Reimbursement Policy and Billing Guidelines for Chiropractic Services

Effective April 1, 2006 for all BCBSMA Products (Revised September 2007)

Policy Statement

Blue Cross Blue Shield of Massachusetts (BCBSMA) reimburses for services provided by a Doctor of Chiropractic who has successfully met BCBSMA's contracting and credentialing guidelines.

Rationale

This *Reimbursement Policy and Billing Guidelines for Chiropractic Services* has been developed with consideration of the latest reimbursement methodologies from sources, including but not limited to:

- Coding descriptions and instructions as identified in the latest release of the American Medical Association's (AMA) Current Procedural Terminology (CPT®)
- Healthcare Common Procedure Coding System (HCPCS) developed by the Centers for Medicare and Medicaid Services (CMS), 17th edition (Ingenix Publishing Group)
- *Procedural Utilization Facts, Chiropractic Care Standards: A Reference Guide*, 6th edition (Data Management Ventures, Inc.)
- Applicable Massachusetts laws.

BCBSMA uses *Evaluation and Management Guidelines (Muscular System)* (CMS 1997). These guidelines are available on the Internet at **http://cms.hhs.gov/medlearn/emdoc.asp.**

Operational Statements

- To qualify for reimbursement, all services must be performed by a licensed chiropractor. Services performed by chiropractic assistants (CAs), massage therapists, or other unlicensed providers, even when performed under direct supervision by a licensed chiropractor, are not eligible for reimbursement.
- Chiropractic services are subject to current procedural coding edits.
- Under the terms of its provider agreements, BCBSMA may review a chiropractic provider's records (medical and other) to ensure compliance with these guidelines and detect potential fraud or abuse.
- The member must have a significant neuromusculoskeletal condition necessitating appropriate, medically necessary evaluation and treatment services.
- All services provided must be clinically indicated, medically necessary, in accordance with each subscriber certificate, and appropriately documented in the medical record.
- There must be a reasonable expectation of recovery or improvement in function to support the onset and continuation of a therapeutic level care plan.
- Management of long-term spinal conditions wherein care is not essential to improving the net health outcome of a member is not considered medically necessary and not a covered service unless treatment improves a member's function.
- Select subscriber certificates can limit coverage for chiropractic services. Please remember to check member benefits **prior** to rendering services.
- Coverage is excluded for chiropractic services:
  a) When provided by a practitioner who ordinarily resides in the patient's home or who is a family member; or
  b) For which no charge is made, or for which the patient would not be required to pay if they did not have this benefit.

Covered Services

Chiropractic coverage includes evaluation and management (E&M) services, radiology (diagnostic plain-film x-rays), chiropractic spinal manipulative treatment, and physical medicine modalities and procedures according to the subscriber certificate and reimbursement policies, as detailed below. Note: **CPT codes are subject to change**.

Covered Services, *Continued*

Evaluation and Management Office or Other Outpatient Services New Patient (no services within the past three years)		
CPT	**CPT Description[1]**	**Reimbursement Policy**
99201	Evaluation and management of a new patient, which requires these three key components: • Problem-focused history; • Problem-focused examination; and • Straightforward medical decision-making.	Select the appropriate code based on the level of service provided when you are seeing a new patient for initial evaluation of a neuromusculoskeletal condition or injury. Reimbursement frequency in accordance with the New Patient definition in the latest Current Procedural Terminology (CPT) annual edition. We may also reimburse a clinically indicated and medically necessary spinal manipulation on the same date of service, subject to the subscriber certificate.
99202	Evaluation and management of a new patient, which requires these three key components: • Expanded problem-focused history; • Expanded problem-focused examination; and • Straightforward medical decision-making.	
99203	Evaluation and management of a new patient, which requires these three key components: • Detailed history; • Detailed examination; and • Low complexity medical decision-making	
99204	Evaluation and management of a new patient, which requires these three key components: • Comprehensive history; • Comprehensive examination; and • Moderate complexity medical decision making	

