

CHIROPRACTIC CARE

Chiropractic care focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. Chiropractic care is used most often to treat neuromusculoskeletal complaints, including but not limited to back pain, neck pain, headaches and pain in the joints of the arms or legs. Chiropractors utilize a drug-free, hands-on approach to health care that includes patient examination, diagnosis and treatment.

The most common therapeutic procedure performed by doctors of chiropractic medicine is known as spinal manipulation. The purpose of 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. Manipulation, or adjustment of the affected joint and tissues, restores mobility, thereby alleviating pain and muscle tightness, and allowing tissues to heal.

ORIGINAL MEDICARE

Original Medicare only pays for chiropractic care services deemed to be medically necessary and reasonable¹.

Under the Original Medicare program, coverage of chiropractic care is specifically limited to treatment by means of manual manipulation (by use of the hands) of the spine to correct a subluxation provided such treatment is legal in the state where performed. Additionally, 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 or for the device itself. All other services furnished or ordered by chiropractors are not covered.

The patient must have a significant health problem in the form of a neuromuscular-skeletal condition necessitating treatment. The patient primary diagnosis must be subluxation of the spine. The precise level of the subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine. A subluxation may be demonstrated by an X-ray or by physical examination.

The manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. For Medicare purposes, a chiropractor must place an AT (acute treatment) modifier on the claim when providing active or corrective treatment to treat acute or chronic subluxation.

Maintenance therapy is defined as services that seek to prevent disease, promote health and prolong and enhance the quality of life; or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. The AT modifier must not be placed on the claim when maintenance therapy has been provided. Claims without an AT modifier are considered maintenance therapy and denied.

Coverage criteria for chiropractic services are based on Medicare laws, regulations and guidelines and local coverage determinations established by Medicare carriers and Part A/Part B Medicare Administrative Contractors. Original Medicare does not impose caps and limits for covered chiropractic care. There may be review screens (numbers of visits at which the Medicare carrier or A/B MAC may require a review of documentation²).

¹ Social Security Act, title XVIII, section 1862(a) (1) (a)
http://www.ssa.gov/OP_Home/ssact/title18/1862.htm

MEDICARE ADVANTAGE

Coverage for additional chiropractic benefits, including diagnostic X-rays, evaluation and management services, mechanical traction therapy and spinal manipulation for additional conditions, is provided to members under select group Medicare Advantage private fee-for-service plans and varies by group. The member's cost-sharing and other coverage conditions, such as frequency, are determined by the group.

There may be review screens (numbers of visits at which BCBSM Medicare Advantage private fee-for-service plans may require a review of documentation), but caps and limits are not imposed.

Emergency treatment of an acute spinal condition must be provided within 48 hours of the injury. Medicare Advantage private fee-for-service does not pay for follow-up services unless the injury for which services were provided results in an ongoing acute or chronic condition. In that case, payment may be made for follow-up services for chiropractic manipulative treatment.

Conditions for payment

BCBSM Medicare Advantage private fee-for-service plans use Centers for Medicare & Medicaid Services deemed provider³ concept for group specific benefits. The table below specifies payment conditions for additional chiropractic care:

Conditions for payment		
Eligible provider	Chiropractor	
Deemed provider	See terms and conditions on bcbsm.com/ma	
Payable location	Office	
Frequency	Varies based on CPT codes listed below.	
CPT/HCPCS codes	Diagnostic radiology	72010, 72020, 72040, 72050, 72052, 72069, 72070, 72072, 72074, 72080, 72090, 72100, 72110, 72114, 72120, 72170, 72190, 72200, 72202, 72220 <ul style="list-style-type: none">• X-rays of the area of chief complaint may be taken at the start of treatment.• Follow-up X-rays should be performed within 90 days for acute conditions and within 365 days for chronic conditions.
	Evaluation & management	<ul style="list-style-type: none">• New patient visits (99201, 99202, 99203) payable once every 36 months per chiropractor.• Established patient visits (99212, 99213, 99214) payable once every 12 months per chiropractor.
	Physical therapy	97012 (May be billed once per day, per patient and must be performed in conjunction with one of the following codes: 98940, 98941, 98942)
	Spinal manipulation	98940, 98941, 98942 (AT modifier required – may be billed once per day)

