

Reimbursement Policy

Chiropractic Services (Spinal Manipulation)

Policy Number: 2109

Version Number: 11

Version Effective Date: 05/01/2022

Product Applicability	<input type="checkbox"/> All Plan+ Products
Well Sense Health Plan	Boston Medical Center HealthNet Plan
<input type="checkbox"/> NH Medicaid	<input checked="" type="checkbox"/> MassHealth MCO
<input type="checkbox"/> NH Medicare Advantage	<input checked="" type="checkbox"/> MassHealth ACO
	<input checked="" type="checkbox"/> Qualified Health Plans/ConnectorCare/Employer Choice Direct
	<input type="checkbox"/> Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan reimburses covered chiropractic services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy.

Prior-Authorization

Please refer to the Plan's Prior Authorization Requirements Matrix at www.bmchp.org.

Definitions

Chiropractic Care or Spinal Manipulation – a manual technique where the hands are used to manipulate, massage, mobilize, adjust, stimulate, apply traction to, or otherwise influence the synovial joints and paraspinal tissues in the spinal column.

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Provider Reimbursement

The Plan reimburses providers for chiropractic manipulative treatment, office visits, and radiology services in accordance with Medicare and Medicaid rules.

Chiropractic Manipulative Treatment

The Plan reimburses spinal chiropractic manipulative treatment. Extraspinal manipulative treatment is not a reimbursable service. Manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. However, no additional payment is available for use of the device.

Office Visits

The Plan will pay for evaluation and management (E&M) services in conjunction with radiology services; however, when any manipulation service(s) are billed on the same date of service as the E&M, the E&M is considered to be included in the manipulation service(s).

Radiology Services

The Plan pays for radiology services when the services are needed to confirm the existence of a neuromusculoskeletal condition requiring treatment. Payment for radiology services is not included in the fees for office visits or chiropractic manipulative treatment and must be claimed separately.

The Plan pays chiropractors for only those radiology services provided in the chiropractor's office and only when the films are developed and read in the chiropractor's office.

Service Limitations

The Plan excludes the following services, including, but not limited to:

- Chiropractic care provided by anyone other than a licensed chiropractor or a doctor of osteopathic medicine who is licensed/contracted to perform chiropractic care
- Maintenance therapy that is defined as chiropractic treatment to maintain health or prevent regression when the member is no longer symptomatic
- Extraspinal manipulative treatment
- Laboratory services
- Orthotic devices, corrective devices, and orthopedic appliances
- Supportive services that include nutritional counseling, educational services and printed materials
- Physiotherapy, physical therapy, muscular stimulation, heat packs, and massage
- Vitamins, minerals, food supplements or other such supplies
- Services that are investigational, unproven or medically unnecessary
- Radiologic services that are not medically necessary for treatment

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Applicable Coding and Billing Guidelines

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.

CPT	Description
72020	Radiologic examination, spine, single view, specify level
72040	Radiologic examination, spine, cervical; 2 or 3 views
72070	Radiologic examination, spine; thoracic, 2 views
72080	Radiologic examination, spine; thoracolumbar junction, minimum of 2 views
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views
98940	Chiropractic manipulative treatment (cmt); spinal, 1-2 regions
98941	Chiropractic manipulative treatment (cmt); spinal, 3-4 regions
98942	Chiropractic manipulative treatment (cmt); spinal, 5 regions
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 are of total time is spent face-to-face 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.
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.

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CPT	Description
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 visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
10/26/2011	10/26/2011	Payment Policy	Payment Policy Committee

Policy Revisions History

Review Date	Summary of Revisions	Revision Effective Date	Approved by
06/24/2013	Removed product limitation on E/M coding effective 1/1/2012	06/24/2013	Payment Policy Committee
12/02/2013	Updated template, product applicability section, and references for BMC HealthNet Plan Qualified Health Plans, including ConnectorCare	12/02/2013	Payment Policy Committee
04/01/2014	Added ICD-10 Diagnosis Coding	04/01/2014	Payment Policy Committee

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Policy Revisions History			
05/12/2015	Annual review, updated template, updated product applicability, changed policy number	07/01/2015	Payment Policy Committee
12/15/2015	CPT coding updated, diagnosis coding removed	01/01/2016	Payment Policy Committee
10/15/2019	Annual Review, updated template, updated product applicability box	01/01/2020	Payment Policy Committee
01/01/2021	Revised code descriptions 2021 code load. Removed terminated code 99201.	01/01/2021	Payment Policy Committee
11/16/2021	Updated coding table	12/01/2021	Payment Policy Committee
12/14/2021	Updated coding table description for 99211	01/01/2022	Payment Policy Committee
04/19/2022	Annual Review	05/01/2022	Payment Policy Committee

Other Applicable Policies

- General Billing and Coding Guidelines, 2119
- General Clinical Editing and Payment Accuracy Review Guidelines, 2120
- Physician and Non Physician Practitioner Services, 2096
- Modifiers, 2088

References

- 130 CMR 441.00: Chiropractor Manual
- 130 CMR 405.00: Community Health Center Manual
- 101 CMR 317.00: Medicine
- 101 CMR 318.00: Radiology
- Contract between The Office of Health and Human Services (EOHHS), and Boston Medical Center HealthNet Plan MassHealth
- BMC HealthNet Plan Qualified Health Plans, including ConnectorCare Evidence of Coverage

Disclaimer Information

This Policy provides information about the Plan's reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member's benefit plan. Unless otherwise

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specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan's discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan's audit policies, refer to the Provider Manual.

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