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 are not covered.

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.

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 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 documentation).

Medicare Plus Blue 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 does not 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 are not 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 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

The table below specifies payment conditions for additional chiropractic care. Note: Use ICD-9 Diagnosis codes for DOS through September 30, 2015. For DOS beginning with October 1, 2015 and later ICD-10 codes must be used.

Conditions for payment		
Eligible provider	Chiropractor	
Payable location	Office	
Frequency	Based on CPT codes billed	
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 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	New patient visits (99201, 99202, and 99203) payable once every 36 months per chiropractor. Established patient visits (99212, 99213 and 99214) payable once every 12 months per chiropractor.
	Physical therapy	Therapy service (97012) for application of a modality to one or more areas; hot or cold packs, mechanical traction, may be billed once per day, per patient and must be performed in conjunction with spinal manipulation services.
	Spinal manipulation	Spinal manipulation services (98940, 98941 and 98942): modifier AT required – may be billed once per day.

Conditions for payment		
Diagnosis restrictions	Diagnostic radiology	X–rays of areas other than that of the chief complaint must be supported by documentation showing medical necessity. Diagnosis codes: (ICD-9) 739.0–739.5, 839.01–839.08, 839.20–839.21, 839.41–839.42; (ICD-10) 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 & management	Must be medically necessary, diagnosis codes: (ICD-9) 307.81, 353.0–353.4, 353.8, 718.48, 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; (ICD-10) 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
	Physical therapy	Must be medically necessary, diagnosis codes: (ICD-9) 739.0, 739.4, 839.01–839.08, 839.20–839.21, 839.41–839.42, (ICD-10) 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
	Spinal manipulation	Must be medically necessary, diagnosis codes: (ICD-9) 307.81, 346.00–346.01, 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, 718.48, 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, 721.6, 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;

Conditions for payment		
		(ICD-10) 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
Age restrictions	No restrictions	

Reimbursement

Medicare Plus Blue plan's 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 balance 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 non–covered service, he or she is responsible for the entire charge associated with the non–covered service.

To verify benefits and cost–share, providers may utilize web-Denis 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 BCBS 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 (BCBSM Electronic Data Interchange (EDI) Institutional 837/835 Companion Documents) are available on the BCBSM website under the reference library section at: **http://www.bcbsm.com/providers/help/faqs/electronic-connectivity-edi.html**.

   b. Providers outside of Michigan should contact their local BCBS plan.

Revision History

Policy Number: MAPPO 1003

Revised: 8/18/2015, 2/2014

8/18/2015: 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.