley 1999
Neck Disability Index (NDI)	Young 2019; MacDermid 2009
Oswestry Disability Index (ODI)	Davidson 2002; Maughan 2010; Clohesy 2018
Patient Specific Functional Scale (PSFS)	Horn 2012; Hefford 2012; Maughan 2010; Rysstad 2020
Roland-Morris Disability Questionnaire (RMDQ)	Stratford 1996; Ostelo 2004; Clohesy 2018; Maughan 2010
Short Form-12 of the Short Form-36 Health Survey (SF-12)	Díaz-Arribas 2017; Cheak-Zamora 2009; McHorney 1994; Davidson 2002
Shoulder Pain and Disability Index (SPADI)	Schmidt 2014; Angst 2011

CHIRO-2.2: Mental Health Considerations

Referral to a qualified mental health professional is required when there are signs of an unmanaged behavioral health disorder. Immediate referral to a counselor or helpline is required if there are ANY indications of thoughts or plans for self-harm. The National Suicide Prevention Lifeline is available 24 hours every day at 1-800-273-8255.

PROMIS PATIENT REPORTED OUTCOME MEASUREMENT INSTRUMENTS

- General Pain Index
- Patient Specific Functional Scale
- PROMIS Short Form – Pain Interference
- Pain and Functional Rating Scale (VA & DOD)
- Oswestry (LBP index)
- Neck Disability Index

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. **LIFE –SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

