

CHIROPRACTIC

Policy

NHP reimburses participating chiropractors for medically necessary chiropractic services related to a neuromusculoskeletal condition provided to NHP members having chiropractic benefits coverage.

Prerequisites

Authorization, Notification and Referral

Service	Requirement
For Commercial Members With A Chiropractic Benefit, Visits 1-10	No Auth required
For MassHealth Standard, MassHealth Basic, MassHealth Family Assistance plan members: first 20 chiropractic services per contract year	No Auth required
For MassHealth Standard, MassHealth Basic, and MassHealth Family Assistance plan members age 21 or older: Chiropractic services <i>beyond</i> the first 20 chiropractic services per contract year	Prior Auth required
For MassHealth Essential Members For Commonwealth Care Members	Not a covered benefit
For HVMA Members	A referral number for most specialists is required for NHP members with a Harvard Vanguard Medical Associates PCP seeking non-emergency care outside of the Harvard Vanguard Medical Associates Network. Please verify that the member has the appropriate referral number prior to rendering care.

Limitations

For commercial plan members, if the benefit exists, it is limited to a maximum of 10 chiropractic services (the total of office visits or chiropractic manipulative treatments, or any combination of office visits and chiropractic manipulative treatments) per calendar year.

For MassHealth Standard, MassHealth Basic, and MassHealth Family Assistance plan members: Chiropractic manipulative services for plan members are limited to 20 chiropractic services (the total of office visits or chiropractic manipulative treatments, or any combination of office visits and chiropractic manipulative treatments) per contract year.

The chiropractic manipulative services rendered must have a direct therapeutic relationship to the patient's condition and the services must provide reasonable expectation of recovery of improvement of function.

Reimbursement is limited to the services listed on the provider contract and fee schedule.

Exceptions to Policy Criteria

General Chiropractic Services

Services must be provided in a chiropractor's office by a licensed chiropractor and must have a direct therapeutic relation to the patient's condition. The services must provide reasonable expectation of recovery or improvement of function.

Services provided by chiropractic assistants (CAs), massage therapists, or other unlicensed providers, even when performed under the direct supervision of a licensed chiropractor are **not** eligible for reimbursement.

Chiropractic maintenance therapy is not considered to be medically reasonable or necessary and is therefore not reimbursable.

Conditions that may be considered to provide therapeutic grounds for chiropractic treatment include functional disabilities of the spine, nerve pains, and documented incidents that produce sprains and strains of the spinal axis.

NHP limits payment for chiropractic services to the total of office visits or chiropractic manipulative treatments, or any combination of office visits and chiropractic manipulative treatments allowed annually, under the member's benefit schedule.

Diagnostic Imaging Services

NHP limits reimbursement for diagnostic imaging services to the plain film x-ray related to the purpose of the diagnostic visit to confirm the existence of a neuromusculoskeletal condition requiring treatment. The imaging services must be performed and developed in the chiropractor's office, and read by the treating chiropractor.

Chiropractic diagnostic imaging services are separately reimbursable from the chiropractic manipulative service and/or evaluation and management service, and limited by the NHP member's benefit coverage. Diagnostic imaging services must meet all NHP radiology policies and guidelines, including prior authorization, if any.

All X-rays must be labeled with the member's name and the date of the examination. The nature of the radiologic examination and findings must be documented in the patient's record. The X-rays must be maintained as part of the member's medical record

Member Cost-Sharing

The provider is responsible for verifying at each encounter and when applicable for each day of care when the patient is hospitalized, coverage, available benefits, and member out-of-pocket costs; copayments, coinsurance, and deductible required, if any.

