Chiropractic care

Applies to:

☐ BCN Advantage Individual ☐ BCN Advantage Group ☒ Both

BCN Advantage HMO℠
BCN Advantage HMO-POS℠

Blue Care Network of Michigan

Medicare and more

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.

BCN Advantage enhanced benefit

BCN Advantage 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 BCN Advantage to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Since Original Medicare limits coverage for chiropractic care, enhanced chiropractic care coverage is provided to BCN Advantage individual members and select BCN Advantage group plans that include this benefit. Coverage for one set of diagnostic X-rays (up to three views) and one routine office visit at no cost is provided once annually to all BCN Advantage members that have this benefit. The member's cost sharing is determined by BCN for individual coverage and by the group for those with group-based coverage.

Conditions for payment

The table below specifies payment conditions for additional chiropractic care.

Conditions for payment	
Eligible provider	Chiropractor
Payable location	Office
Frequency	X-rays: once annually New patient visits: payable once every 36 months per chiropractor Established patient visits: payable once every 12 months per chiropractor
CPT codes	72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114, 72120, 72170, 72190, 72200, 72202, 72220, 72081 through 72084, 73501, 73551, 73552 X-rays of the area of chief complaint may be taken at the start of treatment. New patient visits: 99202 and 99203 Established patient visits: 99212, 99213, 99214
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 BCN Advantage 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

- BCN Advantage 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 BCN Advantage 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 BCN before providing the item or service to the member. If a provider provides a noncovered item or 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 1-800-344-8525.

Billing instructions for providers

1. Bill services on the CMS 1500 (02/12) claim form.
2. Use the BCN Advantage 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. 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 837/835Companion Documents) are available on the Blue Cross website under the reference library section at **bcbsm.com/providers/help/edi/**.
   b. **Providers outside Michigan:** Members of BCN Advantage HMO-POS plans have a point-of-service benefit offered through the nationwide network of Blue Plan Providers via the Blue Cross and Blue Shield Association. Providers outside Michigan who participate with Blue plans can provide preauthorized routine and follow-up care as necessary. Contact your local Blue plan for billing instructions.

      Coverage outside Michigan for members of BCN Advantage HMO plans is limited to medical emergencies, urgently needed services and renal dialysis unless BCN Advantage has approved the out-of-network services, which members must request in advance.
6. Send paper claims to:

   BCN Advantage Claims
   Blue Care Network
   P.O. Box 68753
   Grand Rapids, MI 49516-8753

Revision history

Policy number: BCNA

Effective: 01/01/2023

Reviewed: 11/27/2024, 10/4/2023

Revised: 10/4/2023

10/4/2023: Updated policy to add 3 additional codes (73501, 73551, 73552) for Group and Individual.