PATIENT NAME _____ DATE _____

SCORE _____ [60] BENCHMARK = 5 _____

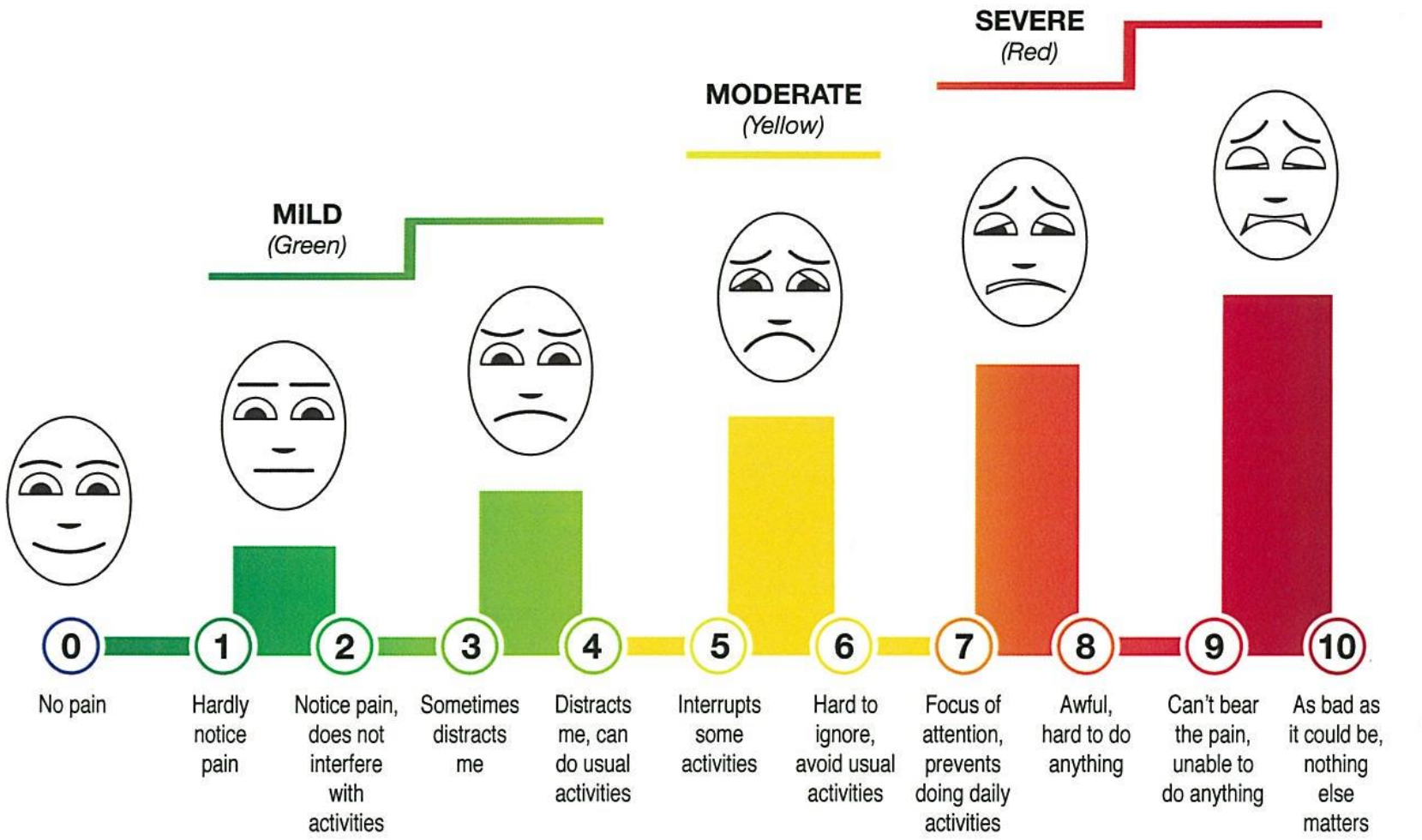
Pain Interference – Short Form 6a

Please respond to each question or statement by marking one box per row.

In the past 7 days…

		Not at all	A little bit	Somewhat	Quite a bit	Very much
1	How much did pain interfere with your day to day activities?	☐	☐	☐	☐	☐
2	How much did pain interfere with work around the home?.....	☐	☐	☐	☐	☐
3	How much did pain interfere with your ability to participate in social activities?	☐	☐	☐	☐	☐
4	How much did pain interfere with your household chores?.....	☐	☐	☐	☐	☐
5	How much did pain interfere with the things you usually do for fun?	☐	☐	☐	☐	☐
6	How much did pain interfere with your enjoyment of social activities?.....	☐	☐	☐	☐	☐

Defense and Veterans Pain Rating Scale



v 2.0

DoD/VA Pain Supplemental Questions

For clinicians to evaluate the biopsychosocial impact of pain

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual <u>ACTIVITY</u>:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your <u>SLEEP</u>:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

3. Circle the one number that describes how, during the past 24 hours, pain has affected your <u>MOOD</u>:

0	1	2	3	4	5	6	7	8	9	10
Does not affect										Completely affects

4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your <u>STRESS</u>:

0	1	2	3	4	5	6	7	8	9	10
Does not contribute										Contributes a great deal

**Reference for pain interference: Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. Ann Acad Med Singapore 23(2): 129-138, 1994.*

v 2.0

Modifier	Definition
22	Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding the modifier '-22' to the usual procedure number or by use of the separate five-digit modifier code 09922. A report may also be appropriate.
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure or Other Service: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative or postoperative care associated with the procedure that was performed. This circumstance may be reported ay adding the modifier '-25' to the appropriate level of E/M service, or the separate five digit modifier 09925 may be used. Use this modifier on the E&M code when it is performed in the same visit at chiropractic manipulation.
26	Professional Component: Certain procedures combine a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '-26' to the usual procedure number, or the service may be reported by use of the separate five-digit modifier code 09926.
32	Mandated Services: Service related to mandated consultation and/or related services (e.g. PRO, 3rd party payer) may be identified by adding the modifier '-32' to the basic procedure or the service may be reported by use of the five-digit modifier 09932.
50	Bilateral Procedure: is used to report bilateral procedures that are performed during the same operative session by the same physician in either separate operative areas (e.g. hands, feet, legs, arms, ears), or one (same) operative area (e.g. nose, eyes, breasts).
51	Multiple Procedures: When multiple procedures, other than Evaluation and Management Services, are performed on the same day or at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier '-51' to the additional procedure or service code(s) or by the use of the separate five-digit modifier 09951. This modifier should not be appended to designated "add-on" codes

52	Reduced Services: Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of the modifier '-52,' signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Modifier code 09952 may be an alternative to modifier '-52.' This modifier is also not be used for timed services done 7 minutes or less when a timed service is done 7 minutes or less it is not billable. United Health Care will reduce the payment by 50% when this modifier is used. It is also not appropriate to use this modifier with evaluation and management codes.
59	Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier "-59" is used to identify procedures/services that are not normally reported together but are appropriate under the circumstances. Modifier code 09959 may be an alternative to modifier "-59". Use this modifier on 97112, 97124, & 97140 when done in the same visit as Chiropractic Manipulative Therapy, to a separate region from the spine regions of CMT. However, it would be more accurate to use the XS modifier to demonstrate a separate region.
XE	Separate Encounter: A service that is distinct because it occurred during a separate encounter
XS	Separate Structure: A service that is distinct because it was performed on a separate organ/structure. This modifier would be used for services such as 97112, 97124 and 97140 when provided in the same visit as spinal CMT to demonstrate a separate region from CMT.
XP	Separate Practitioner: A service that is distinct because it was performed by a different practitioner
XU	Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap the usual components of the main service.
76	Repeat Procedure by Same Physician: The physician may need to indicate that a procedure or service was repeated after the original service. This circumstance may be reported by adding the modifier '-76' to the repeated service or the separate five-digit modifier code 09976 may be used
90	Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician by adding the modifier '-90' to the usual procedure number.