Definitions

Chiropractic Manipulative Treatment: A manual procedure that involves a directed thrust to move a joint past its physiological range of motion, without exceeding the anatomical limit. During manipulation, a passive joint movement, the joint is moved into a parapsycho-physiologic zone. This results in cavitations or gapping of the joint, which usually produces an audible "pop" or "click" as a result of an intrasynovial vacuum phenomenon, which is thought to involve gas separating from fluid. For purposes of CMT, the five spinal regions referred to are:

- Cervical region (includes atlanto-occipital joint)
- Thoracic region (includes costovertebral and costotransverse joints)
- Lumbar region
- Sacral region
- Pelvic region (sacro-iliac joint)

The five extra-spinal regions referred to are:

- Head region (including temporomandibular joint, excluding atlanto-occipital)
- Lower extremities
- Upper extremities
- Rib cage (excluding costotransverse and costovertebral joints)
- Abdomen

Chiropractic mobilization: A passive movement of a joint within its physiological range for the purpose of increasing overall joint motion.

Chiropractor: One who is licensed to practice chiropractic manipulation to correct interference with spinal nerves by adjusting the spinal column.

Chiropractic maintenance therapy: This includes services that seek to prevent disease, promote health, and prolong and enhance 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.

Contract Year: For Mass Health members only, the contract year is from October 1 through September 30.

Diagnostic imaging services: The purpose of diagnostic imaging is to gain diagnostic information regarding the patient with regard to diagnosis, prognosis, and therapy planning.

Dynamic thrust: The therapeutic force or maneuver delivered by the physician during manipulation in the anatomic region of involvement. A relative contraindication is a condition that adds significant risk of injury to the patient from dynamic thrust, but does not rule out the use of dynamic thrust. The doctor should discuss the risk with the patient and record this in the chart.

Manual devise usage: Hand held devices with the thrust of force of the device being controlled manually, may be used by chiropractors in performing manipulation of the spine.

Spinal subluxation: A motion segment, in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact.

- Acute subluxation: The patient is being treated for a new injury, identified by x-ray or physical exam. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression of the patient's condition.
- Chronic subluxation: The patient's condition is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the functional status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

Visit: For the purposes of NHP benefit coverage, a visit is defined as an office visit, or an office contact during which a chiropractor provides a session of chiropractic manipulative treatment.

Neighborhood Health Plan Reimburses

- One manual spinal manipulation per day.
- The initial diagnostic x-ray related to the purpose of the diagnostic visit.

Neighborhood Health Plan Does *Not* Reimburse

- An evaluation and management service provided on the same day as a chiropractic manipulative treatment.
- Extraspinal chiropractic manipulative treatment (CPT 98943).
- Chiropractors for other services provided or ordered not described in the Procedures Table, below. (E.g. Osteopathic manipulative treatment (CPT 98925-98929), physical medicine and rehabilitation (CPT 97001-97006), modalities (CPT 97010-97039), or therapeutic procedures (CPT 97110-97546).
- Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) for ANY of the following, as they are considered not medically necessary:
 - manipulations or modalities that are not related to the individual's symptoms, not likely to result in long-term improvement, or do not have defined endpoints, including:
 - Maintenance, preventive or supportive care or care provided to prevent reoccurrences or slow deterioration.
 - Services provided to reduce potential risk factors where significant improvement is not expected.
- Additionally for use of a manual device.
- Extra charges for the manual device itself.
- Duplicated services for the same condition, when provided by such as a physical therapist or other health professional.
- Chiropractic manipulation and adjunct therapeutic procedures or modalities (e.g., mobilization, therapeutic exercise, traction) for treatment of non-neuromusculoskeletal conditions because they are considered experimental, investigational or unproven.
- Chiropractic services provided by chiropractic assistants (CAs), massage therapists, or other unlicensed providers.

Procedures Codes Applicable to Guideline

Note: This list of codes may not be all-inclusive.

CPT Code	Descriptor	Comments
98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions	During the course of a single visit, submit one of the following procedure codes for a manipulative treatment, as appropriate.
98941	Chiropractic manipulative treatment (CMT); spinal, three to four regions	
98942	Chiropractic manipulative treatment (CMT); spinal, five regions	
98943	Chiropractic manipulative treatment (CMT); extraspinal, one or more regions	Not a covered benefit
99201	Office/outpatient visit, new	Use for evaluation and management services
99212	Office/outpatient visit, est	

Coding for diagnostic imaging procedures is limited to the NHP provider's contractual agreement regarding the billable service codes.