Evaluation and Management Office or Other Outpatient Services Established Patient (received services within the past three years)		
CPT	**CPT Description[2]**	**Reimbursement Policy**
99211	Evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	Select the appropriate code based on the level of service provided when you are seeing an established patient for initial evaluation of a new or unrelated condition or injury, or to assess an exacerbation of the patient's condition. Reimbursable only once per episode of care for the presenting condition or injury. Refer to Established Patient definition in the latest Current Procedural Terminology (CPT) annual edition. We may also reimburse a clinically indicated and medically necessary spinal manipulation on the same date of service, subject to the subscriber certificate.
99212	Evaluation and management of an established patient, which requires at least two of these three key components: • Problem-focused history; • Problem-focused examination; • Straightforward medical decision-making.	
99213	Evaluation and management of an established patient, which requires at least two of these three key components: • Expanded problem-focused history; • Expanded problem-focused examination; • Low complexity medical decision-making.	
99214	Evaluation and management of an established patient, which requires at least two of these three key components: • Detailed history; • Detailed examination; • Moderate complexity medical decision-making.	

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

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

Covered Services*, Continued*

The descriptors for the levels of E&M services recognize seven components, six of which are used in defining the levels of E&M services. These components are:

1. History (key component); four recognized types of history (problem-focused, expanded problem-focused, detailed, and comprehensive)
2. Examination (key component); four recognized types of examination (problem-focused, expanded problem-focused, detailed, and comprehensive)
3. Medical decision-making (key component); four recognized types of medical decision-making (straightforward, low complexity, moderate complexity, and high complexity)
4. Counseling (contributory factor)
5. Coordination of care (contributory factor)
6. Nature of presenting problem (contributory factor)
7. Time

When selecting the appropriate level of service for an Office Evaluation and Management (E/M) CPT code, the following requirements must be satisfied and adequately documented in the clinical record:

- New Patient (CPT 99201-99204) – requires all three key components
- Established Patient (CPT 99212-99214) – requires two of the three key components

Diagnostic Imaging Services

The purpose of diagnostic imaging is to gain diagnostic information regarding the patient in terms of diagnosis, prognosis, and therapy planning. The chiropractic provider must be credentialed with BCBSMA to bill and receive reimbursement for the technical component of the radiology service.

If the treating chiropractic provider refers the reading or interpretation of a radiology service to a radiologist, reimbursement for the professional component of that service will only be made to the radiologist and the treating chiropractic provider should not bill for that component. In isolated cases where the treating chiropractor performs the professional component and suspects a diagnostic finding of clinical significance with implications related to patient management, then reimbursement may be considered for the professional component from both practitioners with appropriate documentation in the clinical record, including written radiology reports.

Radiology requirements for chiropractors are outlined on the following page.

Diagnostic Imaging Services, *continued*

Radiology Requirements	
Required standards	Each imaging study must meet the following four standards: 1. The study must be obtained based on clinical need; 2. The study must be of sufficient diagnostic quality; 3. There must be documented interpretation of the study to reach a diagnostic conclusion; and 4. The information from the study must be correlated with patient management.
Patient Selection	The selection of patients for radiographic examination is based on the following guidelines: 1. The need for radiographic examination is based on history and physical examination findings; 2. The potential diagnostic benefits of the radiographic examination is judged to outweigh the risks of ionizing radiation; 3. 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; 4. 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 patient's medical record and must contain: • Patient identification; • Location where studies were performed; • Study dates; • Types of studies; • Radiographic findings; • Diagnostic impressions; and • Signature with professional qualifications included. It may also include recommendations for follow-up studies; and comments for further patient evaluation.
Billing for the Technical and Diagnostic Components of Radiology Services	The technical component, represented by the addition of modifier "-TC" to the x-ray CPT code, is that portion of radiology services that includes providing the facilities, equipment, resources, personnel, supplies, and support needed to perform and produce the diagnostic study. The professional component, signified by the addition of modifier "-26" to the x-ray CPT code, represents the participation and services rendered by a licensed practitioner to perform the diagnostic interpretation of each study. It is required to document the diagnostic conclusions of the study by a written and signed radiology report.
Covered Services	Refer to the current fee schedule for a listing of covered radiology CPT codes.

