Chiropractic care

Applies to:

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

☒ Medicare Plus Blue℠ PPO ☐ Medicare Plus Blue℠ Group PPO ☐ Both

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 most often used 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 reasonable.

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 aren't covered including x-rays taken to document medical necessity or any other diagnostic or therapeutic service.

In order for Original Medicare to make payment for chiropractic care, the patient must have a significant health problem in the form of a neuromuscular-skeletal condition necessitating treatment. The patient's 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 modifier AT (acute treatment) on the claim when providing active or corrective treatment to treat acute or chronic subluxation.

Original Medicare will not pay for chiropractic maintenance therapy. Maintenance therapy is defined as services that seek to prevent disease, promote health, 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 modifier AT must not be placed on the claim when maintenance therapy has been provided. Claims without modifier AT 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 A/B Medicare Administrative Contractors. Original Medicare doesn't impose specific caps or dollar value limits for covered chiropractic care. However, Medicare carriers and A/B Medicare Administrative Contractors may have criteria (numerical or dollar) after which medical documentation or chart review may be required prior to the payment of billed services.

Medicare Plus Blue℠ PPO enhanced benefit

Medicare Plus Blue is a Medicare Advantage plan that provides at least the same level of benefit coverage as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue Cross to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Coverage for one set of diagnostic X-rays (up to three views) and one routine office visit at no cost, is provided to all individual Medicare Plus Blue members once annually. The member's cost sharing for additional X-rays is determined by Blue Cross.

Emergency treatment of an acute spinal condition must be provided within 48 hours of the injury.
Medicare Plus Blue PPO for select group plans doesn't 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

The table below specifies payment conditions for additional chiropractic care.

Conditions for payment	
Eligible provider	Chiropractor
Payable location	Office
Frequency	Once annually
CPT codes	X-rays of the area of chief complaint may be taken at the start of treatment. 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114, 72120, 72170, 72190, 72200, 72202, 72220, 72081 through 72084 E&M new patient: 99202, 99203 once every 36 months per chiropractor. E&M established patient: 99212, 99213 and 99214 once every 12 months per chiropractor.
Diagnosis restrictions	X-rays of areas other than that of the chief complaint must be supported by documentation showing medical necessity. No diagnosis restrictions.
Age restrictions	No restrictions

Reimbursement

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

Member cost sharing

- Medicare Plus Blue providers should collect the applicable cost sharing from the member at the time of the service when possible. Cost sharing refers to a flat dollar copayment, a percentage coinsurance or a deductible. Providers can only collect the appropriate Medicare Plus Blue cost sharing amounts from the member.
- If the member elects to receive a service that's not covered, he or she is responsible for the entire charge associated with that service.

- Providers may not have members sign an ABN to accept financial responsibility for noncovered items or services. If there is any question about whether an item or service is covered, seek a coverage determination from Blue Cross before providing the item or service to the member. If a provider provides a noncovered item/service to a member without first obtaining a coverage determination, the member must be held harmless for all charges except for any applicable cost-share.
- Cost share amounts incurred by the member under this benefit don't count toward the plan deductible or the combined maximum out of pocket limit as listed in the Evidence of Coverage document (applies to all members with individual coverage).

To verify benefits and cost share, providers may utilize our provider portal or call 1-866-309-1719.

Billing instructions for providers

1. Bill services on the CMS 1500 (02/12) claim form, UB-04 or the 837 equivalent claim.
2. Use the Medicare Advantage PPO 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 Blue Cross plan.
6. Use electronic billing:
   a. Michigan providers:
   Copies of the ANSI ASC X 12N 837 and 835 Institutional Health Care Claim And Health Care Claim Payment/Advice (Blue Cross Electronic Data Interchange (EDI) Institutional 837/835 Companion Documents) are available on the Blue Cross website in the provider online tools section at **bcbsm.com/providers/help/edi**.

   b. Providers outside of Michigan should contact their local Blue Cross plan.

Revision history

Policy number: MAPPO 1007

Effective date: 01/01/2013

Reviewed: 08/30/2023, 11/15/2022, 08/25/2021, 11/20/2020, 08/27/2019, 07/17/2018

Revised: 11/15/2022, 08/27/2019, 08/28/2017

Created date: 08/02/2017

11/15/2022: Added one routine office visit per year to enhanced benefit.

08/27/2019: Removed CPT code 72090.

08/28/2017: Under Original Medicare Section added clarification that Medicare does not cover x-rays or other diagnostic tests ordered or performed by chiropractors, added at paragraph 3 'In order for Original Medicare to make payment for chiropractic care,', added at paragraph 5 'Original Medicare will not pay for chiropractic maintenance therapy.', at paragraph 6 modified the second sentence by the addition of the words 'specific' 'or dollar value', deleted 'There may be review screens (numbers of visits at which the Medicare carrier or A/B MAC may require a review of documentation). Replaced with 'However, Medicare carriers and A/B Medicare Administrative Contractors may have criteria (numerical or dollar) after which medical documentation and/or chart review may be required prior to the payment of billed services.'; Under Conditions for payment section removed procedure codes end-dated by the American Medical Association as of 12/31/2015 72010 and 72069 and replaced with new codes 72081, 72082, 72083 and 72084.

01/01/2016: Cost share amounts not applied to deductible or maximum out of pocket limits.