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Reimbursement Policy

Chiropractic Services (Spinal Manipulation)

Policy Number: 2131
Version Number: 6
Version Effective Date: 05/01/2022

Product Applicability	☐ **All Plan⁺ Products**
Well Sense Health Plan ☐ NH Medicaid ☐ NH Medicare Advantage	**Boston Medical Center HealthNet Plan** ☐ MassHealth MCO ☐ MassHealth ACO ☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☒ Senior Care Options

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

Policy Summary

The Plan reimburses covered 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.

⁺ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

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 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
- Chiropractic services provided in inpatient or outpatient hospitals, nursing facilities, rest homes and the member’s home
- 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

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.

Modifiers

The "AT" modifier must be used on a claim with 98940, 98941, and/or 98942 when providing active/corrective treatment to treat acute or chronic subluxation.

CPT	Description
72020	Radiologic examination, spine, single view, specify level
72040	Radiologic examination, spine, cervical; 2 or 3 views
72050	Radiologic examination, spine, cervical; 42 or 35 view
72052	Radiologic examination, spine, cervical; 46 or more 5 views
72070	Radiologic examination, spine; thoracic, 2 views
72072	Radiologic examination, spine; thoracic, 3 views
72074	Radiologic examination, spine; thoracic, minimum of 4 views
72080	Radiologic examination, spine; thoracolumbar junction, minimum of 2 views
72081	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view
72082	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); 2 or 3 views
72083	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); 4 or 5 view
72084	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); minimum of 6 views
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views
72110	Radiologic examination, spine, lumbosacral; minimum of 4 views
72114	Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 view
72120	Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views

CPT	Description
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.
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.

CPT	Description
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
10/14/2015	01/01/2016	Payment Policy	SCO Product Subgroup

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
10/15/2019	Annual Review, new template and 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 description of 99211 for 1/1/2022 code load	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, 2136
- General Clinical Editing and Payment Accuracy Review Guidelines, 2137
- Physician and Non Physician Practitioner Services , 2151
- Modifiers, 2145

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
- Medicare Claims Processing Manual Chapter 12; Section 220 – Chiropractic Services
- Medicare Benefit Policy Manual; Chapter 15 Section 240 – Chiropractic Services

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 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.