If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSOK may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSOK has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Chiropractic Care Services

Policy Number: CPCP016

Version 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: January 12, 2024

Plan Effective Date: January 25, 2024

Description

The practice of chiropractic care services focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. These services are provided on an inpatient or outpatient basis, within the scope of licensure and practice of a chiropractor, to the extent services would be covered if provided by a Medical Doctor or Chiropractor.

Definitions:

Chiropractic Manipulative Treatment (CMT) - CMT procedures use high-velocity, short-lever, low-amplitude thrust by hand or instrument to remove structural dysfunction in joints and muscles that may be associated with neurologic or mechanical dysfunction of the spinal joints and surrounding tissue.

There are 2 types of CMT:

- **Spinal**: manipulative treatment of cervical, thoracic, lumbar, sacral, and pelvic regions
- **Extraspinal**: manipulative treatment of the appendicular skeleton

Chiropractic Maintenance Care - A maintenance program consists of activities that preserve the patient's present level of function and prevents regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur. Ongoing treatment after a condition has been stabilized or reached a clinical plateau (Maximum Therapeutic Benefit) does not qualify as medically necessary and is considered maintenance care. Supportive therapy also refers to therapy that is needed to maintain or sustain level of function. Maintenance Care and Supportive Care are not medically reasonable or necessary and are NOT payable.

Providers of Chiropractic Services – Qualified providers of chiropractic services act within the scope of their license that is regulated by the Federal and State governments. Only those healthcare practitioners who hold an active license, certification, or registration with the applicable state board or agency may provide services under the direction and supervision of a chiropractor. The scope and extent of such services, when provided as part of a chiropractic treatment plan and billed by the chiropractor, may be regulated by the applicable state board responsible for the licensure of the chiropractor. Nonqualified personnel that do not meet the definition of qualified healthcare professional (QHP) are limited to non-skilled services. They may not bill any direct treatments, modalities, or procedures.

Date of Injury (DOI) - The actual date of the current injury. This information is entered in Box 14 of the CMS-1500 claim form.

Durable Condition Specific Benefit- A measurable improvement in or restoration of a functional impairment that resulted from a specific disease, trauma, congenital anomaly, or therapeutic intervention; and able to be sustained long-term without significant deterioration.

Exacerbation - An increase in severity of the patient's condition or symptoms.

Qualified Healthcare Professional (QHP) - Is an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.

Initial Treatment Date (ITD) - The date of the initial treatment (visit). This information is entered in Box 15 (other date) of the CMS-1500 claim form.

Therapeutic Procedure - A manner of affecting change through the application of clinical skills and/or services that attempt to improve function.

Reimbursement Information:

Providers are to bill and document appropriately for all services submitted. The plan reserves the right to request supporting documentation. Failure to adhere to coding and billing policies may impact claims processing and reimbursement. Claims may be reviewed on a case-by-case basis. If you have any questions, please contact your provider network representative.

Chiropractors may not bill for any chiropractic manipulative treatment, constant attendance modalities or therapeutic procedures, unless the services were directly performed by the chiropractor.

Documentation Standards

Records must:

- Indicate the dates any professional service was provided.
- List the direct one-on-one contact time spent for each timed code per CPT nomenclature.
- Be **legible** in both readability and content. Documentation that is not legible cannot be used to support services rendered.
- Contain only those terms and abbreviations easily comprehended by peers of similar licensure. If a legend is needed to review your records, maintain it with your records. Include documentation showing the members need for chiropractic care and any changes since the last visit. Documentation must also include a clear description of the treatment provided and how the member tolerated the treatment.
- Contain clinically pertinent subjective information from the member. Include the chief complaint and any changes in the members condition, the members response to care since the previous visit, and the members subjective progress relative to the outcome measures documented in the treatment plan. (**Subjective information and history)**.
- Contain clinically pertinent objective data or examination findings from your exam of the member. This data provides a way to verify diagnosis codes, establishes changes in response to care and provides evidence for the necessity of the treatment that day. **(Objective data)**
- Indicate the initial diagnosis and the member's initial reason for seeking the provider's care. The diagnosis should be recorded in the record and reflected on the claim form. Each daily visit must also include an assessment of the member's condition. The assessment of the member's progression must be based upon the subjective and objective findings. Include the diagnosis being managed on the visit and the assessment of the overall progress. Provide rationale for continued care or changes in the therapeutic direction. Provide an evaluation of the treatment effectiveness and progress or lack thereof as it relates to the treatment goals and plan of care. **(Assessment)**
- Document the treatment details performed during the visit including the medical rationale. Include any member instructions. Documentation must support that each manipulation or treatment reported relates to a relevant symptomatic spinal and/or extraspinal region. Symptoms must bear a direct relationship to the level of subluxation cited. Documentation of "pain" is not sufficient; the location of pain or condition must be described. Also, include the member's immediate response to care and plans for future care. Indicate when the member is to return, visit number as it relates to the treatment plan with the anticipated date of next evaluation. Include any goals and outcome measures for a new problem or a problem re-assessment. **(Plan)**
- A written plan of treatment relating to the type, amount, frequency, and duration of care is required for all members. The plan of care must be updated as the member's condition changes. A treatment plan is not valid for longer than 90 calendar days from the first treatment day under the certified treatment plan. The goal of the treatment plan should be to achieve functional improvements in the member's condition. Specific

treatment goals must be documented with anticipated time frames and objective measures to evaluate treatment effectiveness. Each complaint should be listed with selected treatment, duration, frequency, treatment goals, and objective measures to evaluate progress. The treatment plan should include the rationale for all services provided. A plan of care should be individualized for each member. **(Plan of Care)**

- Signature requirements- Each medical record must be signed and dated by the clinician performing the service. A legible physical or electronic signature is required. The medical record should be signed at the time services are rendered. Providers should not add late signatures to the medical record beyond the short delay that occurs during the transcription process. Generally, 24-48 hours is the typical turnaround time for the provider transcription process.
- It is essential for the provider to document clinical findings and justify the medical necessity of care. It is strongly suggested this justification be documented via formal progress note using S.O.A.P. (Subjective, Objective, Assessment, Plan) note format, which is considered a medical standard. Check marks, small entries and other commonly illegible notions seldom provide adequate documentation to support services billed. Please ensure that the medical records documentation is concise and complete.
- For additional information on Templated, Copy and Paste or Cloned Medical Records, please see **CPCP029 Medical Record Documentation**.

