2023-2024
The Complete ICD & CPT Essentials
For Maximum Reimbursement

Book 2

"it is critical to stay abreast of changes in CPT and ICD10 and payer billing guidelines related to coding…maintaining current knowledge is imperative for the long-term survival and safety of a practice."

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Medical Necessity

American Specialty Health

- Diagnosis
- Past medical history (traumatic, repetitive, acute, subacute, chronic, exacerbation, recurrent, chronic)
- Comorbid factors and complications
- ROM (quantify)
- Palpation (quantify)
- Ortho testing (quantify)
- Neurologic testing (quantify)
- Functional limitations (validated outcome assessments)
- Therapeutic goals

- Chiropractic Services performed at a frequency, duration, or quantity that exceeds the amount of medically necessary Chiropractic Services for the individual's condition based on:
  - The severity of the clinical findings
  - The presence or absence of complicating factors
  - The natural history of the condition, and
  - The expectation for progressive improvement in the ability to perform Activities of Daily Living
  - Generally Accepted Standards of Practice as defined in CHIRO-1.1: Definitions.
- Chiropractic Services that are performed in the presence of signs and/or symptoms that suggest life or limb threatening conditions and require additional evaluation, immediate referral, or medical comanagement prior to treatment based on Generally Accepted Standards of Practice as defined in CHIRO-1.1: Definitions. These include findings that are likely to reflect a serious underlying condition such as:
  - Aneurysm or dissection
  - Cancer
  - Cauda equina syndrome
  - Fracture
  - Infection
  - Progressive neurologic conditions
  - Suicidal ideation (See CHIRO-2.2: Mental Health Considerations)
- Chiropractic Services that replace or delay other medically necessary care based on Generally Accepted Standards of Practice as defined in CHIRO-1.1: Definitions.

Complicating Conditions: Medicare has determined that these conditions by themselves do not constitute a need for care, but other condition or superimposed on them will increase the need (length) for care.

Kissing spine
Ankylosing vertebral hyperostosis
Schmorl's nodes Thoracic spine
Schmorl's nodes Lumbar spine
Senile Osteoporosis
Kyphosis (acquired, postural)
Kyphosis postlaminectomy
Lordosis (acquired, postural)
Lordosis postlaminectomy
Other post surgical lordosis
Scoliosis and kyphoscoliosis (idiopathic)
Thoracogenic Scoliosis
Acquired deformity of neck
Congenital scoliosis
Spondylosis, lumbosacral region
Absence of vertebra, congenital
Hemivertebra
Fusion of spine (vertebra), congenital
Klippel-Feil syndrome

Mercy Conference Guidelines: Factors hat Delay Recovery

– Pain > 8 days	1.5x
– Severe Pain	2.0x
– > three previous episodes	2.0x
– Injury superimposed	1.5-2.0x

Other Factors

1. Recurrences, exacerbations and flare-ups
2. Underlying diseases (Diabetes)
3. Posture (antalgia)
4. Gait
5. Stress and Depression

Clinical Information

10. Choose any of the following clinical exam findings that are present:

- ☐ None/unknown specific exam findings
- ☐ Localized pain reproduced on palpation or orthopedic testing
- ☐ Diffuse ache on passive motion
- ☐ Radiating pain below knee reproduced on nerve compression of stretch test
- ☐ Pain referred from muscle or trigger points

11. Was a functional measure used to evaluate the patient's function? ◯ Yes ◯ No ◯ Don't Know

12. What is the patient's level (%) of disability?

13. What was disability measured by?

- ◯ Oswestry Disability Index/Lower Thoracic
- ◯ Other disability measure:
- ◯ Neck Disability Index/Upper Thoracic

14. Select all neurological deficits that apply: ☐ Sensory deficits ☐ None/unknown

15. Is there any decrease in range-of-motion in the thoracic spine? ◯ Yes ◯ No ◯ Don't Know

16. What location has the greatest decreased range of motion (ROM)? ◯ Unknown

- ◯ Flexion
- ◯ Right Rotation
- ◯ Left Rotation
- ◯ Extension
- ◯ Right Lateral Bending
- ◯ Left Lateral Bending

17. Are there any complicating factors? Select all that apply.

- ☐ None/unknown
- ☐ Thyroid disease
- ☐ Congenital or acquired joint anomaly
- ☐ Pernicious anemia
- ☐ Spondylolisthesis
- ☐ Overweight > 100 lbs relative to height
- ☐ Diabetes mellitus
- ☐ Spinal stenosis
- ☐ Degenerative joint disease (DJD)
- ☐ 3rd trimester pregnancy
- ☐ Other:

18. What is the intended treatment plan? Select all that apply.

- ☐ Spinal Manipulation
- ☐ Extraspinal Manipulation
- ☐ Other Treatment:
- ☐ Active Modalities
- ☐ Passive Modalities

Additonal Information/Comments:

Number: 0107

Aetna Clinical Policy Bulletin 03/23/23 next review 1/25/2024

Note: Some plans have limitations or exclusions applicable to chiropractic care. Please check benefit plan descriptions for details.

