Worldwide Coverage – Chiropractic Care

Applies to:

Blue Cross Blue Shield Nebraska MA Core (HMO)
Blue Cross Blue Shield Nebraska MA Choice (HMO-POS)

Chiropractic Care

Chiropractic care focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. Chiropractic care is most often used to treat neuromusculoskeletal complaints, including but not limited to back pain, neck pain, headaches, and pain in the joints of the arms or legs. Chiropractors utilize a drug-free, hands-on approach to health care that includes patient examination, diagnosis and treatment.

The most common therapeutic procedure performed by doctors of chiropractic medicine is known as spinal manipulation. The purpose of manipulation is to restore joint mobility by manually applying a controlled force into joints that have become hypomobile or restricted in their movement as a result of a tissue injury. Manipulation, or adjustment of the affected joint and tissues, restores mobility, thereby alleviating pain and muscle tightness, and allowing tissues to heal.

Original Medicare

Original Medicare only pays for chiropractic care services deemed to be medically necessary and reasonable.

Under the Original Medicare program, coverage of chiropractic care is specifically limited to treatment by means of manual manipulation (by use of the hands) of the spine to correct a subluxation provided such treatment is legal in the state where performed. Additionally, manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. However, no additional payment is available for use of the device or for the device itself. All other services furnished or ordered by chiropractors are not covered including x-rays taken to document medical necessity or any other diagnostic or therapeutic service.

In order for Original Medicare to make payment for chiropractic care, the patient must have a significant health problem in the form of a neuromuscular-skeletal condition necessitating treatment. The patient's primary diagnosis must be subluxation of the spine. The precise level of the subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine. A subluxation may be demonstrated by an X-ray or by physical examination.

The manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. For Medicare purposes, a chiropractor must place modifier AT (acute treatment) on the claim when providing active or corrective treatment to treat acute or chronic subluxation.

Original Medicare will not pay for Maintenance therapy. Maintenance therapy is defined as services that seek to prevent disease, promote health, prolong and enhance the 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. The modifier AT must not be placed on the claim when maintenance therapy has been provided. Claims without modifier AT are considered maintenance therapy and denied.

Coverage criteria for chiropractic services are based on Medicare laws, regulations and guidelines and local coverage determinations established by Medicare carriers and A/B Medicare Administrative Contractors (MAC). Original Medicare does not impose caps and limits for covered chiropractic care. However, Medicare carriers and A/B Medicare Administrative Contractors may have criteria (numerical or dollar) after which medical documentation and/or chart review may be required prior to the payment of billed services.

MA Core (HMO) and MA Choice (HMO-POS) Enhanced Benefit

MA Core (HMO) and MA Choice (HMO-POS) are Medicare Advantage plans that provide at least the same level of benefit coverage as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue Cross and Blue Shield of Nebraska to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Coverage for chiropractic care is provided to members under the MA Core (HMO) and MA Choice (HMO-POS) plans. The scope of the benefit, reimbursement methodology, maximum payment amounts, and the member's cost–sharing are determined by Blue Cross and Blue Shield of Nebraska.

The MA Core (HMO) and/or MA Choice (HMO-POS) plans offer the following coverage:

- The first annual office visit for routine care to a chiropractor has a $0 copay, subsequent visits covered under this benefit are subject to the chiropractic co-pay amount.
- One set of diagnostic x-rays (up to three views) performed by a chiropractor annually at no cost to the member are provided under this benefit.

Coverage for mechanical traction therapy or other physical therapy services, and spinal manipulation for conditions not listed under the conditions for payment is not provided under this benefit.

Emergency treatment of an acute spinal condition must be provided within 48 hours of the injury. MA Core (HMO) and MA Choice (HMO-POS) do not pay for follow-up services unless the injury for which services were provided results in an ongoing acute or chronic condition. In that case, payment may be made for follow-up services for chiropractic manipulative treatment.

Conditions for payment

The table below specifies the payment conditions for chiropractic services.

Conditions for payment		
Eligible provider	Chiropractor	
Payable location	Office	
Frequency	Based on CPT codes billed	
CPT / HCPCS codes	Diagnostic radiology	72020, 72040, 72050, 72052, , 72070, 72072,72074, 72080, 72090, 72100, 72110, 72114, 72120, 72170, 72190, 72200, 72202, 72220, 72081, 72082, 72083, 72084 X-rays of the area of chief complaint may be taken at the start of treatment.
	Evaluation & management	New patient visits (99201, 99202, and 99203) payable once every 36 months per chiropractor. Established patient visits (99212, 99213 and 99214) payable once every 12 months per chiropractor.
	Spinal manipulation	Spinal manipulation services (98940, 98941 and 98942): modifier AT required – may be billed once per day.
Diagnosis restrictions	Diagnostic radiology	No restrictions. X-rays of areas other than that of the chief complaint must be supported by documentation showing medical necessity.
	Evaluation & management	No restrictions. Must be medically necessary.
	Spinal manipulation	Consistent with Original Medicare. Must be medically necessary.
Age restrictions	No restrictions	

Reimbursement

MA Core (HMO) and/or MA Choice (HMO-POS) plans' maximum payment amount for chiropractic care services is consistent with Original Medicare. The provider will be paid the lesser of the allowed amount or the provider's charge, minus the member's cost share. This represents payment in full and providers are not allowed to balance bill the member for the difference between the allowed amount and the charge.

Member cost-sharing

- NE Medicare Advantage providers should collect the applicable cost–sharing from the member at the time of the service when possible. Cost–sharing refers to a flat–dollar copayment, a percentage coinsurance or a deductible. Providers can only collect the appropriate NE Medicare Advantage cost–sharing amount from the member.
- If the member elects to receive a non–covered service, he or she is responsible for the entire charge associated with the non–covered service.

To verify benefits and cost-share, providers may call 888-505-2022.

Billing instructions for providers

1. Bill services on the CMS 1500 (02/12) claim form or the 837 equivalent claim.
2. Use the MA Core (HMO) and/or MA Choice (HMO-POS) unique billing requirements.
3. Report HCPCS codes and diagnosis codes to the highest level of specificity.
4. Report your National Provider Identifier number on all claims.
5. Submit claims to your local BCBS plan.

Revision history

Policy number: NEHMO 1012

Policy created: 06/16/2017

Policy effective: 01/01/2018

Revised: 11/07/2017, 08/28/2017

11/02/2017: Clarified the language in the policy.

8/28/2017: Added at paragraph 3 'In order for Original Medicare to make payment for chiropractic care,', added at paragraph 5 'Original Medicare will not pay for chiropractic maintenance therapy.', at paragraph 6 modified the second sentence by the addition of the words 'specific' 'or dollar value', deleted 'There may be review screens (numbers of visits at which the Medicare carrier or A/B MAC may require a review of documentation). Replaced with 'However, Medicare carriers and A/B Medicare Administrative Contractors may have criteria (numerical or dollar) after which medical documentation and/or chart review may be required prior to the payment of billed services.'