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 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 employ 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 (hand-held, with 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 that requires 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 provided 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 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

Medicare Plus Blue for individual and select group plans provides at least the same level of benefit coverage as Original Medicare (Part A and Part B) and provides enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows BCBSM 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 members under Medicare Plus Blue PPO and select Medicare Plus Blue Group PPO plans. The member's costsharing and other coverage conditions, such as frequency, are determined by the group.

Medicare Plus Blue PPO and select Medicare Plus Blue Group PPO plans may require a review of documentation based on the number of visits billed, but no limits are imposed at this time.

Emergency treatment of an acute spinal condition must be provided within 48 hours of the injury. Medicare Plus Blue for individual and 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. The Medicare Plus Blue PPO enhanced benefit for chiropractic care is limited to X-ray services as indicated in the chart below.

Conditions for payment		
Eligible provider	Chiropractor	
Payable location	Office	
Frequency	Based on CPT codes billed	
CPT / HCPCS codes	Diagnostic radiology	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. **Medicare Plus Blue PPO – Individual plans only:** One set of X-rays (up to 3 views) per year performed by a chiropractor. Cost share is same as diagnostic X-ray.
	Evaluation & management	New patient visits payable once every 36 months per chiropractor. Established patient visits payable once every 12 months per chiropractor. **Evaluation and management services do not apply to Medicare Plus Blue PPO individual plans.**
	Physical therapy	Therapy service for application of a modality to one or more areas; hot or cold packs, traction, mechanical may be billed once per day, per patient and must be performed in conjunction with spinal manipulation services. **Physical therapy services do not apply to Medicare Plus Blue PPO individual plans.**

Conditions for payment		
	Spinal manipulation	Spinal manipulation services: modifier AT required – may be billed once per day.
Diagnosis restrictions	Diagnostic radiology	X-rays of areas other than that of chief complaint must be supported by documentation showing medical necessity.
	Evaluation & management	Must be medically necessary.
	Physical therapy	
	Spinal manipulation	
Age restrictions	No restrictions	

Reimbursement

Medicare Plus Blue PPO and select Medicare Plus Blue Group PPO plans' maximum payment amount for chiropractic care services is consistent with Original Medicare. The provider will be paid the lesser of Medicare's allowed amount or the provider's charge, minus the member's costshare. 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 Advantage PPO 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 Advantage PPO cost–sharing amounts from 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.

For detailed information about Medicare Plus Blue member's benefits and cost–share, providers may verify member benefits via web-DENIS or call CAREN at 1-866-309-1719.

Billing instructions

1. Bill services on the CMS 1500 (8/05) 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:
      - A copy of the *BCBSM EDI Professional 837/835 Companion Document* is available at: **bcbsm.com/pdf/systems_resources_prof_837_835.pdf**
   b. Providers outside of Michigan should contact their local BCBS plan.