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

A. The member has a neuromusculoskeletal disorder; *and*
B. The medical necessity for treatment is clearly documented; *and*
C. 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.

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

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

Manipulation is considered experimental and investigational when it is rendered for non-neuromusculoskeletal conditions (e.g., attention-deficit hyperactivity disorder, asthma, autism spectrum disorder, depression, dizziness/vertigo, dysmenorrhea, epilepsy, female infertility, gastro-intestinal disorders, improvement of brain function, and menopause-associated vasomotor symptoms); not an all-inclusive list) because its effectiveness for these indications is unproven.

Aetna Chiropractic Services

Medical Clinical Policy Bulletin Number: 0107

Last Review 03/23/2023
Effective: 03/25/1995
Next Review: 01/25/2024

CPT Codes / HCPCS Codes / ICD-10 Codes

CPT codes covered if selection criteria are met:
Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+":

Code	Code Description
98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions
98941	spinal, three to four regions
98942	spinal, five regions
98943	extraspinal, one or more regions

CPT codes not covered for indications listed in the CPB:

***ConnecTX, inertial traction, positional release therapy, IntraDiscNutrosis program, Origin insertion release technique, Ultralign adjusting device* -hyphen no specific code:**

22505	Manipulation of spine requiring anesthesia, any region
97530	Therapeutic activities, direct (one-on-none) patient contact (use of dynamic activities to improve functional performance), each 15 minutes [not covered for Functional and Kinetic Treatment with Rehab]
	Other codes of the CPB
20552	Injection(s); single or multiple trigger point(s), one or two muscle(s)
20553	single or multiple trigger point(s), three or more muscle(s)
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)
20561	3 or more muscles
95836 - 95857	Muscle and range of motion testing
95860 - 95887	Electromyography and nerve conduction tests
95907 - 95913	Nerve conduction studies
95937	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method
96000 - 96004	Motion analysis
97010 - 97799	Physical medicine and rehabilitation

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,** • **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
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,**	Dislocation and sprains of joint and ligaments

• **S63.001+ - S63.92X+,** • **S73.001+ - S73.199+,** • **S83.001 - S83.92X+,** • **S93.01X+ - S93.699+**	
• **S14.2xx+ - S14.9xx+,** • **S24.2xx+ - S24.9XX+,** • **S34.21x+ - S34.9XX+**	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+	Injury of nerves at shoulder and upper arm level
• **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 muscle, fascia and tendon 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+,** • **S76.811+ - S76.819+,** • **S76.911+ - S76.919+**	Injury and strain of muscle, fascia and tendon at hip and thigh level
S84.00x+ - hyphen 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+ - 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+ - n S96.919+**	Injury of muscle, fascia and tendon at ankle and foot level

ICD-hyphen10 codes covered if selection criteria are met 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
G57.00 - G59	Mononeuritis of lower 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
Numerous options	Other, multiple, and ill-hyphendefined dislocations [including vertebra]
Q65.00 -n 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 -n Q77.9 • Q78.9	Osteochrondrodysplasia
R51.x	Headache
S03.40x+ - S03.42x+	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+,**	Dislocation and sprains of joints and ligaments

• **S73.001+ - S73.199+,** • **S83.001 - S83.92X+,** • **S93.01X+ - S93.699+**	
• S14.2xx+ - S14.9xx+, • S24.2xx+ - S24.9XX+ • • S34.21x+ - S34.9xx+	Injuries to nerve root(s), spinal plexus(es) 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+	Injury of nerves at shoulder and upper arm level
• **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 muscle, fascia and tendon at shoulder and upper arm level
S74.00x+ - S74.92x+	Injury of nerves at hip and thigh level
• **S76.011+ - S76.019+,**	Injury and strain of muscle, fascia and tendon at hip and thigh level

• **S76.111+ - S76.119+,** • **S76.211+ - S76.219+,** • **S76.311+ - S76.319+,** • **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+ - 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+**	Injury of nerves at ankle and foot level
• **S96.001+ - S96.019+,** • **S96.111+ - S96.119+,** • **S96.211+ - S96.219+,**	Injury of muscle, fascia and tendon at ankle and foot level

- S96.811+
  - S96.819+,
- S96.911+
  - S96.919+

Cigna Medical Coverage Policy- Therapy Services Chiropractic Care

Effective Date: 12/15/2022
Next Review Date: 12/15/2023

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

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.

