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 caps and 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℠ Group 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 additional chiropractic benefits, including diagnostic X-rays, evaluation and management services, mechanical traction therapy and spinal manipulation for additional conditions, is provided to select Medicare Plus Blue℠ Group PPO plans that include this benefit. The member's cost sharing, and other coverage conditions such as frequency, are determined by the group. This policy doesn't apply to Medicare Plus Blue℠ PPO individual members.

Select Medicare Plus Blue Group PPO plans may require a review of documentation based on the number of visits billed, but limits aren't imposed at this time.

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	Based on CPT codes billed

CPT / HCPCS codes	Diagnostic radiology	72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114, 72120, 72170, 72190, 72200, 72202, 72220, 72081 through 72084 X-rays of the area of chief complaint may be taken at the start of treatment. **University of Michigan MA only** 73501, 73551 and 73552
	Evaluation & management	New patient visits (99202 and 99203) payable once every 36 months per chiropractor. Established patient visits (99212, 99213 and 99214) payable once every 12 months per chiropractor. **State Health Plan MA only** New patient visits (99202, 99203, 99204 and 99205) payable once every 36 months per chiropractor. Established patient visits (99211, 99212, 99213, 99214 and 99215) payable once every 12 months per chiropractor.
	Physical therapy	Therapy service for application of a modality to one or more areas (97140); hot or cold packs (97010), mechanical traction (97012), unlisted physical therapy modality (97039), may be billed once per day, per patient and must be performed in conjunction with spinal manipulation services. **State Health Plan MA and City of Livonia 19551 only:** This code is in addition to the current codes listed: Physical Therapy Massage (97124)
	Spinal manipulation	Spinal manipulation services (98940, 98941 and 98942): modifier AT required – may be billed once per day. The following groups do not require the modifier AT – may be billed once per day: • **Operating Engineers Local 324 Health Care Plan** • **City of Livonia 19551** • **University of Michigan MA only** **State Health Plan MA only** This code is in addition to current codes listed: Spinal manipulation services (98943.)
Diagnosis restrictions	Diagnostic radiology	X-rays of areas other than that of the chief complaint must be supported by documentation showing medical necessity. No restrictions.
	Evaluation & management	Must be medically necessary. No diagnosis restrictions.
	Physical therapy	Must be medically necessary. No diagnosis restrictions.
	Spinal manipulation	Must be medically necessary. Consistent with Original Medicare.
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 share. 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.

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 under the reference library section at **bcbsm.com/providers/help/edi**.

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

Revision history

Policy number: MAPPO 1006

Reviewed: 11/27/2024, 10/17/2023, 11/17/2022, 08/31/2022, 11/20/2020, 01/06/2020, 11/13/2019, 08/27/2019, 07/17/2018

Revised: 03/22/2024, 10/17/2023, 11/17/2022, 01/06/2020, 11/13/2019, 08/27/19, 08/28/17, 08/22/2016, 08/18/2015, 02/2014

03/22/2024: Added University of Michigan MA only plan to groups that do not require the modifier AT – may be billed once per day. Effective retroactively to 1/1/2024.

10/17/2023: Added new codes to accommodate additional diagnostic radiology coverage for University of Michigan only (73501, 73551 and 73552).

11/17/2022: Added new benefit for City of Livonia 19551 Plan: Spinal manipulation services (98940, 98941 and 98942). This group does not require the modifier AT – may be billed once per day. Effective 8/1/2022.

01/06/2020: Added new benefit for Operating Engineers Local 324 Health Care Plan Only: Spinal manipulation

services (98940, 98941 and 98942): This group does not require the modifier AT – may be billed once per day. Effective 3/1/2020.

11/13/2019: Added new codes to accommodate the State Health Plan MA benefit: New patient visits (99204, 99205), Established patient visits (99211 and 99215), Physical Therapy Massage (97124) and Spinal Manipulation (98943).

08/27/2019: Removed CPT code 72090.

