

In the event of a conflict between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. Plan documents include but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents.

In the event of a conflict between a Clinical Payment and Coding Policy 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.

Chiropractic Services

Policy Number: CPCP016

Version 7.0

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Description:

The practice of chiropractic 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. Chiropractic services are provided on an inpatient or outpatient basis when medically appropriate and necessary as determined and **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.**

Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and/or federal law. Policies contained in this document do not constitute plan authorization, nor are they an explanation of benefits. Contact Provider Service for specific coverage or policy information.

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.

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.

Initial Treatment Date (ITD) - The first date the patient had the same or similar injury. This information is entered in box 15 of the CMS-1500 claim form.

Modalities - Any physical agent applied to produce a therapeutic change to biological tissue; includes but is not limited to thermal, acoustic, light, mechanical, or electrical energy.

Supervised: Provider needs to watch over the application, though not necessarily at the patient's side.

These are procedure/service based and units are always one (1).

Constant Attendance: Provider must be with the patient at all times. These are time-based, one unit = 15 minutes.

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

Documentation Standards

Records must:

- Indicate the dates any professional service was provided.
- List start and stop times on all timed codes 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 patient's 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 patient tolerated the treatment.
- Contain clinically pertinent subjective information from the patient. Include the chief complaint and any changes in the patient's condition, the patient response to care since the previous visit, and the patient's 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 patient. 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 patient'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 patient's condition. The assessment of the patient'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 patient instructions. Also, include patient's immediate response to care and plans for future care. Indicate when the patient 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 patients. The plan of care must be updated as the patient'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 patient'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 patient. 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. **(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, 24-72 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.



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- Cloned or canned documentation is not acceptable. Documentation is considered “cut and paste” or cloned when each entry in the medical record for a patient is identical or significantly similar to previous entries. This also occurs when medical documentation is identical when comparing one patient to another. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Provider must use caution when applying templated language as the medical record must be an accurate description of services rendered. Documentation identified as cloned, copied and pasted, pulled forward, or inserted via template without identifiable and appropriate updates specific to the current visit will not be considered for the purposes of determining services provided for that service.

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 the 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 code should point to the specific procedure that addresses the diagnosed condition. (Box 24E of the CMS-1500 claim form).

CPT® Codes:

Evaluation and Management Services (CPT® Codes: 99201-99205, 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 separate and distinct from any other service you perform on the patient that day.

You may locate the guidelines for billing evaluation and management services in the CPT® coding manual. This manual also defines new and established patients.

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 at least three ICD-10-CM codes indicating the three different regions treated.

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.

The frequency and duration of chiropractic treatment must be medically necessary and based on the individual patient’s condition and response to treatment.

CMT Components

Pre-Service	A brief evaluation of the patient 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

Physical Medicine (CPT® codes 97010 - 97140 and 97530)

For physical medicine services to be considered for coverage as medically necessary, the following conditions must be met.

- The therapy must be of a skilled nature and require the services of a skilled provider. If services are delegated to a staff member, documentation must include what specifically was delegated and who performed the service.
- The services/therapy must not be maintenance in nature. Ongoing physical medicine treatment after a condition has stabilized or reached a clinical plateau (maximum medical improvement) does not qualify as medically necessary, and would be considered “maintenance care.”
- Services performed must achieve a specific diagnosis-related goal.
- There must always be a documented expectation that the patient will, in fact, achieve reasonable improvement over a predictable period of time for the services to be eligible for reimbursement.

Common Physical Medicine Codes

CPT® 97140 (manual therapy techniques, 1 or more regions, each 15 minutes): Documentation must include (1) the area being treated, (2) the therapy technique being used and **(3) the start and stop times of the treatment or at a minimum, the direct one-on-one contact time spent on each individual activity.** The manual therapy performed should require the skills of qualified healthcare provider. The expected functional performance improvement should be discernable in the records. This code should not be used interchangeably with codes 98940-98942 or 97124. Under certain circumstances, it may be appropriate to report CMT codes in addition to 97140 if it is performed in a body region outside of the manipulation.

