BlueCross BlueShield Minnesota

COMMERCIAL REIMBURSEMENT POLICY

Chiropractic Services

Active

Section: General Coding
Policy Number: 010
Effective Date: 06/03/24

Description

This policy addresses coding and reimbursement for chiropractic services reported on a professional (837P) claim.

This policy does not apply to FEP.

Policy Statement

The chiropractic manipulative treatment (CMT) codes 98940-98943 include a pre-manipulation patient assessment. Codes 98940-98942 are used to indicate the number of spinal regions manipulated. One spinal CMT procedure is reimbursable per date of service.

Code 98943 is used to report manipulation of one or more of the extra-spinal regions (head region; lower extremities; upper extremities; rib cage; abdomen). One extraspinal CMT procedure code is reimbursable per date of service.

If the patient's condition requires a significant, separately identifiable evaluation and management (E/M) service above and beyond the usual pre-service and post-service work associated with the CMT procedure, additional E/M services (99202-99205, 99211-99215) may be reported separately using modifier 25.

Imaging Procedures

Blue Cross and Blue Shield of Minnesota (Blue Cross) will allow chiropractors to perform and bill for most X-rays. Services billed for consultation on X-ray exams performed elsewhere, however, are not reimbursable. Per Current Procedural Terminology (CPT®), CMT procedures include the review of prior radiologic imaging, and the consultation is, therefore, considered an inclusive component of the CMT codes.

Blue Cross will allow chiropractors to order other necessary radiology services such as computed tomography (CT), magnetic resonance imaging (MRI) and ultrasound, as permitted by the provider's scope of practice; however, Blue Cross will not reimburse these services when billed by a chiropractor.

Massage Therapy

Massage therapy may be denied either as incidental (provider liability) or subscriber liability.

- Massages that are provided as preparation for chiropractic manipulation are considered an integral part of the therapy and will be denied as provider liability. Submission of the 59 or GA modifiers will not affect or change the denial.

- If a massage is billed alone (i.e. without a chiropractic therapy), then it is subject to the subscriber's contract benefits. Some benefit plans may not cover this service.

Maintenance or Palliative Care and Modifier AT
The AT modifier (Active Treatment) distinguishes active/corrective treatment from maintenance therapy.

- The AT modifier should be appended to the chiropractic manipulation (98940-98943) to show active treatment.
- The absence of the AT modifier would indicate maintenance or palliative care. Claims without the AT modifier may be denied.

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, the applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	25	59	AT	GA		
ICD-10 Diagnosis:	N/A					
ICD-10 Procedure:	N/A					
CPT/HCPCS:	76140	97124	98940	98941	98942	98943
Revenue Codes:	N/A					

BlueCross BlueShield Minnesota

Resources
Current Procedural Terminology (CPT®)
Healthcare Common Procedure Coding System (HCPCS)

Policy History	
03/24/2015	Initial Committee Approval
01/07/2019	Annual Policy Review
01/26/2021	Annual Policy Review
11/29/2021	Revised
05/23/2023	Revised
05/28/2024	Annual Policy Review