Chiropractic Services

Policy

Mass General Brigham Health Plan reimburses participating chiropractic providers for medically necessary chiropractic services related to a neuromusculoskeletal condition provided to Mass General Brigham Health Plan members having chiropractic benefits coverage.

Authorization, Notification and Referral

Service	Requirement
Commercial Members and Medicare Advantage members, refer to individual plan materials	No prior authorization required up to the benefit limit
For MassHealth Standard, MassHealth CommonHealth, MassHealth CarePlus, MassHealth Family Assistance plan members, 20 visits per benefit period	No prior authorization required visits 1-20; Prior authorization required for additional visits beyond 20

Limitations

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 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 licensed 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.

Mass General Brigham Health Plan limits payment for chiropractic services to the total of office visits, therapeutic treatments, chiropractic manipulative treatments, or any combination of office visits, therapeutic treatments and chiropractic treatments allowed annually, under the member's benefit schedule.

Diagnostic Imaging Services
Mass General Brigham Health Plan 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, therapeutic treatments, and/or evaluation and management service and limited by the Mass General Brigham Health Plan member's benefit coverage. Diagnostic imaging services must meet all Mass General Brigham Health Plan radiology policies and guidelines.

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 member'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 paraphysiologic zone. This results in

cavitations or gapping of the joint, which usually procedures 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.

Diagnostic imagining services: The purpose of diagnostic imaging is to gain diagnostic information regarding the member 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 provider should discuss the risk with the member and record this in the chart.

Manual devise usage: Handheld devices with the thrust of force 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 member is being treated for a new injury, identified by x-ray or physical examination. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression of the member's condition.
- Chronic subluxation: The member'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 Mass General Brigham Health Plan benefit coverage, a visit is defined as an office evaluation and management service, or an office contact during which a chiropractor provides a session of chiropractic manipulation or therapeutic treatment.

Mass General Brigham Health Plan Reimburses

- One manual spinal manipulation per day
- The initial diagnostic x-ray related to the purpose of the diagnostic visit
- Therapeutic treatment modalities within the chiropractor's scope of licensure
- Significant, separately identifiable evaluation and management service

Mass General Brigham Health Plan Does *Not* Reimburse

- An evaluation and management service provided on the same day as chiropractic treatment unless separately identifiable
- Other services provided or ordered and not described in the Procedures Table below.
- Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) for ANY of the following, as they are deemed 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
- Additional reimbursement for use of a manual device
- 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.
- Any services that are considered experimental or investigational are not covered.
- Chiropractic services provided to infants are considered experimental, investigational.

Procedure Codes Applicable to Guideline

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

CPT code	Description	Comments
97010	Application of a modality to one or more areas; hot or cold packs	Not separately reimbursable for Commercial and MassHealth members. No covered for Medicare Advantage members
97012	Application of a modality to 1 or more areas; traction, mechanical	
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)	
97016	Application of a modality to 1 or more areas; vasopneumatic devices	
97018	Application of a modality to one or more areas; paraffin bath	
97022	Application of a modality to one or more areas; whirlpool	

CPT code	Description	Comments
97024	Diathermy (e.g., microwave)	
97026	Infrared	
97028	Application of a modality to one or more areas; ultraviolet	
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	
97033	Iontophoresis, each 15 minutes	
97034	Application of a modality to one or more areas; contrast baths, each 15 minutes	
97035	Ultrasound	
97036	Application of a modality to one or more areas; Hubbard tank, each 15 minutes	
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes	
98940	CMT, spinal, one to two regions	
98941	CMT, spinal, three to four regions	
98942	CMT, spinal, five regions	
98943	CMT, extraspinal, 1 or more regions	

CPT code	Description	Comments
99202	Office or other outpatient visit for the evaluation and management of a new patient, low to moderate severity. Physicians typically spend 20 minutes face to face with the patient and/or family.	
99203	Office or other outpatient visit for the evaluation and management of a new patient, moderate severity. Physicians typically spend 30 minutes face to face with the patient and/or family.	
99204	Office or other outpatient visit for the evaluation and management of a new patient, moderate to high severity. Physicians typically spend 45 minutes face to face with the patient and/or family.	
99205	Office or other outpatient visit for the evaluation and management of a new patient, moderate to high severity. Physicians typically spend 60 minutes face to face with the patient and/or family.	
99212	Office or other outpatient visit for the evaluation and management of an established patient, self-limited or minor. Physicians typically spent 10 minutes face to face with the patient and/or family.	
99213	Office or other outpatient visit for the evaluation and management of an established patient, low to moderate severity. Physicians typically spent 15 minutes face to face with the patient and/or family.	
99214	Office or other outpatient visit for the evaluation and management of an established patient, moderate to high severity. Physicians typically spent 25 minutes face to face with the patient and/or family.	
99215	Office or other outpatient visit for the evaluation and management of an established patient, moderate to high severity. Physicians typically spent 40 minutes face to face with the patient and/or family.	

Coding for diagnostic imaging procedures is limited to the Mass General Brigham Health Plan provider's

contractual agreement regarding the billable service codes.

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
- 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 an office visit, chiropractic manipulation, or therapeutic treatment modalities.
- Submit charges only for those chiropractic manipulative services, evaluation and management services, therapeutic treatment modalities, and diagnostic imaging services listed in your applicable fee schedule in effect on the date services were rendered.

Documentation

The information in the member'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 or pain is not sufficient to support medical necessity for the treatments. The precise level(s) of the subluxation(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 and auditing purposes.

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
CMS Local Coverage Article, Chiropractic Services - Medical Policy Article (A57889)

Publication History

Topic: Chiropractic	Owner: Network Management

August 7, 2009	*Original documentation*
July 6, 2011	*Authorization grid, definitions update; deleted CPT codes 98943, 99202-99203, 99211, 99213 from grid; Mass General Brigham Health Plan does not reimburse, references and disclaimer updated, diagnosis requirement added.*
January 17, 2012	*Referral Grid updated, added definition "contract year" for MassHealth members.*
July 17, 2015	*Updated visit limits, removed diagnosis requirements, added therapeutic treatment language, updated Procedure Code list*
January 1, 2019	*Document restructure; codes, code descriptor and references updated*
January 1, 2023	*Document rebrand; updated references; updated CPT grid*

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. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Health Partners Insurance Company.