<u>Not Medically Necessary</u>

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.
   - The documentation fails to objectively verify functional progress over a reasonable period of time.
   - Improvement or restoration of function could reasonably be expected as the individual gradually resumes normal activities without the provision of skilled therapy services. For example:
     1. An individual suffers a transient and easily reversible loss or reduction in function which could reasonably be expected to improve spontaneously as the individual gradually resumes normal activities;
     2. A fully functional individual who develops temporary weakness from a period of bed rest.
   - The treatment visit extends beyond 4 timed unit services per date of service per provider (equivalent to one hour).

- Chiropractic services that do not require the skills of a qualified provider of chiropractic services. Examples include but not limited to:
    - Activities for the general good and welfare of the individual:
        1. General exercises (basic aerobic, strength, flexibility or aquatic programs) to promote overall fitness/conditioning
        2. Services/programs for the primary purpose of enhancing or returning to athletic or recreational sports.
        3. Massages and whirlpools for relaxation
        4. General public education/instruction sessions
    - Activities and services that an individual can practice independently and can be self-administered safely and effectively:
        1. Activities that require only routine supervision and NOT the skilled services of a chiropractor
        2. When a home exercise program is sufficient and can be utilized to continue therapy (examples of exceptions include but would not be limited to the following: if individual has poor exercise technique that requires cueing and feedback, lack of support at home if necessary for exercise program completion, and/or cognitive impairment that doesn't allow the individual to complete the exercise program)
- The physical medicine and rehabilitation modalities are not preparatory to other skilled treatment procedures or are not necessary in order to safely and effectively provide other skilled treatment procedures.
- Modalities that have been deemed to provide minimal to no clinical value independently or within a comprehensive treatment for any condition and/or not considered the current standard of care within a treatment program
    - Infrared light therapy
    - Vasopneumatic device
- Treatments/services that are not supported in peer-reviewed literature and not performed in accordance with this and other applicable standards of practice and clinical practice guidelines or medical policies.
- Services provided to reduce potential risk factors where significant improvement is not expected
- Use of upper extremity manipulation/mobilization as a part of multimodal treatment program for epicondylitis/epicondylalgia and carpal tunnel syndrome.
    - In the absence of contraindications and if examination/evaluation suggest additional findings indicating manipulation/mobilization of UE joints in addition to standard care may be beneficial (e.g., restricted joint play of humeroradial joint, restricted joint play of radiocarpal joint), use of these interventions is reasonable.
- Use of lower extremity manipulation/mobilization combined with multimodal treatment program for the treatment of hip osteoarthritis, knee osteoarthritis, and/or plantar fasciitis.
    - In the absence of contraindications and if examination/evaluation suggest additional findings indicating manipulation/mobilization of LE joints in addition to standard care may be beneficial (e.g., restricted joint play of iliofemoral joint, restricted joint play of the proximal tibiofibular joint)), use of these interventions is reasonable.

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.

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

factors. A reasonable trial of care for chiropractic services is generally 2-8 weeks and is influenced by the diagnosis; clinical evaluation findings; stage of the condition (acute, sub-acute, chronic); severity of the condition; and patient-specific findings (age, gender, past and current medical history, family history, and any relevant psychosocial factors).

Chiropractic care may be a primary method of treatment for some medical conditions, such as lower back pain, or may complement or support medical treatment for other conditions by relieving the musculoskeletal aspects associated with the condition. Chiropractors may refer patients to the appropriate health care provider when chiropractic care is not suitable for the patient's condition, or the condition warrants co-management in conjunction with other health care providers.

Spinal manipulation (sometimes referred to as a "chiropractic adjustment") is a common, therapeutic procedure performed by doctors of chiropractic. The purpose of spinal manipulation is to restore joint mobility by manually applying a controlled force into joints that have become hypomobile, or restricted in their movement, as a result of a tissue injury. Tissue injury can be caused by a single traumatic event or through repetitive stresses. In either case, injured tissues undergo physical and chemical changes that can cause inflammation, pain, and diminished function. Manipulation, or adjustment of the affected joint and tissues, restores mobility, thereby alleviating pain and muscle tightness allowing tissues to heal. In addition to manual therapy other procedures/modalities, both passive and active, are often used as adjunct treatments throughout the treatment program.

GENERAL BACKGROUND

Chiropractic spinal manipulation requires professional skills to identify spinal segmental joint dysfunction characterized by altered joint alignment, motion, or physiologic function in an intact spinal motion segment. The primary objectives of chiropractic spinal manipulation are to alleviate musculoskeletal pain, muscle spasm, and functional impairment of the spine. This form of manipulation is a therapeutic procedure characterized by controlled force, leverage, direction, amplitude, and velocity (directional, high velocity, low amplitude thrust) (Peterson & Bergmann, 2002).

Response to chiropractic treatment typically occurs within two to eight weeks. The medical necessity of continued chiropractic care is dependent on documented progress toward therapeutic goals. Maximum therapeutic benefit has been reached when the patient fails to show improvement, or when a pre-injury level of functioning has been reached. Chiropractic physicians should document in clinical records the objective findings and subjective complaints that support the necessity for a chiropractic treatment regimen. A treatment plan should be developed 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.

