

## Chapter 18

# Chiropractic Services

## Definition

Chiropractic services are medically necessary therapies that employ manipulation and specific adjustment of body structures, such as the spinal column, provided by a licensed doctor of chiropractic.

## Eligible Providers

Chiropractors who are licensed under Minnesota law

## Eligible Recipients

All PrimeWest Health members

## Covered Services

1. Acupuncture is covered for chronic pain. Authorization is required in excess of 10 sessions and must be 1) performed by an MD or licensed acupuncturist employed and supervised by an MD; or 2) provided through a hospital pain management program by an MD or licensed acupuncturist who is supervised by an MD. Use the Physician Extender modifier for non-physician services.
2. Evaluation and management services for new and established patients, not to exceed one per calendar year.
3. Manual manipulation of the spine for treatment of subluxation (incomplete or partial dislocation) determined to be medically necessary by generally accepted chiropractic standards of care.
4. X-rays that are needed to support a diagnosis of subluxation.

## Non-covered Services

The following list of non-covered services is not all inclusive. There may also be other services that are not covered.

1. Office visits that do not include manual spinal manipulation
2. Laboratory services
3. Vitamins or nutritional supplements and/or counseling
4. Treatment for a neurogenic or congenital condition that is not related to a diagnosis of subluxation
5. Medical supplies or equipment supplied or prescribed by a chiropractor
6. X-rays, other than those needed to support a diagnosis of subluxation
7. Exercise counseling, activities of daily living counseling
8. Physiotherapy modalities including, but not limited to:
  - a. Ultrasound
  - b. Diathermy
  - c. Electrical muscle stimulation
  - d. Interferential current
  - e. Russian stimulation
  - f. Application of hot/cold packs
  - g. Massage
  - h. Manual muscle stimulation
  - i. Activator

## Payment Limitations

1. Prior to January 1, 2011, payment for manual manipulation of the spine is limited to 24 per calendar year unless authorization is obtained. **Effective January 1, 2011, payment for chiropractic services will be limited to one annual evaluation and 12 visits per calendar year unless prior authorization of a greater number of visits is obtained.** An office visit for manual manipulation of the spine is considered part of the service and cannot be billed separately to PrimeWest Health or members.
2. Payment for X-rays is limited to radiological examinations of the full spine; the cervical, thoracic, lumbar, and lumbosacral areas of the spine; the pelvis; and the sacroiliac joints.

## Authorization Requirements

Authorization is required for any combination of Current Procedural Terminology (CPT) codes 98940, 98941, and 98942, in excess of 24 visits (12 visits effective January 1, 2011) per calendar year per member. To request an authorization, submit the [Medical Service Authorization Request Form](#) along with an indication of the treatment provided to date, member's response to treatment, treatment plan beyond the 24 (12 effective January 1, 2011) manual manipulations for the calendar year, and treatment goals.

### Authorization Criteria

The diagnosis of subluxation may be demonstrated using X-ray or physical examination. If X-rays (or radiologic report) are submitted as documentation of the diagnosis, the X-ray (or radiologic report) must be no older than 12 months prior to the start of treatment.

### Documenting subluxation by physical examination

Evaluation of musculoskeletal/nervous system to identify the following:

- Pain/tenderness evaluated in terms of location, quality, and intensity
- Asymmetry/misalignment identified on a sectional or segmental level
- Range of motion abnormality (changes in active, passive, and accessory joint)
- Changes in the characteristics of contiguous or associated soft tissues, including skin, fascia, muscle, and ligament (change in tone)

Two of the above criteria are required to demonstrate subluxation based on physical examination; one of which must be:

- Asymmetry/misalignment
- Range of motion abnormality

Whether the subluxation is demonstrated by X-ray or physical exam, the documentation required for initial visits and subsequent visits must be submitted to support the authorization request for additional units of care.

## Radiology

X-ray Codes			
X-ray Codes	Brief Description	X-ray Codes	Brief Description
72010	Full Spine	72020	Spine, Single View
72040	Cervical	72050	Cervical, Min. 4 Views
72052	Cervical Complete	72070	Thoracic, A & P
72074	Thoracic, Comp. Obl 4 Views	72080	Thoracolumbar, A & P
72090	Scoliosis Study	72100	Lumbosacral, A & P
72110	Lumbosacral, Comp. Obl	72114	Lumbosacral, Comp. Bld.
72120	Lumbosacral, Bending	72170	Pelvis
72190	Pelvis, Comp. Min. 3 Views	72200	Sacroiliac Joints
72202	Sacroiliac, 3 or more views	72220	Sacrum & Coccyx Min. 2 views

## PrimeWest Health Chiropractic Benefits/Coding for MA and MinnesotaCare members

Chiropractic Services		
Procedure Code	Brief Description	Limitations
98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions	Prior to January 1, 2011, authorization is required for any combination of chiropractic manipulative treatment codes in excess of 24 treatments per calendar year. Effective January 1, 2011, authorization is required for any combination of chiropractic manipulative treatment codes in excess of 12 treatments per calendar year.
98941	Spinal, three to four regions	
98942	Spinal, five regions	

Extraspinal manipulative treatment (98943) and physiotherapeutic codes are not covered codes.

## Diagnosis Codes

Providers must submit the most applicable diagnosis codes (ICD-9-CM) when billing for subluxation on claims.

If you submit MA or MinnesotaCare claims with diagnosis codes that are not on this list, the claim will be denied with EXWT (DENY – INVALID DIAGNOSIS).

