Policy

Overview
This policy describes Optum’s requirements for reimbursement of CPT codes 98940, 98941, 98942
(Spinal Chiropractic Manipulative Treatment) and 98943 (Extraspinal Chiropractic Manipulative
Treatment).

The purpose of this policy is to ensure that Optum reimburses for services that are billed and
documented, without reimbursing for billing submission or data entry errors or for non-documented
services.

Reimbursement Guidelines

Spinal Manipulation
Optum will align reimbursement values with CPT definition. One spinal CMT procedure code is
reimbursable per date of service.

Extraspinal Manipulation
Optum will align reimbursement values with CPT definition. One extraspinal CMT procedure code is
reimbursable per date of service.

Manipulation + Evaluation and Management
The CMT codes include a premanipulative patient assessment. Additional Evaluation & Management
(E/M) services 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.

Extraspinal Manipulation + Spinal Manipulation
Modifier -51 (Multiple Procedures) is not required to be appended to the extraspinal CMT procedural code
(98943), when billed on the same date of service as a spinal CMT code (98940-98942).

Manipulation + Manual Therapy
CPT code 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 noncontiguous body region than the CMT.
When these procedures are billed together, modifier -59 or the appropriate -X modifier, is required to be
appended to CPT code 97140 to delineate that an independent procedure was performed.
CMS has established the following four HCPCS modifiers (referred to collectively as -X(EPSU) modifiers)
to define specific subsets of the -59 modifier:
  • 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,
  • XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different
    Practitioner, and
  • XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does
    Not Overlap Usual Components Of The Main Service.
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.
**Background Information**

There are four CPT codes, which have been developed to assist chiropractic providers with accurately describing and reporting their manipulative treatment services. The work value of the CMT codes includes both cognitive (clinician judgment) and technical (skill) components. The work value or “work per unit of time” is divided into three sections: preservice, intraservice, and postservice.

The *preservice* (before patient arrives) includes: documentation and chart review, imaging review, test interpretation, and care planning. The *intraservice* (face-to-face time with patient) comprises: the premanipulation patient assessment (palpation, etc.), manipulation, and postmanipulation procedures (assessment, etc.). The *postservice* (after the patient leaves) period includes: chart documentation, consultation, and reporting.

For the purposes of reporting CMT codes, there are five spinal regions and five extraspinal regions. The *Spinal* regions are: cervical (includes atlanto-occipital joint); thoracic (includes costotransverse and costovertebral joints); lumbar, sacral; and pelvic (sacroiliac joint). The *Extraspinal* regions are: head (including temporomandibular joint, excluding the atlanto-occipital joint); lower extremities; upper extremities; rib cage (excluding costotransverse and costovertebral joints); and abdomen.

CPT describes the application of modifier -25 when E/M services are reported in conjunction with CMT procedural codes (98940-98943). “The chiropractic manipulative treatment codes include a premanipulation patient assessment. Additional Evaluation and Management services may be reported separately using the 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.”

Modifier -51 (Multiple Procedures) does not need to be appended to the extraspinal CMT code (98943), when billed in conjunction with chiropractic manipulative treatment (CMT) codes (98940-98943).

According to “The CPT® Assistant” [December 2013], these are separate and distinct procedures and the use of modifier 51 does not apply.

The National Correct Coding Initiative (NCCI) Edits – developed by the CMS – provides guidance in the application of modifier -59. “Use of modifier -59 to indicate different procedures/surgeries does not require a different diagnosis for each HCPCS/CPT coded procedure/surgery. Additionally, different diagnoses are not adequate criteria for use of modifier -59. The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters… From an NCCI perspective, the definition of different anatomic sites includes different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ. For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes a single anatomic site. Treatment of posterior segment structures in the eye constitutes a single anatomic site. Arthroscopic treatment of a shoulder injury in adjoining areas of the ipsilateral shoulder constitutes treatment of a single anatomic site.”

**Documentation Guidelines**

**General Guidelines**

All ICD-9-CM diagnosis codes and CPT treatment and procedure codes must be validated in the patient chart and coordinated as to the diagnoses and treatment code descriptors. A valid diagnosis is the most appropriate ICD-9-CM code that is supported by subjective symptoms, physical findings, and diagnostic testing/imaging (if appropriate)...

Documentation should be recorded on the day of the patient visit and include all of the following:

1. a subjective record of the patient complaint i.e., location, quality, and intensity
2. physical findings to support manipulation in a region or segment e.g., regional/segmental asymmetry or misalignment, range of motion abnormality, soft tissue tone and/or tenderness
3. characteristics
4. assessment of change in patient condition, as appropriate
   a record of the specific segments manipulated

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 per appropriate Optum medical policy.

97140: Manual therapy techniques (e.g. mobilization, manipulation, manual lymphatic drainage, manual traction) one or more regions, each 15 minutes.
When reporting the CPT code 97140 in conjunction with CMT codes, there are six criteria that must be documented to validate the service:
   1. Manipulation was not performed to the same anatomic region or a contiguous anatomic region e.g., cervical and thoracic regions are contiguous; cervical and pelvic regions are noncontiguous
   2. The clinical rationale for a separate and identifiable service must be documented e.g., contraindication to CMT is present
   3. Description of the 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., number of minutes spent in performing the services associated with this procedure meets the timed-therapy services requirement
   6. CPT code 97140 is appended with the modifier -59 or the appropriate -X modifier

Resources
- Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
- Centers for Medicare and Medicaid Services