95	Synchronous telemedicine service is rendered via a real-time interactive audio and video telecommunications system. Append this modifier to an appropriate CPT code for real-time interaction between a physician or other qualified healthcare professional and a patient who is located at a distant site from the reporting provider. Some payers may request modifiers GT or GQ. Note that with the use of this modifier, it must also be indicated place of service 02.
GT	Telemedicine via interactive audio and video telecommunication systems. Use only when directed by your payer instead of modifier 95.
GQ	Telemedicine via an asynchronous telecommunications system applies only when reporting telehealth services.
GP	Services delivered under an outpatient physical therapy plan of care are also referred to as the "always therapy" modifier. This modifier is required on all physical medicine services on claims to the VA, United Health Care, and Medicare claims performed by Doctor of Chiropractic.
97	When a service or procedure that may be either habilitative or rehabilitative is provided for rehabilitative purposes, the physician or other qualified healthcare professional may add modifier 97- to the service or procedure code to indicate that the service or procedure provided was rehabilitative. Humana requires this modifier for chiropractic claims on CMT and physical medicine services.
GA	The GA modifier is used when you report a mandatory advance beneficiary notice of noncoverage (ABN) for an item or service. This means the patient knows the item or service doesn't meet the definition of any Medicare or Medicaid policies and will therefore not be covered. Waiver of Liability Statement Issued, as Required by Payer Policy. This is used for chiropractic claims where spinal CMT is considered maintenance, and the patient has signed an ABN
GY	Item or service statutorily excluded does not meet the definition of any Medicare benefit. For chiropractic claims, this would be appended to all services that are not spinal manipulation
AT	Acute treatment (chiropractic claims) - This modifier should be used when reporting CPT codes 98940, 98941, and 98942 for chiropractic Medicare claims
GX	The GX modifier is used to report that a voluntary Advance Beneficiary Notice of Noncoverage (ABN) has been issued to the beneficiary before/upon receipt of their Part B procedure/service because it is statutorily noncovered or does not meet the definition of a Medicare benefit. This modifier is not typically used but could be used for an excluded service to indicate a waiver of liability was signed and would be included with a GY. A waiver of excluded services is not required to be signed and therefore is not required or often used.

GZ	The provider expects a medical necessity denial, however, did not provide an Advance Beneficiary Notice of Noncoverage (ABN) to the patient. The line item containing the GZ modifier is denied the provider liable. This would be used when an ABN should have been issued but did not and to inform Medicare it is maintenance. This is used to meet the mandatory submission of a spinal CMT and will automatically be denied with provider liability and no collection from the patient for the covered service.
GW	The GW modifier is used when a physician is providing a service that **is not** related to the diagnosis for which a patient has been enrolled in hospice. This physician is not associated with the hospice and is providing services as the attending physician.
Q6	Service furnished by a locum tenens physician
QU	Physician service in an urban HPSA.
KR	Rental item, durable medical equipment billing for a partial month
RR	Rental (use the RR modifier when DME is a rental)
NU	New equipment (DME)
LT	Left Side - Used to identify procedures performed on the left side of the body.
RT	Right Side - Used to identify procedures performed on the right side of the body.

HCPCS Codes

HCPCS (often referred to as *"hick-picks"*) is a uniform coding system designed for health care providers to report supplies and other professional services. Many health insurance companies are now requiring the use of these codes to identify supports and or other supplies. The following list is a compilation of commonly used supplies in chiropractic offices.

97760, Orthotic management and training including assessments and fitting (when not otherwise reported), for the upper extremity, lower extremity, and/or trunk; each 15 minutes. Assessment includes but is not limited to, determining the patient's need for an orthotic, determining the type of orthotic required, assessing the ROM, strength testing, sensation testing, and designing and fabricating the orthotic.

97763 Orthotic and prosthetic management and/or training for the upper and lower extremities and/or trunk for each 15 minutes on subsequent encounter
Status check for fit of orthotic-skin integrity, sensation and observation are performed. Using one on one contact. Necessary modifications to the orthotic are completed. Patient is trained on proper use, wearing schedule , care and precautions

Use of an L code includes the following items.