(2) The use of a system of record keeping that does not provide sufficient information (e.g., checking boxes, circling items from lists, arrows, travel cards with only dates of visit and listings) should not be submitted. These types of medical record keeping may result in an adverse determination (partial approval or denial) of those services.

Effective and appropriate documentation that meets professional standards of medical record keeping that adequately detail a proper assessment of the patient's status, the nature and severity of patient complaint(s) or condition(s), and/or other relevant clinical information (e.g., history, parameters of each therapy performed, objective findings, progress towards treatment goals, response to care, prognosis.) is expected.

Modalities and Procedures

In some states, Chiropractic physicians are required to hold a specific certification to use physical medicine modalities in practice. The American Medical Association (AMA) Current Procedural Terminology (CPT) manual defines a modality as "any physical agent applied to produce therapeutic changes to biologic tissue; includes but is not limited to thermal, acoustic, light, mechanical, or electric energy" (AMA, 2018). Modalities may be supervised, which means that the application of the modality doesn't require direct one-on-one patient contact by the practitioner; or modalities may involve constant attendance, which indicates that the modality requires direct one-on-one patient contact by the practitioner. Examples of supervised modalities include application of hot or cold packs, mechanical traction, and unattended electrical stimulation. Examples of modalities that require constant attendance include ultrasound, manually applied electrical stimulation, and iontophoresis.

Passive modalities are most effective during the acute phase of treatment, since they are typically directed at reducing pain, inflammation, and swelling. They may also be utilized during the acute phase of the exacerbation of a chronic condition. The use of passive modalities are not generally considered medically necessary unless they are preparatory and essential to the safe and effective delivery of other skilled treatment procedures (e.g. chiropractic manipulation, therapeutic exercise training, etc.). After one or two weeks, the clinical effectiveness of passive modalities begins to decline significantly. The need for passive modalities beyond two weeks should be objectively documented in the clinical record.

The AMA CPT manual defines therapeutic procedures as "A manner of effecting change through the application of clinical skills and/or services that attempt to improve function" (AMA, 2018). Examples of therapeutic procedures include therapeutic exercise to develop strength and endurance, range of motion and flexibility; neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioceptive activities; aquatic therapy; and manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction); or therapeutic activities using dynamic activities to improve functional performance (direct one-on-one patient contact by the practitioner).

Transition from passive physiotherapy modalities to active treatment procedures should be timely and evidenced in the medical record, including instructions on self/home care. And in most cases, active treatment should be initiated in addition to modality use at a level that is appropriate for the patient.

Active therapeutic procedures are typically started as swelling, pain, and inflammation are reduced. The need for stabilization and support is replaced by the need for increased range of motion and restoration of function. Active

care elements include increasing range of motion, strengthening primary and secondary stabilizers of a given region, and increasing the endurance capability of the muscles. Care focuses on active participation of the patient in their exercise program. Activities of Daily Living (ADLs) training, muscle strengthening, movement retraining, and progressive resistive exercises are considered active procedures. In general, patients should progress from active procedures to a home exercise program.

Certain physical medicine modalities and therapeutic procedures are considered duplicative in nature and it would be inappropriate to perform or bill for these services during the same session, such as:

- Functional activities and ADLs;
- More than one deep heating modality;
- Massage therapy and myofascial release;
- Orthotics training and prosthetic training; and
- Whirlpool and Hubbard tank.

The medical necessity of neuromuscular reeducation, therapeutic exercises, and/or therapeutic activities, performed on the same day, must be documented in the medical record.
Only one heat modality would be considered medically necessary during the same treatment session, with the exception of use of one form of superficial heat and one form of deep heat (i.e., ultrasound or diathermy and hot packs). Use of two forms of deep or superficial heat would not be acceptable. Hot or cold packs should not be used in the absence of other modalities or manipulation and must be part of a multi-modal rehabilitation program.

Exacerbation/Re-injury
According to the CCGPP consensus recommendations for the management of chronic spine related conditions, "An exacerbation is characterized by a return of atypical pain and/or other symptoms and/or pain-related difficulty performing tasks and actions equivalent to the appropriate minimal clinically important change value for the outcome of interest." (Farabaugh, et al., 2010). Once maximum therapeutic benefit has been reached and documented, additional chiropractic services may be warranted when there is an exacerbation of the condition or re-injury. Management of chronic pain conditions involves an understanding and compliance with self-directed home care, and when self-directed care fails to sustain previously achieved gains during exacerbation or re-injury, 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) and/or manual muscle testing (MMT) (CPT codes 95831 – 95834), including digital wireless dynamometers and inclinometers or other such electronic device that measures strength and/or 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-

If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSIL may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSIL has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Chiropractic Care Services

Policy Number: CPCP016

Version 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: March 15, 2023

Plan Effective Date: March 15, 2023

Description

The practice of chiropractic care services focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. These services are provided on an inpatient or outpatient basis, within the scope of licensure and practice of a chiropractor, to the extent services would be covered if provided by a Medical Doctor or Chiropractor.