<b>Subluxation Diagnosis Codes</b>			
<b>ICD-9-CM</b>	<b>Brief Description</b>	<b>ICD-9-CM</b>	<b>Brief Description</b>
739.0	Head region	839.05	Fifth cervical vertebra
739.1	Cervical region	839.06	Sixth cervical vertebra
739.2	Thoracic region	839.07	Seventh cervical vertebra
739.3	Lumbar region	839.08	Multiple cervical vertebra
739.4	Sacral region		
739.5	Pelvic region	839.20	Lumbar vertebra
		839.21	Thoracic vertebra
839.00	Cervical vertebra unspecified		
839.01	First cervical vertebra	839.40	Vertebra, unspecified site
839.02	Second cervical vertebra	839.41	Coccyx
839.03	Third cervical vertebra	839.42	Sacrum
839.04	Fourth cervical vertebra		

## PrimeWest Health Chiropractic Benefits/Coding for Medicare Advantage Plan (Minnesota Senior Health Options [MSHO]<sup>\*</sup>, Minnesota Senior Care Plus [MSC+], and Special Needs BasicCare [SNBC])<sup>\*\*</sup> members

Chiropractic Services		
Procedure Code	Brief Description	Limitations
98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions	Prior to January 1, 2011, authorization is required for any combination of chiropractic manipulative treatment codes in excess of 24 treatments per calendar year. Effective January 1, 2011, authorization is required for any combination of chiropractic manipulative treatment codes in excess of 12 treatments per calendar year.  For MSC+ members who have Medicare primary (in which PrimeWest Health is not their Medicare), PrimeWest Health will continue to follow Medicare guidelines.
98941	Spinal, three to four regions	
98942	Spinal, five regions	

Extraspinal manipulative treatment (98943) and physiotherapeutic codes are not covered codes.

Radiology services for PrimeWest Health MSHO and SNBC members would be covered by their Medicaid wraparound benefit.

### Allowed Diagnosis Codes

*Note – the first diagnosis code must be the primary subluxation code:*

739.0	739.3
739.1	739.4
739.2	739.5

*Note – the second diagnosis code must be primary complaint/symptom code:*

307.81	722.51
346.00	722.52
346.01	722.81
346.10	722.82
346.11	722.83
346.20	722.91
346.21	722.92
346.80	722.93
346.81	723.0
346.90	723.1
346.91	723.2
353.0	723.3

<sup>\*</sup>PrimeWest Health's name for this program is PrimeWest Senior Health Complete (HMO SNP)

<sup>\*\*</sup>PrimeWest Health's name for this program is Prime Health Complete (HMO SNP)/(SNBC) 5

353.1	723.4
353.2	723.5
353.3	724.02
353.4	724.1
353.8	724.2
355.0	724.3
355.1	724.4
355.2	724.5
355.8	724.6
719.01-719.09	724.79
719.11-719.19	724.8
719.21-719.29	728.85
719.31-719.39	729.1
719.41-719.49	729.4
719.51-719.59	738.4
719.61-719.69	756.11
719.7	756.12
719.81-719.89	784.0
720.1	846.0
721.0	846.1
721.2	846.2
721.3	846.3
721.7	846.8
721.90	847.0
722.0	847.1
722.10	847.2
722.11	847.3
722.4	847.4
724.01	

*Note the third and additional diagnosis codes on the 837P claim format may be secondary and tertiary subluxation codes or additional complaint/symptom codes.*

**The use of diagnosis pointers for MSHO and SNBC claims must follow Medicare billing guidelines. Accordingly, the first diagnosis pointer on each service line must refer to the primary subluxation listed at the header level of the claim.**

## General Claim Submission Notes

When PrimeWest Health is the secondary payer, submit claims for those members according to the claims submission requirements of the primary payer. When submitting a secondary claim, always include the COB information from the primary payer.

### MA and MinnesotaCare Claims

Providers must choose all applicable subluxation ICD-9-CM code(s) to identify the area(s) of subluxation. This guideline affects CPT codes 98940, 98941, and 98942. Listing all applicable diagnoses will confirm the medical necessity for the treatment provided. For example, if 98942 (five regions) is submitted with only four subluxation codes, it would be denied with EX64 (DENY – PROCEDURE INCONSISTENT WITH DIAGNOSIS – DTR-1202).

## MSHO, MSC+, and SNBC Claims

Providers must first submit the subluxation ICD-9-CM code(s) (739.0 – 739.5) to identify the area(s) of subluxation. The secondary diagnosis code must be the primary complaint/symptom code. Any additional symptoms or subluxations should then be listed. Listing all applicable diagnoses will confirm the medical necessity for the treatment provided. For example, if 98942 (five regions) is submitted with only four subluxation codes, it would be denied with EX64 (DENY – PROCEDURE INCONSISTENT WITH DIAGNOSIS – DTR-1202).

### **PART Date is required.**

Documentation of Subluxation. A subluxation may be demonstrated by an X-ray or by physical examination to identify PART (PART = Pain, Asymmetry, Range of motion, and tissue tone changes). The PART date is listed as: PART MMDDYY Subluxation levels Complaint (example: PART 062207 C2 T5 L3 NECK PAIN).

## Helpful Links

[DHS Chiropractic Guidelines](#)

[Medicare Chiropractic Guidelines](#)

Please refer to [Billing Policy, Chapter 4](#), for additional information.

## Legal References

MN Rules [9505.0245](#)

MS [148.01 to 148.106](#) (licensing requirements)

42 CFR 440.60(b)