- Assessment of the patient regarding the orthotic
- Measurement and/or fitting
- Supplies to fabricate or modify the orthotic
- Time associated with making the orthotic

CPT 97760 should be used for orthotic "training" completed by qualified professionals/auxiliary personnel. CPT 97760 may be used in conjunction with the L code only for the time spent training the patient in the use of the orthotic. Orthotic training may include teaching the patient regarding a wearing schedule, placing and removing the orthosis, skin care and performing tasks while wearing the device. To avoid duplicate billing, the time spent assessing, measuring and/or fitting, fabricating or modifying, or making the orthotic may not be included in calculating the number of units to bill for CPT 97760 when also billing the appropriate L code

Modifiers for Durable Medical Equipment

Rental Modifiers The following modifiers indicate that an item has been rented:

- RR Rental
- KH Initial Claim, purchase or first month rental
- KI Second or third monthly rental
- KJ Capped rental months four to fifteen
- KR Partial month

Purchase Modifiers The following modifiers indicate that an item has been purchased:

- NU New Equipment (use the NR modifier when DME which was new at the time of rental is subsequently purchased)

- UE Used Equipment
- NR New when rented
- KM Replacement of facial prosthesis including new impression/moulage
- KN Replacement of facial prosthesis using previous master model
- ➢ LT = Left RT = Right

Cervical

L0120	Cervical Collar *(foam),* flexible, non-adjustable. Prefabricated, off-the -shelf
L0130	Cervical Collar flexible, thermoplastic collar molded to patient
L0140	Cervical Collar semirigid *(plastic) adjustable*
L0150	Cervical Collar semirigid, adjustable molded chin cup (plastic collar with mandibular/occipital piece)

Pillow or Wedge

E0190	Positioning Cushion/Pillow/ Wedge any shape or size includes all components and accessories or (neck, low back, leg spacer etc.)

Thoracic

L0220	Thoracic, rib belt, custom fabricated
L0450	TLSO, flexible provides trunk support, upper thoracic region, produces intracavity pressure to reduce load on IVD with rigid stays or panel(s) includes shoulder straps and closures, prefabricated, off-the – shelf
L0452	TLSO, flexible provides trunk support, upper thoracic region, produces intracavity pressure to reduce load on IVD with rigid stays or panel(s) includes shoulder straps and closures, prefabricated, custom fabricated
L0454	TLSO flexible, provides trunk support, extends from sacrococcygeal junction to above t-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L0455	TLSO flexible, provides trunk support, extends from sacrococcygeal junction to above t-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, off-the-shelf

Sacroiliac

L0621	Sacroiliac orthosis flexile, provides pelvic sacral support, reduces motion about the SI joint includes straps, closures and may include pendulous abdomen design, prefabricated off-the-shelf
L0622	Sacroiliac orthosis flexile, provides pelvic sacral support, reduces motion about the SI joint includes straps, closures and may include pendulous abdomen design, custom fabricated
L0623	Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, off-the-shelf
L0624	Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated

Lumbar

L0625	Lumbar orthosis, flexible, provides lumbar support, posterior extends from l-1 to below l-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated off-the-shelf
L0626	Lumbar orthosis, sagittal control with rigid posterior panel(s) posterior extends from l-1 to below l-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise.
L0627	Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from l-1 to below l-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise.

Lumbosacral

L0628	Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, prefabricated off-the-shelf
L0629	Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom fabricated
L0630	Lumbar-sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, that has been trimmed, bent molded, assembled or otherwise customized to fit a specific patient by and individual with expertise.
L0631	Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, that has been trimmed, bent molded, assembled or otherwise
L0632	Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated.
L0633	Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, that has been trimmed, bent molded, assembled or otherwise customized to fit a specific patient by and individual with expertise.

Shoulder

L3650	Clavicle/Shoulder Brace figure 8 design, prefabricated
A4565	Slings
A4566	Shoulder sling or vest design abduction restrainer
A4570	Splint

Elbow, Wrist & Hand

L3908	Wrist hand orthoses, wrist extension control cock up, prefabricated *(includes fitting and adjustment)*
L3710	Elbow orthoses elastic with metal joints, prefabricated *(includes fitting and adjustment)*
L3999	Upper limb orthoses not otherwise specified
A4466	Garment, belt, sleeve or other covering elastic or similar stretchable material any type, each. (tennis elbow, forearm etc neoprene sleeve)

Knee

L1812	Knee orthosis, elastic with joints prefabricated , *off the shelf*
L1820	Knee Support elastic with condylar pad and joints with or without patellar control prefabricated *(includes fitting and adjustment)*
A4466	Garment, belt, sleeve or other covering elastic or similar stretchable material any type, each. (thigh, knee etc. neoprene sleeve)