Definitions:

Chiropractic Manipulative Treatment (CMT) - CMT procedures use high-velocity, short-lever, low-amplitude

thrust by hand or instrument to remove structural dysfunction in joints and muscles that may be associated with neurologic or mechanical dysfunction of the spinal joints and surrounding tissue.

There are 2 types of CMT:

- **Spinal**: manipulative treatment of cervical, thoracic, lumbar, sacral, and pelvic regions
- **Extraspinal**: manipulative treatment of the appendicular skeleton

Chiropractic Maintenance Care - A maintenance program consists of activities that preserve the patient's present level of function and prevents regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur. Ongoing treatment after a condition has been stabilized or reached a clinical plateau (Maximum Therapeutic Benefit) does not qualify as medically necessary and is considered maintenance care. Supportive therapy also refers to therapy that is needed to maintain or sustain level of function. Maintenance Care and Supportive Care are not medically reasonable or necessary and are NOT payable.

Providers of Chiropractic Services – Qualified providers of chiropractic services act within the scope of their license that is regulated by the Federal and State governments. Only those healthcare practitioners who hold an active license, certification, or registration with the applicable state board or agency may provide services under the direction and supervision of a chiropractor. The scope and extent of such services, when provided as part of a chiropractic treatment plan and billed by the chiropractor, may be regulated by the applicable state board responsible for the licensure of the chiropractor. Nonqualified personnel that do not meet the definition of qualified healthcare professional (QHP) are limited to non-skilled services. They may not bill any direct treatments, modalities, or procedures.

Date of Injury (DOI) - The actual date of the current injury. This information is entered in Box 14 of the CMS-1500 claim form.

Durable Condition Specific Benefit- A measurable improvement in or restoration of a functional impairment that resulted from a specific disease, trauma, congenital anomaly, or therapeutic intervention; and able to be sustained long-term without significant deterioration.

Exacerbation - An increase in severity of the patient's condition or symptoms.

Qualified Healthcare Professional (QHP) - Is 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.

Initial Treatment Date (ITD) - The date of the initial treatment (visit). This information is entered in Box 15 (other date) of the CMS-1500 claim form.

Therapeutic Procedure - A manner of affecting change through the application of clinical skills and/or services that attempt to improve function.

Reimbursement Information:

Providers are to bill and document appropriately for all services submitted. The plan reserves the right to request supporting documentation. Failure to adhere to coding and billing policies may impact claims processing and reimbursement. Claims may be reviewed on a case-by-case basis. If you have any questions, please contact your provider network representative.

Documentation Standards

Records must:

- Indicate the dates any professional service was provided.
- List the direct one-on-one contact time spent for each timed code per CPT nomenclature.
- Be **legible** in both readability and content. Documentation that is not legible cannot be used to support services rendered.
- Contain only those terms and abbreviations easily comprehended by peers of similar licensure. If a legend is needed to review your records, maintain it with your records. Include documentation showing the members need for chiropractic care and any changes since the last visit. Documentation must also include a clear description of the treatment provided and how the member tolerated the treatment.
- Contain clinically pertinent subjective information from the member. Include the chief complaint and any changes in the members condition, the members response to care since the previous visit, and the members subjective progress relative to the outcome measures documented in the treatment plan. **(Subjective information and history)**.
- Contain clinically pertinent objective data or examination findings from your exam of the member. This data provides a way to verify diagnosis codes, establishes changes in response to care and provides evidence for the necessity of the treatment that day. **(Objective data)**
- Indicate the initial diagnosis and the member's initial reason for seeking the provider's care. The diagnosis should be recorded in the record and reflected on the claim form. Each daily visit must also include an assessment of the member's condition. The assessment of the member's progression must be based upon the subjective and objective findings. Include the diagnosis being managed on the visit and the assessment of the overall progress. Provide rationale for continued care or changes in the therapeutic direction. Provide an evaluation of the treatment effectiveness and progress or lack thereof as it relates to the treatment goals and plan of care. **(Assessment)**
- Document the treatment details performed during the visit including the medical rationale. Include any member instructions. Documentation must support that each manipulation or treatment reported relates to a relevant symptomatic spinal and/or extraspinal region. Symptoms must bear a direct relationship to the level of subluxation cited. Documentation of "pain" is not sufficient; the location of pain or condition must be described. Also, include the member's immediate response to care and plans for future care. Indicate when the member is to return, visit number as it relates to the treatment plan with the anticipated date of next evaluation. Include any goals and outcome measures for a new problem or a problem re-assessment. **(Plan)**
- A written plan of treatment relating to the type, amount, frequency, and duration of care is required for all members. The plan of care must be updated as the member's condition changes. A treatment plan is not valid for longer than 90 calendar days from the first treatment day under the certified treatment plan. The goal of the treatment plan should be to achieve functional improvements in the member's condition. Specific treatment goals must be documented with anticipated time frames and objective measures to evaluate treatment effectiveness. Each complaint should be listed with selected treatment, duration, frequency, treatment goals, and objective measures to evaluate progress. The treatment plan

should include the rationale for all services provided. A plan of care should be individualized for each member. **(Plan of Care)**