² <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0749.pdf>

³ 2009 Terms & Conditions – <http://www.bcbsm.com/ma/>

Conditions for payment		
Diagnosis restrictions	Diagnostic radiology	739.0-739.4, 839.01- 839.08, 839.20-839.21, 839.41-839.42 Note: X-rays of areas other than that of chief complaint must be supported by documentation showing medical necessity.
	Evaluation & management	307.81, 353.0-353.4, 353.8, 719.48, 720.0-720.2, 720.81, 720.89, 721.0-721.3, 721.41-721.42, 721.5-721.8, 721.90-721.91, 722.0, 722.10-722.11, 722.2, 722.30-722.32, 722.39, 722.4, 722.51-722.52, 722.6, 722.70-722.73, 722.80-722.83, 722.90-722.93, 723.0-723.9, 724.00-724.02, 724.09, 724.1-724.6, 724.70-724.71, 724.79, 724.8-724.9, 729.0-729.2, 729.30-729.31, 729.39, 729.4-729.6, 729.81-729.82, 729.89, 729.9, 737.0, 737.10-737.12, 737.19 737.22, 737.29-737.33
	Physical therapy	739.0-739.4, 839.01- 839.08, 839.20-839.21, 839.41-839.42
	Spinal manipulation	307.81, 346.00-364.01, 346.10-346.11, 346.20-346.21, 346.80-346.81, 346.90-346.91, 353.0-353.4, 353.8, 355.0-355.2, 355.8, 719.01-719.09, 719.11-719.19, 719.21-719.29, 719.31-719.39, 719.41-719.49, 719.51-719.59, 719.61-719.69, 719.7, 719.81-719.89, 720.1, 721.0-721.3, 721.7, 721.90, 722.0, 722.10-722.11, 722.4, 722.51-722.52, 722.81-722.83, 722.91-722.93, 723.0-723.5, 724.01-724.02, 724.1-724.2, 724.3, 724.4-724.6, 724.79-724.8, 728.85, 729.4, 738.4, 739.0-739.5, 756.11-756.12, 784.0, 839.01-839.08, 839.20-839.21, 839.41-839.42, 846.0-846.3, 846.8, 847.0-847.4
Age restrictions	No restrictions	

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2008 American Medical Association. All rights reserved.

Reimbursement

The maximum payment amount for chiropractic care services is consistent with Original Medicare. The provider will be paid the lesser of Medicare's allowed amount or the provider's charge, minus the member's cost-share. This represents payment in full and providers are not allowed to balance bill the member for the difference between the allowed amount and the charge.

Member cost-sharing

- Deemed providers must agree to collect from the member only the cost-sharing amounts described in the table below. They may not otherwise charge or bill the member.
- If the member elects to receive a noncovered service, he or she is responsible for the entire charge associated with the noncovered service.

For detailed information about BCBSM Medicare Advantage member's benefits and cost-share, review the group plan's [Summary of Benefits](#).

The chart below identifies members with additional chiropractic care coverage:

Group name and number		
BCBSM/NBU Retirees 80311, 80312		BCBSM/BU Retirees 80306
City of Detroit Option E 81100, 81101	City of Detroit Option F 54731, 81097	City of Detroit Option G 04436
Hope College 51623		Kadant Johnson 50309
MPSERS 59000		
State of MI Retirees Troopers 81820		State of MI Retirees Nontroopers 81821 & 81828

Billing instructions

1. Bill services on the CMS 1500 (8/05) claim form or the 837 equivalent claim.
2. Use the Medicare Advantage private fee-for-service unique billing requirements.
3. Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
4. Report your National Provider Identifier number on all claims.
5. Submit claims to your local BCBS plan.
6. Use electronic billing:
 - a. Michigan providers:
 - A copy of the BCBSM EDI Professional 837/835 Companion Document is available at:
http://www.bcbsm.com/pdf/systems_resources_prof_837_835.pdf
 - b. Providers outside of Michigan should contact their local BCBS plan.