CPT® 97530 (therapeutic activities, direct patient contact, each 15 minutes): Documentation must include (1) the area being treated, (2) the specific activity or technique being used and **(3) the start and stop times of the treatment or at a minimum, the direct one-on-one contact time spent on each individual activity.** These activities should require the skills of a qualified healthcare provider. Supervising patients who are exercising independently is not a skilled service. The expected functional performance improvement should be discernable in the records.



CPT® 97110 (therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility): Documentation must include (1) the specific exercises performed, (2) the purpose of the exercises as related to function and **(3) the start and stop times of the treatment or at a minimum, the direct one-on-one contact time spent on each individual activity.** These exercises should require the skills of a qualified healthcare provider. Supervising patients who are exercising independently is not a skilled service. The expected functional performance improvement should be discernable in the records.

CPT® 97112 (therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities): Documentation must include (1) the specific exercises/activities performed, (2) the purpose of the exercises/activities as related to function and **(3) the start and stop times of the treatment or at a minimum, the direct one-on-one contact time spent on each individual activity.** These activities should require the skills of a qualified healthcare provider. Supervising patients who are performing activities independently is not a skilled service. The expected functional performance improvement should be discernable in the records. Appropriate use of CPT® 97112 is for neuromuscular (NM) diagnoses such as post-Cerebral Vascular Accident, Parkinson's Disease, cerebral palsy, Multiple Sclerosis, and other neuromuscular disorders. CPT® 97112 is not appropriate for acute musculoskeletal problems and should not be used for spine or extremity stabilization. CPT® code 97112 is not the appropriate code for providers using Soft Tissue Mobilization techniques. **Direct patient contact:** The above listed codes require direct one-on-one contact throughout the procedure. The provider is required to maintain visual, verbal, and/or manual contact with the patient.

Coding Reminders:

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 use an E/M code instead of a CMT code to get around limits on CMT. It is required to bill the code that best describes the service rendered.

Billing CPT® 97140 in Place of a CMT code:

Billing for multiple time-based codes such as several manual therapies (CPT® 97140), when a CMT was the only service performed, is inappropriate. A CMT CPT® code may not be replaced with another CPT® code if the CMT was the actual service performed. It is a requirement to use the code that best describes the service rendered.

Reimbursement Information:

Reporting units for timed codes: When multiple units of therapies or modalities are provided, the 8-minute rule must be followed when billing for these services. A provider should not report a direct treatment service if only one attended modality or therapeutic procedure is provided in a day and the procedure is performed for less than 8 minutes. (refer to external link below *)

- The time reported should be the time actually spent in the delivery of the modality and/or therapeutic procedure. This means that pre and post-delivery services should not be counted in determining the treatment time.
- The time that the patient spends not being treated, due to resting periods or waiting for a piece of equipment to become available, is not considered treatment time.
- All treatment time, including the beginning and ending time of the direct treatment, must be recorded in the patient's medical record, along with the note describing the specific modality or procedure.
- Each minute of time may only be counted once. Any actual time the therapist uses to attend one-on-one to a patient receiving a supervised modality cannot be counted for any other service provided by the therapist.

The following unit of service billing guideline has been published by Medicare. It is the standard when billing multiple units of service with timed procedures defined as per each 15 minutes.

1. unit: \geq 8 minutes through 22 minutes
2. units: \geq 23 minutes through 37 minutes
3. units: \geq 38 minutes through 52 minutes
4. units: \geq 53 minutes through 67 minutes
5. units: \geq 68 minutes through 82 minutes
6. units: \geq 83 minutes through 97 minutes
7. units: \geq 98 minutes through 112 minutes
8. units: \geq 113 minutes through 127 minutes



If any 15-minute timed service that is performed for 7 minutes or less on the same day as another 15-minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater, then bill one unit for the service performed for the most minutes. The same logic is applied when three or more different services are provided for 7 minutes or less.

For example, if a provider renders:

- 5 minutes of 97035 (ultrasound),
- 6 minutes of 97110 (therapeutic procedure), and
- 7 minutes of 97140 (manual therapy techniques)

Then claim should be filed with 1 unit of 97140 since the total minutes of direct treatment is 18 minutes. The patient's medical record should document that all three modalities and procedures were rendered and include the direct treatment time for each.

If any direct patient contact timed service is performed on the same day as another direct patient contact timed service, then the total units billed cannot exceed the total treatment time for these services.