- Signature requirements- Each medical record must be signed and dated by the clinician performing the service. A legible physical or electronic signature is required. The medical record should be signed at the time services are rendered. Providers should not add late signatures to the medical record beyond the short delay that occurs during the transcription process. Generally, 24-48 hours is the typical turnaround time for the provider transcription process.
- It is essential for the provider to document clinical findings and justify the medical necessity of care. It is strongly suggested this justification be documented via formal progress note using S.O.A.P. (Subjective, Objective, Assessment, Plan) note format, which is considered a medical standard. Check marks, small entries and other commonly illegible notions seldom provide adequate documentation to support services billed. Please ensure that the medical records documentation is concise and complete.
- For additional information on Templated, Copy and Paste or Cloned Medical Records, please see CPCP029 Medical Record Documentation.

Coding Standards

- Proper coding is essential for correct reimbursement. Providers are encouraged to utilize current copies of ICD-10 -CM, CPT, and HCPCS books published by the American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS).
- Use the diagnosis and procedure codes effective for the date of service.

Diagnosis Codes

- New ICD10-CM diagnosis codes are updated annually in October.
- Some diagnosis codes require a 7th digit to code to the highest specificity.
- Update diagnosis and coding for every new episode, including a re-exam or an examination for a 'new' problem. Document any diagnosis coding change even if it is minor.
- Link the diagnosis to the service provided to support medical necessity and specificity. For example, when performing manual therapy with manipulation, the diagnosis pointer code(s) should point to the specific diagnosed condition that supports specific procedures billed. (Box 24E of the CMS-1500 claim form).

CPT Codes

Evaluation and Management (E/M) Services (CPT Codes: 99202-99205, 99211-99215)
To bill for an evaluation and management service, the complete CPT guidelines must be met for each service. The service must also be separately identifiable and distinct from any other service you perform on the member that day.

Chiropractic Manipulative Treatment (CPT codes 98940-98943)
Each CPT code reflects a specific number of regions, regardless of how many manipulations are performed in that region. For example, chiropractic manipulation applied to C3 and C5 during the same visit represent treatment to only one region (cervical) and should be reported with CPT code 98940.
All CPT codes for CMT must have a supporting ICD-10-CM diagnosis code to justify the level of care provided. For example, when billing CPT 98941, there must be ICD-10-CMcodes that incorporate at least three different

regions.

To bill these codes, the documentation must include:

- Location of pain/condition for which treatment is being sought.
- The specific spinal regions adjusted, and the technique used.
- The response to the treatment/adjustment, including whether or not the pain/condition being treated increased, reduced, or eliminated the problem.
- Each manipulation reported must be related to the patient's complaints and a relevant symptomatic spinal or extraspinal level.

For physical therapy services, providers should refer to CPCP040 Physical Medicine & Rehabilitation Services

CMT Components

Pre-Service	A brief evaluation of the member's medical record documentation and chart review, imaging review, test interpretation and care planning
Intra-Service	Treatment applied, Pre-manipulation (e.g., palpation, etc.), Manipulation, Post-manipulation (e.g., assessment, etc.)
Post-Service	Chart entry and documentation, including subjective, objective, assessment, plan consultation reporting

Evaluation and Management (E/M) Coding and CMT Codes

Billing an Evaluation and Management (E/M) Code **with a CMT code:**
In general, it is inappropriate to bill an established office/outpatient E/M CPT code (99211-99215) on the same visit as Chiropractic Manipulative Treatment (CPT code 98940-98943) because CMT codes already include a brief pre-manipulation assessment. There are times when it would be appropriate, but it should not be routine. Examples of when it may be appropriate to bill an additional E/M service would be the evaluation of new patients, new injuries, exacerbations, or periodic re-evaluations.

Billing an Evaluation and Management Code **in place of a CMT code:**
It is not appropriate to bill an E/M code instead of a CMT code to circumvent CMT limits. It is required to bill the code that best describes the service rendered.

Diagnostic Imaging Services

The purpose of diagnostic imaging is to gain diagnostic information regarding the member in terms of diagnosis, prognosis, and therapy planning. Required standards for each imaging study must meet the following four standards:

- The study must be obtained based on clinical need;
- The study must be of sufficient diagnostic quality;
- There must be documented interpretation of the study to reach a diagnostic conclusion; and
- The information from the study must be correlated with patient management.