Coding Standards

- Proper coding is essential for correct reimbursement. Providers are encouraged to utilize current copies of ICD-10 -CM, CPT, and HCPCS books published by the American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS).
- Use the diagnosis and procedure codes effective for the date of service.

Diagnosis Codes

- New ICD10-CM diagnosis codes are updated annually in October.
- Some diagnosis codes require a 7th digit to code to the highest specificity.
- Update diagnosis and coding for every new episode, including a re-exam or an examination for a 'new' problem. Document any diagnosis coding change even if it is minor.
- Link the diagnosis to the service provided to support medical necessity and specificity. For example, when performing manual therapy with manipulation, the diagnosis pointer code(s) should point to the specific diagnosed condition that supports specific procedures billed. (Box 24E of the CMS-1500 claim form).

CPT Codes

Evaluation and Management (E/M) Services (CPT Codes: 99202-99205, 99211-99215)
To bill for an evaluation and management service, the complete CPT guidelines must be met for each service. The service must also be separately identifiable and distinct from any other service you perform on the member that day.

Chiropractic Manipulative Treatment (CPT codes 98940-98943)
Each CPT code reflects a specific number of regions, regardless of how many manipulations are performed in that region. For example, chiropractic manipulation applied to C3 and C5 during the same visit represent treatment to only one region (cervical) and should be reported with CPT code 98940.

All CPT codes for CMT must have a supporting ICD-10-CM diagnosis code to justify the level of care provided. For example, when billing CPT 98941, there must be ICD-10-CM codes that incorporate at least three different regions.

To bill these codes, the documentation must include:

- Location of pain/condition for which treatment is being sought.
- The specific spinal regions adjusted, and the technique used.
- The response to the treatment/adjustment, including whether or not the pain/condition being treated increased, reduced, or eliminated the problem.
- Each manipulation reported must be related to the patient's complaints and a relevant symptomatic spinal or extraspinal level.

For physical therapy services, providers should refer to CPCP040 Physical Medicine & Rehabilitation Services

CMT Components

Pre-Service	A brief evaluation of the member's medical record documentation and chart review, imaging review, test interpretation and care planning
Intra-Service	Treatment applied, Pre-manipulation (e.g., palpation, etc.), Manipulation, Post-manipulation (e.g., assessment, etc.)
Post-Service	Chart entry and documentation, including subjective, objective, assessment, plan consultation reporting

Evaluation and Management (E/M) Coding and CMT Codes

Billing an Evaluation and Management (E/M) Code **with a CMT code:**
In general, it is inappropriate to bill an established office/outpatient E/M CPT code (99211-99215) on the same visit as Chiropractic Manipulative Treatment (CPT code 98940-98943) because CMT codes already include a brief pre-manipulation assessment. There are times when it would be appropriate, but it should not be routine. Examples of when it may be appropriate to bill an additional E/M service would be the evaluation of new patients, new injuries, exacerbations, or periodic re-evaluations.

Billing an Evaluation and Management Code **in place of a CMT code:**
It is not appropriate to bill an E/M code instead of a CMT code. It is required to bill the code that best describes the service rendered.

Diagnostic Imaging Services

The purpose of diagnostic imaging is to gain diagnostic information regarding the member in terms of diagnosis, prognosis, and therapy planning. Required standards for each imaging study must meet the following four standards:

- The study must be obtained based on clinical need;

- The study must be of sufficient diagnostic quality;
- There must be documented interpretation of the study to reach a diagnostic conclusion; and
- The information from the study must be correlated with patient management.

The selection of patients for radiographic examination is based on the following criteria.

- The need for radiographic examination is based on history and physical examination findings.
- The potential diagnostic benefit of the radiographic examination is judged to outweigh the risks of ionizing radiation.
- Radiography is used to help the practitioner diagnosis pathology, identify contraindications to chiropractic care, identify bone and joint morphology, and acquire postural, kinematic, and biomechanical information.
- Routine radiography of patients as a screening procedure is not appropriate practice except under public health guidelines.

Components of a Written Radiology Report

As a written record of the interpretive findings, the radiology report serves as an important part of the member's medical record and must contain the following items:

- Patient identification
- Location where studies were performed
- Study dates
- Types of studies
- Radiographic findings
- Diagnostic impressions; and
- Signature with professional qualifications included

Radiology reports may also include recommendations for follow-up studies and comments for further patient evaluation.

Additional Resources:

Clinical Payment and Coding Policies

CPCP029 Medical Record Documentation Guideline

CPCP040 Physical Medicine & Rehabilitation Services

References:

Policy Update History:

Approval Date	Description

03/21/2018	New policy
08/03/2018	Reference revision
06/25/2019	Annual Review
08/15/2019	Updated time-based codes verbiage due to regulatory changes.
09/25/2020	Annual Review, Disclaimer Update; Verbiage Update
12/16/2021	Annual Review
03/15/2023	Annual Review, Policy split, removed non-chiropractic services.
01/12/2024	Annual Review