For example, if a provider renders:

- 8 minutes of 97530 (therapeutic activities),
- 8 minutes of 97110 (therapeutic procedure), and
- 8 minutes of 97140 (manual therapy techniques)

Then claim should be filed with a total of 2 units since the total minutes of direct treatment is 24 minutes. The patient's medical record should document that all three modalities and procedures were rendered and include the direct treatment time for each.



Orthopedic Braces

General Coverage

Generally, DME is **eligible for coverage when the equipment meets all of the following criteria:**

- Serves a medical purpose; AND
- Generally, not useful to a person in the absence of illness, injury, or disease; AND
- Used in the patient's home/place of residence; AND
- Reasonable and medically necessary for the individual patient; AND
- Prescribed by a physician within the scope of his/her license; AND
- Does not serve as a comfort or convenience item; AND
- Has been approved by the US Food and Drug Administration (FDA) (where applicable) and is otherwise generally considered to be safe and effective for the purpose intended.

Customized DME

In order to qualify as "customized", a DME, prosthetic, or orthotic device must be specifically constructed to meet an individual patient's specific needs. An invoice should be included with billing for any customized DME, prosthetic, or orthotic device for which a procedure code or HCPCS code does not exist. The prescription for customized equipment should include:

- The reason the patient requires a customized item; AND
- Specific documentation, e.g., physical therapy records or physician's records.

The following are examples of items that **do not meet the requirement to be considered customized:**

- Adjustable brace with Velcro closures; AND
- Pull-on elastic brace; AND
- Lightweight, high-strength wheelchair with padding added.

The following additional criteria apply to custom-fitted and custom fabricated back braces.

- A custom-fitted back brace (a prefabricated back brace modified to a specific member) is considered medically necessary where there is a failure, contraindication or intolerance to an unmodified, prefabricated (off the shelf) back brace.
- A custom-fitted back brace is considered medically necessary as the initial brace after a surgical stabilization of the spine following traumatic injury.
- A custom-fabricated back brace (individually constructed to fit a specific member from component materials) is considered medical necessary if there is a failure, contraindication, or intolerance to a custom-fitted back brace.
- Custom-fitted and custom-fabricated back braces are considered experimental and investigation when these criteria are not met.

Diagnostic Imaging Services

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

1. The study must be obtained based on clinical need;
2. The study must be of sufficient diagnostic quality;
3. There must be documented interpretation of the study to reach a diagnostic conclusion; and
4. The information from the study must be correlated with patient management.

The selection of patients for radiographic examination is based on the following guidelines:

1. The need for radiographic examination is based on history and physical examination findings;
2. The potential diagnostic benefits of the radiographic examination is judged to outweigh the risks of ionizing radiation;
3. 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;
4. 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 patient's medical record and must contain:

- Patient identification;
- Location where studies were performed;
- Study dates;
- Types of studies;
- Radiographic findings;
- Diagnostic impressions; and
- Signature with professional qualifications included. It may also include recommendations for follow-up studies; and comments for further patient evaluation.

Providers are to bill and document appropriately for all services submitted. It is imperative that providers and their staff are aware of documentation requirements and payor medical policies for all services provided. Claims filed with documentation that do not meet the above listed requirements will be denied. If you have any questions, please locate your Provider Network Representative by your location on the [Contact Us](#) page of the [provider website](#).

References: Medical Policies

<u>Title</u>	<u>Policy Number</u>
Heat and Cold Therapy Devices	THE801.004
Non-Covered Physical Therapy Services	THE803.008
Physical Therapy (PT) and Occupational Therapy (OT) Services	THE803.010
Non-Surgical Spinal Decompression Traction Devices	THE803.21
Surface Electric Stimulation	MED201.026
Interferential Current Stimulation	MED201.041

External References:

Please refer to the American Chiropractic Association (ACA) website at www.acatoday.org, Coding Policies section, for specific guidance on the proper use of E/M with a Chiropractic Manipulative Treatment Code (CMT).

<https://www.acatoday.org/LinkClick.aspx?fileticket=2Z57X7cOARU%3D&portalid=60>

*<https://www.acatoday.org/Practice-Resources/Coding-Documentation-Reimbursement/Coding-Guidance>

Policy Update History:

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03/21/2018	New policy
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