Chiropractic Manipulative Treatment

The chiropractic manipulative treatment codes include a pre-manipulation patient assessment. Additional E&M services may be reported separately using modifier "25," **if the patient's condition requires a significant separately identifiable E&M service, above and beyond the usual pre-service and post-service work associated with the procedure**. For purposes of CMT, the five spinal regions referred to are:

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

Chiropractic Manipulative Treatment*, continued*

Chiropractic Manipulative Treatment (CMT)		
CPT	CPT Description[3]	Reimbursement Policy
98940	CMT; spinal, one to two regions	Payment is allowed for one clinically indicated and medically necessary spinal manipulation code per date of service. Reimbursement of specific CMT codes is subject to the subscriber certificate.
98941	CMT; spinal, three to four regions	
98942	CMT; spinal, five regions	

Physical Medicine and Rehabilitation

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

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

CPT 97140, manual therapy techniques (mobilization/manipulation, manual lymphatic drainage, manual traction, one or more regions, each 15 minutes) cannot be reported or billed if the chiropractor also reports or bills for a chiropractic manipulative treatment (CMT) on the same anatomical region[4] as the therapeutic procedure. If a chiropractor reports both a CPT 98940-series service and CPT 97140 on the same date of service, the chiropractor's medical records must document the differences between the two procedures and that each was conducted on a different anatomical site. To document this, you may use Modifier 59 (Distinct procedural service) when billing for these procedures (i.e., CPT 97140-59).

It is not appropriate to bill CPT 97124, massage, for myofascial release. For myofascial release, CPT 97140 should be reported. When reporting or billing for CPT 97112 (neuromuscular re-education) and CPT 97124 (massage), as well as all other physical medicine modalities and therapeutic procedures, the details of the procedure shall be recorded in the medical record, including clinical rationale, anatomical site, description of service, and time (as required by the selected CPT code).

Reimbursement guidelines for physical medicine and rehabilitation services are outlined on the following page.

[3] Current Procedural Terminology, CPT 2005. Chicago, American Medical Association, 2004.
[4] The five spinal regions are identified in CPT as cervical (includes atlanto-occipital joint), thoracic (includes costovertebral and costotransverse joints), lumbar, sacral, and pelvic (sacroiliac joint).

Physical Medicine and Rehabilitation, *continued*

Physical Medicine and Rehabilitation		
CPT	**CPT Description: Supervised Modalities (application to one or more areas)**	**Reimbursement Policy**
97012	Traction, mechanical	Payment is allowed for one clinically indicated and medically necessary modality or procedure from this list per date of service. Reimbursement of modalities and procedures is subject to the subscriber certificate.
97016	Vasopneumatic devices	
97018	Paraffin bath	
97022	Whirlpool	
97024	Diathermy	
97026	Infrared	
97028	Ultraviolet	
	Constant Attendance Modalities[5] (application to one or more areas)	
97032	Electrical stimulation (manual), each 15 minutes	
97033	Iontophoresis, each 15 minutes	
97034	Contrast baths, each 15 minutes	
97035	Ultrasound, each 15 minutes	
	Therapeutic Procedures[6] (one or more areas)	
97110	Therapeutic exercises, each 15 minutes	
97112	Neuromuscular re-education, each 15 minutes	
97124	Massage, each 15 minutes	
97140	Manual therapy techniques, one or more regions, each 15 minutes	

Treatment of Low Back Pain

We support the National Institutes of Health (NIH) guidelines for treatment of low back pain. The following physical therapy treatments are considered either to be **not** medically necessary, unproven, or ineffective for patients with acute low back pain (<three months):

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

[5] Constant Attendance Modalities: the application of a modality that requires direct (one-on-one) patient contact by the provider (CPT 2005). Direct one-on-one contact requires that the provider maintain continuous visual, verbal, and manual contact with the patient throughout the procedure (CPT Assistant, November 2001).

[6] Therapeutic Procedures: physician or therapist required to have direct (one-on-one) patient contact (CPT 2005).