ICD-9 Diagnosis Codes

Two diagnosis codes must be listed on the claim to support medical necessity.

- The level of subluxation must be specified on the claim and must be listed as the **primary diagnosis**. The level of subluxation identified and under treatment will be in the range 739.x
- The associated neuromusculoskeletal condition necessitating the treatment must also be listed as the **secondary diagnosis**.

Simply listing a diagnostic code from the secondary diagnosis group does not determine that the treatment is covered as a reasonable and medically necessary therapy. The patient's condition must also meet all criteria specified in the Limitations, and Definitions sections above; and the Documentation section below.

For further details, please see the references cited under **References** on page 6.

Provider Payment Guidelines

The chiropractic manipulative treatment codes include a pre-manipulation patient assessment. Additional Evaluation and Management services may be reported separately using modifier -25, if the patient's condition requires a significant, separately identifiable E/M service, above and beyond the usual pre-service and post-service work associated with the procedure.

Bill one chiropractic manipulation code per day with a count of one.

Bill one date of service per claim line.

Bill charges for a diagnostic imaging plain film x-ray in accordance with the provider contract, as a separate service (claim line) item in addition to either an office visit or chiropractic manipulation.

Submit charges only for those chiropractic manipulative services, evaluation and management services and diagnostic imaging services listed in your contractual agreement with NHP, and the applicable fee schedule in effect on the date services were rendered.

Documentation

The information in the patient’s record should support the medical necessity of the procedure as well as the nature and extent of the services rendered. The mere statement or diagnosis of pain is not sufficient to support medical necessity for the treatments. The precise level(s) of the subluxations(s) must be specified by the chiropractor to substantiate a claim for manipulation of each spinal region(s). The need for extensive, prolonged course of treatment should be appropriate to the reported procedure code(s) and must be documented clearly in the medical record. Treatment should result in improvement or arrest of deterioration of subluxation within a reasonable and generally predictable period of time. Any records supporting an appropriate history, physical exam, and progress notes must also be available for review.

References

Commonwealth of Massachusetts, 130 CMR 441.00, dated 11/26/2010

Commonwealth of Massachusetts, MassHealth Provider Manual Series: Chiropractor Manual, Transmittal Letter CRP, dated November 2010.

Current Procedural Terminology, published by the American Medical Association.

LCD # 30269 for Chiropractic Service (Manual Spinal Manipulations) promulgated by NHIC J-14 MAC, Part A and Part B, Revision 4, Effective Date 10/01/2010.

Article ID Number: L30269 (A49347) Local Coverage Article for Chiropractic Educational Guideline-Related to L30269, promulgated by NHIC J-14 MAC-Part B, updated 08/01/2010.

NHP Clinician Quarterly, Volume 13, Number 1, Winter Spring 2009; Routine Lumbar Imaging No Help for Low Back Pain; By Crystal Phend, Staff Writer MedPage Today, Published February 5, 2008

Publication History

Topic: Chiropractic	Owner: Provider Network Management
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2009/08/07 *Original documentation*

2011/07/06 *Authorization grid, definitions update; deleted CPT codes 98943, 99202-99203, 99211, 99213 from grid; NHP does not reimburse, references and disclaimer updated, diagnosis requirement added.*

2012/01/17 *Referral Grid updated, added definition “contract year” for MassHealth members.*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider’s agreement, the terms and conditions of the provider’s agreement shall prevail. Neighborhood Health Plan utilizes McKesson’s claims editing software, ClaimCheck, a clinically oriented, automated program that identifies the “appropriate set” of procedures eligible for provider reimbursement by analyzing the current and historical procedure codes billed on a single date of service and/or multiple dates of service, and also audits across dates of service to identify the unbundling of pre and post-operative care. Please refer to Neighborhood Health Plan’s Provider Manual Billing Guidelines section for additional information on NHP’s billing guidelines and administration policies. Questions may be directed to Provider Network Management at prweb@nhp.org.