Ankle

L1902	Ankle Gauntlet prefabricated *(includes fitting and adjustment)*
L2999	Lower extremity orthoses not otherwise specified
A4466	Garment, belt, sleeve or other covering elastic or similar stretchable material any type, each. (calf neoprene sleeve)

Compression Stocking

A6530	Gradient compression stocking below knee 18-30mmHg, each
A6531	Gradient compression stocking below knee 30-40mm Hg, each
A6532	Gradient compression stocking below knee 40-50mm Hg, each
A6533	Gradient compression stocking thigh length 18-30mmHg, each
A6534	Gradient compression stocking thigh length 30-40mm Hg, each
A6535	Gradient compression stocking thigh length 40-50mm Hg, each

Cane, Crutches, Walker

E0100	Cane, includes canes of all materials, adjustable or fixed with tip
E0105	Cane, quad or three prong includes canes of all materials, adjustable or fixed with tip
E0112	Crutches, underarm, wood, adjustable or fixed, pair with pads, tips and handgrips
E0113	Crutch, underarm, other than wood, adjustable or fixed, pair with pads, tips and handgrips
E0114	Crutches, underarm, other than wood, adjustable or fixed, pair with pads, tips and handgrips
E0116	Crutch, underarm, other than wood, adjustable or fixed, pair with pads, tips and handgrips
E0130	Walker rigid (pick up) adjustable or fixed height
E0135	Walker folding (pick up) adjustable or fixed height
E0141	Walker rigid, wheeled adjustable or fixed height

Foot Orthoses

L3010	Foot insert, molded to patient model longitudinal arch support
L3020	Foot insert, molded to patient model longitudinal/metatarsal support
L3030	Foot insert, removable, formed to patient foot
L3040	Full Foot, arch support removable premolded, each foot
L3060	Foot arch support, removable, premolded
S0395	Impression casting of a foot performed by a practitioner other than the manufacturer of the orthotic

A4580 Cast supplies (e.g plaster)
CPT 29799-RT and CPT 29799-LT when casting for custom orthotics.

L3480	Heel, pad and depression for spur
L3485	Heel, pad, removable for spur
L3300	Lift tapered to metatarsals
L3310	Lift, elevation, heel, and sole, Neoprene, per inch
L3320	Lift, elevation, heel, and sole, cork, per inch
L3334	Lift, elevation, heel, per inch

Tape/Ace Bandages

A4450	Tape non waterproof per 18 square inches
A4452	Tape waterproof per 18 square inches
A6445	Ace Wrap / Elastic Tape cotton/latex

Miscellaneous

99070	Supplies and materials (except spectacles), provided by the physician over and above those usually included in the office visit (list or describe specific item)

Traction (cervical)

E0849	Traction equipment, cervical, free standing stand/frame, pneumatic applying traction force other than the mandible
E0850	Traction stand, free standing, cervical traction
E0855	Cervical traction equipment not requiring an additional stand or frame
E0856	Cervical traction device, cervical collar with inflatable bladder(s)
E0860	Traction equipment, overdoor, cervical
E0942	Cervical head harness/halter
E0941	Gravity assisted traction device, any type
A9285	Inversion eversion corrective device

TENS, Electrical Stimulation and Supplies

E0720	TENS Unit *(two lead)*
E0730	TENS Unit *(four lead)*
E0731	Form-fitting conductive garment for delivery of TENS or NMES with conductive fibers separated from the patient's skin by layers of fabric
E0745	Neuromuscular stimulator, electronic shock unit

E0744	Neuromuscular stimulator for scoliosis
A4595	Electrical stimulator supplies, 2 lead, per month (e.g, TENS, NMES)
A4558	Conductive paste or gel Tens, NMES device
A4559	Conductive paste or gel Ultrasound device
A4630	Replacement batteries

Exercise Equipment

A9300	Exercise equipment (any type)

Heat and Cryotherapy

E0210	Electric Moist Heat Pad
E1399	Unlisted DME. May be used for hot or cold packs but must be sent with explanation
A9273	Hot water bottle, Ice cap or collar, heat and or cold wrap, any type

Vitamins, Supplements, Non-Rx and Food

A9150	Nonprescription drug or similar substance
A9152	Single vitamin/mineral/trace element, per dose
A9153	Multiple vitamins, w or w/ minerals, per dose
S9433	Medical food nutritionally complete, administered orally, providing 100% of nutritional intake