Documentation and Chiropractic Records

BCBSMA requires the following standards for documentation and chiropractic records:

- A chiropractor shall establish and maintain a separate, adequate, and accurate written treatment record for each patient in his or her care.
- The record shall be kept in chronological order and record entries shall be made contemporaneously. Each such entry shall be signed by, or shall otherwise adequately identify, the registered chiropractor who is treating the patient to whom the record pertains.
- Such records shall be legible, self-explanatory, and reasonably susceptible to review by a reviewer or auditor possessing basic knowledge of coding and medical terminology.
- Such records shall include, at a minimum, documentation of the following[7]:
  a) The patient's case history;
  b) Findings of all examinations performed;
  c) Findings of special studies, including but not limited to x-ray studies taken or reviewed;
  d) Clinical impression [including rationale for changes in diagnosis];
  e) Treatment plan [including rationale for changes in duration or frequency];
  f) Informed consent or terms of acceptance;
  g) Progress notes for each patient encounter (Subjective and Objective Assessment and Plan format, Data Assessment and Plan format, or similar work chart notes) [manually dated and signed by the provider who rendered the service(s)];
  h) Details of [and rationale for] supportive procedures or therapies, when administered, dispensed or prescribed; and
  i) Specific description of anatomical site(s) or region(s) of all treatment services.

Definition of Medical Necessity

Medically Necessary service means a health care service that, as determined by the Plan, is required to diagnose or treat a Member's illness, injury, symptom, or complaint and:

- is consistent with the diagnosis and treatment of the Member's health condition and provided in accordance with generally accepted medical practice;
- is supported by scientific evidence concerning the effect on health outcomes and has final approval, if applicable, from the appropriate government regulatory bodies;
- is essential to improve the Member's health and provides a positive effect on health that is greater than its harmful effect;
- is as beneficial as any established alternatives covered under the Member Contract;
- is as cost-effective as any established alternatives;
- is consistent with the level of skilled services that are furnished;
- is furnished in the least intensive type of medical care setting required by the Member's health condition;
- is not furnished solely for the Member's convenience or religious preference or for the convenience of the Member's family or health care provider; and
- is not a service solely intended to promote athletic achievements or a desired lifestyle or to increase or enhance the Member's environmental comfort.

The Plan or its designee will determine if a health care service is Medically Necessary for the Member. The fact that any Group/Provider has furnished, prescribed, ordered, recommended, or approved a treatment, or that a treatment is offered as a last resort, does not of itself make the treatment Medically Necessary. When applicable, the Plan or its designee will use Medicare guidelines to determine whether a health care service is Medically Necessary. Inclusion of a health care service on the Fee Schedule shall not be considered a determination that the procedure is Medically Necessary or generally acceptable in all circumstances.

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[7] Massachusetts Board of Registration of Chiropractors, Rules and Regulations, 233 CMR 4.05(1).

Definition of Medical Necessity (continued)

All determinations by the Plan of Medical Necessity shall be based upon clinical information regarding the Member that was available to the Group/Provider at the time services were rendered. The Plan will at all times be in compliance with the regulations of the Massachusetts Department of Public Health and Division of Insurance regarding Medical Necessity.

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

All covered services, except routine circumcision, voluntary termination of pregnancy, voluntary sterilization, stem cell ("bone marrow") transplant donor suitability testing, and preventive health services, must be medically necessary and appropriate for the member's specific health care needs. This means that all covered services must be consistent with generally accepted principals of professional medical practice. The Plan decides which covered services are medically necessary and appropriate for the member by using the following guidelines.

Non-Covered Maintenance Care

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

BCBSMA does not reimburse for those categories of chiropractic services commonly described as "maintenance care," "wellness care," "supportive care," "palliative care," or "preventive care". For instance, when the functional status of the patient has remained stable for a given illness/condition/injury over approximately four weeks, without functional improvement in the member's net health outcome or expectation of additional objectively measurable clinical improvement, further chiropractic treatment is considered maintenance care. Wellness or preventive care is typically rendered on a regular or periodic basis to help maintain optimal body function, often when there is little or no activity-restricting symptomatology, or in order to support lifestyle activities such as high performance sports. Palliative or supportive care is usually given after chronic symptoms have become stationary after the completion of an initial course of therapeutic care; it may be used for repeated treatment of unresolved, recurrent, or chronic conditions including chronic spinal subluxation. Ongoing care after the condition has stabilized or a patient's condition has reached a clinical plateau, called maximum medical improvement (MMI), does not qualify as "medically necessary."

However, these patterns of care may be subjectively described by the rendering chiropractor, in the absence of clinical documentation that supports the delivery of acute or continuing therapeutic care; the services described above are outside the definition of medical necessity and are not covered under BCBSMA's subscriber certificate.