

Blue Cross Blue Shield of Michigan
Medicare Advantage Private Fee-for-Service

Chiropractic Care

January 1, 2008
Updated October 1, 2008

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 MEDICARE¹

Medicare only pays for chiropractic care services deemed to be medically necessary and reasonable².

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

¹ Medicare benefit policy manual, CMS publication 100-02, chapter 15, §240.1

² Social Security Act, title XVIII, section 1862(a) (1) (a)
http://www.ssa.gov/OP_Home/ssact/title18/1862.htm

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 (A/B MACs). 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 documentation³).

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 the Centers for Medicare & Medicaid Services deemed provider⁴ concept for group specific benefits. The table below specifies payment conditions for additional chiropractic care:

³ <http://www.cms.hhs.gov/MLNMArticles/downloads/SE0749.pdf>

⁴ 2008 Terms and conditions

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 ⁵	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)
Diagnosis restrictions	Diagnostic radiology	739.0-739.4, 839.01- 839.08, 839.20-839.21, 839.41-839.42 <p>Note: X-rays of areas other than that of chief complaint must be supported by documentation showing medical necessity.</p>
	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	

⁵ 2007 & 2008 Benefit grids for BCBSM, COD, MPSERS, and SOM Retirees

Reimbursement

The maximum payment amount for chiropractic care services is consistent with Original Medicare. The provider will be paid the lesser of Medicare's allowable 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.

The cost-sharing chart below identifies members with additional chiropractic care coverage:

Member Cost-Sharing Responsibilities									
Group Name and Number	Type of Service	Annual Deductible		Coinsurance/Copayment		Out-of-Pocket Maximum			
				Professional Claim					
		2007	2008	2007	2008	2007	2008		
BCBSM Retirees 80311, 80312 ⁶	Diagnostic Radiology	No MA PFFS Plan	\$250	No MA PFFS Plan	5%	No MA PFFS Plan	\$1000		
	E & M		\$0		\$10		Does not apply		
	Physical Therapy		\$250		5%		\$1000		
	Spinal Manipulation		\$0		\$10		Does not apply		
City of Detroit Option E 81100, 81101 ⁷	Diagnostic Radiology	\$175 Waived	\$0	\$0	\$0	Does not apply	Does not apply		
	E & M		\$175 for all locations except 21 ⁸		20% for all locations except 21		20% for all locations except 21	\$825	\$825 for all locations except 21
	Physical Therapy		\$175 for all locations except 21		20% for all locations except 21		20% for all locations except 21	\$825	\$825 for all locations except 21
	Spinal Manipulation		\$175 for all locations except 21		20% for all locations except 21		20% for all locations except 21	\$825	\$825 for all locations except 21

⁶ BCBSM Retirees Benefit grid

⁷ City of Detroit - Option E Benefit grid

⁸ Inpatient hospital - 21

Member Cost-Sharing Responsibilities							
Group Name and Number	Type of Service	Annual Deductible		Coinsurance/Copayment		Out-of-Pocket Maximum	
				Professional Claim			
		2007	2008	2007	2008	2007	2008
City of Detroit Option F 54731, 81097 ⁹	Diagnostic Radiology	\$175 Waived	\$175	10%	10%	\$825	\$825
	E & M		\$0	\$10	\$10	Does not apply	Does not apply
	Physical Therapy		\$175 for all locations except 11 ¹⁰ & 21	\$10	10% for all locations except 11 & 21	Does not apply	\$825 for all locations except 11 & 21
	Spinal Manipulation		\$0	\$10	\$10	Does not apply	Does not apply
City of Detroit Option G 04436 ¹¹	Diagnostic Radiology	\$175 Waived	\$175	10%	10%	\$825	\$825
	E & M		\$0	\$10	\$10	Does not apply	Does not apply
	Physical Therapy		\$175 for all locations except 21	\$10	10% for all locations except 21	Does not apply	\$825 for all locations except 21
	Spinal Manipulation		\$0	\$10	\$10	Does not apply	Does not apply
MPSERS ¹² 59000	Diagnostic Radiology	\$250	<u>1/1-3/31</u> \$250 <u>4/1-12/31</u> \$250	10% for all locations except 21	<u>1/1-3/31</u> 10% for all locations except 21 <u>4/1-12/31</u> 10%	\$500	\$500
	Spinal Manipulation		\$0	<u>1/1-3/31</u> \$0 <u>4/1-12/31</u> \$250	10% for all locations except 21	<u>1/1-3/31</u> 10% for all locations except 21 <u>4/1-12/31</u> 10%	Does not apply
State of MI Retirees 81820, 81821, 81828 ¹³	Diagnostic Radiology	No MA PFFS Plan	\$200	No MA PFFS Plan	\$0	No MA PFFS Plan	Does not apply
	E & M		\$0		\$10		Does not apply
	Physical Therapy		\$200		\$0		Does not apply
	Spinal Manipulation		\$200		10%		\$1000

⁹ City of Detroit - Option F Benefit grid

¹⁰ Office - 11

¹¹ City of Detroit - Option G Benefit grid

¹² MPSERS Benefit grid

¹³ State of Michigan Retirees Benefit grid

Billing Instructions

1. Bill services on the CMS 1500 (8/05) claim form, or 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.