The selection of patients for radiographic examination is based on the following criteria.

- The need for radiographic examination is based on history and physical examination findings.
- The potential diagnostic benefit of the radiographic examination is judged to outweigh the risks of ionizing radiation.
- Radiography is used to help the practitioner diagnosis pathology, identify contraindications to chiropractic care, identify bone and joint morphology, and acquire postural, kinematic, and biomechanical information.
- Routine radiography of patients as a screening procedure is not appropriate practice except under public health guidelines.

Components of a Written Radiology Report

As a written record of the interpretive findings, the radiology report serves as an important part of the member's medical record and must contain the following items:

- Patient identification
- Location where studies were performed
- Study dates
- Types of studies
- Radiographic findings
- Diagnostic impressions; and
- Signature with professional qualifications included

Radiology reports may also include recommendations for follow-up studies and comments for further patient evaluation.

Additional Resources:

CPCP040 Physical Medicine & Rehabilitation Services

CPCP029 Medical Record Documentation Guidelines

References:

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

claims payment scenarios where CMS and/or CPT reference is lacking or insufficient, the Payment Policy Committee (PPC) may develop customized payment policies that are based on other accepted or analogous industry payment standards and or expert input.

Resources:
• **American Medical Association** https://www.ama-assn.org/ama • **Centers for Medicare & Medicaid Services** https://www.cms.gov/

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Payment Policy.

Effective Date	Action	Reason
04/08/2015	New Policy Adoption	Payment Policy Committee
01/01/2016	Maintenance	Payment Policy Committee
06/01/2016	Maintenance	Payment Policy Committee
06/15/2016	Maintenance	Payment Policy Committee
01/01/2017	Formatting Revision	Payment Policy Committee
07/08/2017	Formatting Revision	Payment Policy Committee
12/01/2017	Maintenance	Payment Policy Committee
08/03/2018	Maintenance	Payment Policy Committee
01/01/2023	Added strapping codes 29550, 29580	Payment Policy Maintenance

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under an enrollee's contract.

These Policies are subject to change as new information becomes available.

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 time for code selection, 15-29 minutes of total time is spent on the date of the encounter

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 time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

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 time for code selection, 45-59 minutes of total time is spent on the date of the encounter

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 time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

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 time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

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 time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

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.

99215 **Office or other outpatient visi**t 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 time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

99201-99215 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, when performed:
- 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
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

What Time Does Not Count

Time spent for activities normally performed by clinical staff

- Time spent on separately reportable services
  - X-rays
  - Treatment

  - Travel

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** 15-29 min
- **99203** 30-44 min
- **99204** 45-59 min
- **99205** 60-74 min

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

Table 1: Levels of Medical Decision Making (MDM)

►Elements of Medical Decision Making			
Level of MDM (Based on 2 out of 3 Elements of MDM)	**Number and Complexity of Problems Addressed at the Encounter**	**Amount and/or Complexity of Data to Be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the c** ***ombination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
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	**Limited** *(Must meet the requirements of at least 1 out of 2 categories)*	**Low risk of morbidity from additional**

		minor problems; **or** ▪ **1** stable, chronic illness; **or** ▪ **1** acute, uncomplicated illness or injury; **or** ▪ **1** stable, acute illness; **or** ▪ **1** acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**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)*	**diagnostic testing or treatment**
	Moderate	**Moderate**	**Moderate**	**Moderate risk of morbidity from**

		■ **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	*(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	**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

			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)	determinants of health
	High	**High** ▪ **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;	**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:**	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* ▪ Drug therapy requiring intensive

		or ■ **1** acute or chronic illness or injury that poses a threat to life or bodily function	• 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**	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 care ■ Decision not to resuscitate or to de-escalate care because of poor prognosis

			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)	■ Parenteral controlled substances ◀

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)

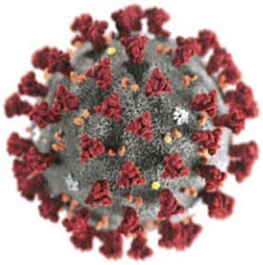
- Eligible for separate reimbursement when billed in addition to CPT new/established level 5 Evaluation and Management codes 99205/99215 for office or other outpatient E/M services. The level 5 office or other outpatient E/M code must be selected using only time as the basis of selection and after the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

Review of Records

- **99358** Prolonged evaluation and management service before and/or after direct patient care, first hour
- **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

Telehealth

- Beyond Covid & Quarantine



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.