08/25/2017: Under Original Medicare Section - added clarification that Medicare does not cover x-rays or other diagnostic tests ordered or performed by chiropractors; Under Conditions for payment section – diagnostic radiology-removed procedure codes end-dated by, 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.' the American Medical Association as of 12/31/2015 72010 and 72069 and replaced with new codes 72081, 72082, 72083 and 72084; removed statement 'Follow-up x-rays should be performed within 90 days for acute conditions and within 365 days for chronic conditions', removed list of specific diagnostic code restrictions from Diagnostic Radiology (M99.00–M99.05, M99.12–M99.14, S13.100A–S13.181A, S23.100A–S23.171A, S33.100A–S33.141, S23.0XXA,S33.0XXA, S33.2XXA), Evaluation and Management (A18.01, G44.209, G54.0–G54.4, G54.8, G55, M08.1, M25.50, M25.78, M35.6, M40.00–M40.05, M40.202–M40.299, M40.30–M40.37, M40.50–M40.57, M41.00–M41.08, M41.112-M41.129, M41.20–M41.27, M43.20–M43.28, M43.6, M43.8X9, M45.0–M46.09, M46.1, M46.40–M46.59, M46.80–M46.89, M47.011–M47.016, M47.021–M47.029, M47.10–M47.9, M48.00–M48.38, M48.8X1–M49.89, M50.00–M53.1, M53.2X7–M53.2X8, M53.3–M53.9, M54.00–M54.9, M60.80–M60.9, M62.830, M67.88, M70.90–M70.99, M72.9, M79.0–M79.5, M79.601–M79.9, M96.1–M96.5, M99.20– M99.79, R25.2, R29.898), and Physical Therapy services (M99.00–M99.05, M99.12–M99.14, S13.100A–S13.181A, S23.0XXA, S23.100A–S23.171A, S33.0XXA, S33.100A–S33.141A, S33.2XXA) and changed each to 'No diagnosis restrictions'. For spinal manipulation services removed list of specific diagnosis code restrictions (G43.009, G43.019, G43.109, G43.119, G43.809, G43.819, G43.909, G43.919, G43.A0-G43.D1, G44.209, G54.0–G54.4, G54.8, G55, G57.00–G57.22, G57.90–G57.92, M12.211–M12.279, M12.28–M12.29, M12.311–M12.379, M12.38–M12.39, M12.411–M12.50, M25.00–M25.879, M43.00–M43.19, M43.27–M43.28, M43.6, M46.00–M46.09, M46.40–M46.49, M47.011–M47.029, M47.11–M47.13, M47.20–M47.9, M48.01–M48.07, M48.30–M48.38, M50.10–M50.93, M51.14–M51.9, M53.0–M53.1, M53.2X7–M53.2X8, M53.3, M53.86–M53.88, M54.03–M54.09, M54.11–M54.17, M54.2, M54.30–M54.6, M62.411–M62.49, M62.831, M63.838, M72.9, M79.643, M79.646, M96.1, M99.00–M99.05, M99.12–M99.14, M99.20–M99.23, M99.30–M99.33, M99.40–M99.43, M99.50–M99.53, M99.60–M99.63, M99.70–M99.73, Q76.2, R26.2, R29.4, R29.898, R51, S13.100A–S13.181A, S13.4XXA, S13.8XXA, S16.1XXA, S23.0XXA, S23.120A-S23.171A, S23.3XXA, S23.8XXA, S33.0XXA, S33.100A–S33.141A, S33.2XXA, S33.5XXA, S33.6XXA, S33.8XXA) and changed to 'Consistent with Original Medicare'.

08/22/2016: corrected applicability of benefit to only groups, added the words 'Group PPO' to Medicare Plus Blue section heading, removed reference to ICD9 versus ICD10 usage, deleted all ICD9 codes from the conditions for payment section, updated revision history section.

08/18/2015: Updated formatting, deleted individual plan references, removed CAREN reference, added ICD-10 codes, updated code lists per LCDs L30328 and L34585, updated provider billing instructions, updated web link, added revision history section.