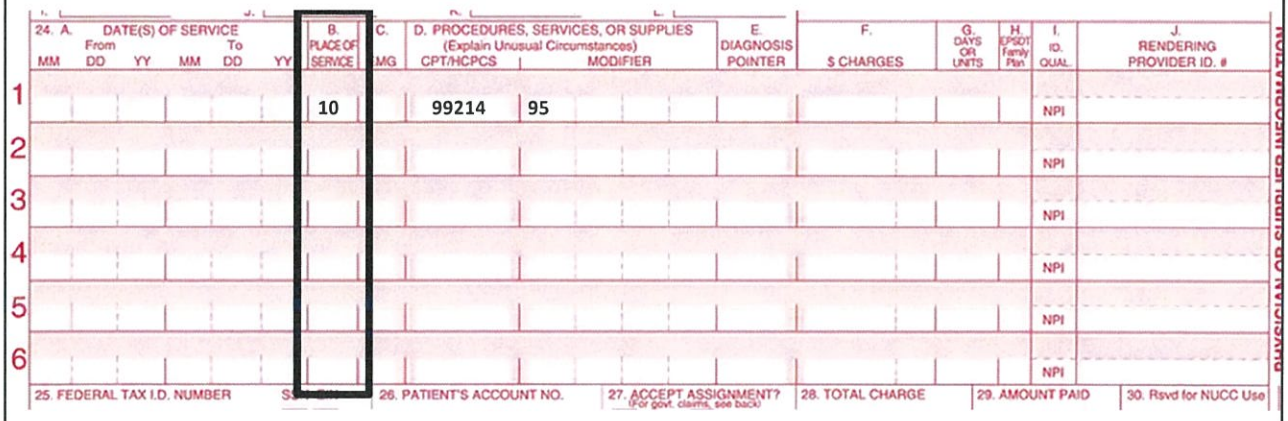
Patient Location

- 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

- Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

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

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

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

2023 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 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, (unattended) **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)
S8930 Electrical stimulation of auricular acupuncture points; each 15 minutes of personal one-on-one contact with the patient

LASER

S8948 Application of a modality with constant attendance to one or more areas; Low-level laser; each 15 minutes
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 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 on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 min.
97535 Self care/home management training (eg. activities of daily living (ADL) and compensatory train ing, safety procedures, and instructions in use of adaptive equipment) direct 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 on one contact by provider, each 15 minutes.
97542 Wheelchair mgmt/propulsion trning, each 15 min.
97545 Work hardening/conditioning; initial 2 hrs.
97546 *each additional hour*
97799 Unlisted physical medicine/rehabilitation service.

ORTHOTIC FITTING AND TRAINING

97760 Orthotics management and training (including as sessment 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, subse quent encounter each 15 minutes

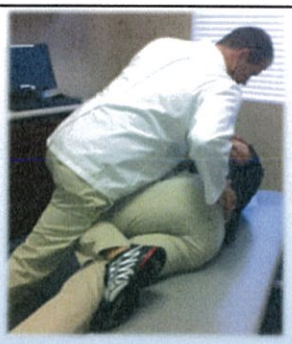
TESTS & MEASUREMENTS

97750 Physical performance test / measurement(eg, mus culoskeletal functional capacity) with written report, each 15 min.

MAINTENANCE CARE

S8990 Physical or manipulative therapy performed for maintenance rather than restoration

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

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- **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
    - Optum Chiropractic Manipulative Treatment Reimbursement Policy

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CCI Edits

S. Chiropractic Manipulative Treatment

Medicare covers 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.

Modifiers

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 a subset of modifiers and XS can be used in lieu of 59.

59 Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day.

XS Separate Structure, A Service That Is Distinct 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, there are six criteria that 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 the appropriate -X modifier

Chiropractic Claim for CMT and 97124
Diagnosis pointers indicate separate regions

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [X] (Medicare#)	MEDICAID [ ] (Medicaid#)	TRICARE [ ] (ID#/DoD#)	CHAMPVA [ ] (Member ID#)	GROUP HEALTH PLAN [ ] (ID#)	FECA BLK LUNG [ ] (ID#)	OTHER [ ] (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
							123-456-789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Beasley, Joe	10 15 1977 M [X] F [ ]	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1234 Maine	Self [X] Spouse [ ] Child [ ] Other [ ]	
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
Any City		
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
00000 / (555) 555-1212		( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on file DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Signature on file

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
01 06 2023		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

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

A. M5412	B. M7912	C. M5450	D. M47894
E.	F.	G.	H.
I.	J.	K.	L.

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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 01 09 23 / 01 09 23	11		98940	AB	50 00	1		NPI	
2 01 09 23 / 01 09 23	11		97124 / 59	CD	110 00	2		NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd.for NUCC Use
987654321 [ ] [X]		[X] YES [ ] NO	$ 160 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof:)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (555) 111-2222
SIGNED DATE	John Smith DC 54321 Spine Ave Any City	John Smith DC 54321 Spine Ave Any City
	a. NPI b.	a. 111222333 b.