MEDICAL MUTUAL®

Reimbursement Policy

Policy: **RP-202204** **Initial Effective Date:** 05/15/2022

SUBJECT: **Chiropractic Reimbursement**

Applicability: This Reimbursement Policy will be applicable to the following Medical Mutual companies and products:

☒ Medical Mutual of Ohio, Medical Mutual Services, LLC (except Mutual Health Services), Medical Health Insuring Corporation of Ohio, MedMutual Life Insurance Company
- ☒ Commercial and Marketplace (Fully-Insured and Self-Funded)
- ☒ Medicare Advantage

☒ Mutual Health Services

Purpose: The Chiropractic Reimbursement Policy addresses routine chiropractic care performed by a licensed chiropractor.

Reimbursement Policy:

I. Coding/Billing

(1) New and Established patients

When submitting an Evaluation and Management (E&M) service (**CPT codes 99201-99215**) for claim payment, providers must include the following documentation in the medical record. Although not required upon claim submission, the documentation must be made available if requested by the Company for review. The Company may audit medical records on a prepayment or post-payment basis to verify that documentation supports the claim submitted.

- Comprehensive and appropriate history and examination
- Counseling/anticipatory guidance/risk factor reduction interventions
- Ordering of appropriate laboratory/diagnostic procedures

Note: Evaluation and Management codes are based on the complexity of the case; the codes are not only time-dependent.

(2) New patient E&M codes: CPT Codes 99201-99205

A new patient is defined as one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years. A new patient visit (**CPT Codes 99201-99205**) can be billed along with a chiropractic manipulative

treatment service (**CPT Codes 98940- 98943**). These coupled codes will be reimbursed by the Company once every three years.

(3) Established patient E&M codes: CPT Codes 99211-99215

An established patient is defined as one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years. An established patient visit (**CPT Codes 99211-99215**) can be billed along with a chiropractic manipulative treatment service (**CPT Codes 98940-98943**) only if the established patient has a new condition, new injury, aggravation, or exacerbation that warrants further examination above and beyond what is included in chiropractic manipulative treatment (CMT) services.

(4) Chiropractic manipulative treatment (CMT): CPT Codes 98940-98943

The primary therapeutic procedure rendered for most chiropractic office visits is a spinal manipulation/adjustment. The CMT codes (**CPT Codes 98940-98943**) include a pre-manipulation patient assessment. Manipulations should be billed using the appropriate CMT codes. E&M codes should not be billed for manipulations.

The work value (work per unit of time) of the four CMT codes includes both cognitive and technical components and is divided into three sections:

1) Pre-service - includes documentation and chart review, imaging review, test interpretation, and care planning.
2) Intra-service - includes pre-manipulation patient assessment and palpation, manipulation, and post-manipulation procedures.
3) Post-service period - includes chart documentation, consultation, and reporting.

For the purposes of reporting CMT codes, there are five spinal regions:

1) cervical (includes atlanto-occipital joint)
2) thoracic
3) lumbar
4) sacral
5) pelvic (sacroiliac joint)

II. Physical medicine and rehabilitation services

Reimbursement for modalities and/or therapeutic procedures performed during a chiropractic office visit is included in the payment for the chiropractic office visit.

Manual therapy: CPT Code 97140

The Company will not reimburse providers for manual therapy services (**CPT Code 97140**) when billed with a CMT code on the same day.

Records for Medical Necessity Review

When the Company requests records for a medical necessity review, documentation submitted by the provider must allow a peer reviewer to discern the medical necessity for each service.

Example:
If a day's service (during a series of treatments) is being reviewed by the Company for medical necessity, submitted documentation must include the initial date of service notes, history, diagnostic tests, examination, and radiology findings where specific details are documented.

III. Reimbursement

The Company will only reimburse for services directly provided by the chiropractor.

The Company does not pay for services considered investigational.

Services for the purpose of enhancing athletic performance or for recreation are not reimbursable by the Company.

Durable Medical Equipment (DME) will only be reimbursed if it is provided by a licensed DME provider and documented by a prescription or orders along with records supporting medical necessity. Other terms, conditions, and limitations of benefits in the member's benefit plan or certificate apply.

The Company applies National Correct Coding Initiative (NCCI) edits to claims, as stated in the Provider Manual.

The Company makes payment determinations consistent with the terms, conditions, and limitations of benefits in the member's benefit plan or certificate. It is the responsibility of the member and the provider to reference the member's benefit plan or certificate to determine any benefit limitations.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its reimbursement process. The Company may deny reimbursement when it has determined that the services performed/billed are not separately payable regardless of coding used and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation must be made available upon request to the Company. Documentation requested may include patient records, test results, and/or credentials of the provider ordering or performing a service as well as itemized bills. The Company also reserves the right to modify, revise, change, apply, and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

NOTE: After reviewing the relevant documentation, the Company reserves the right to apply this policy to the service, procedure, supply, product, or accommodation performed regardless of how the service, procedure, supply, product, or accommodation was coded by the Provider.

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Sources of Information:

- American Medical Association. (March 9, 2021). CPT® Evaluation and Management. Available at: https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management. Accessed March 14, 2022.

Corporate medical policies are available on our website: https://www.medmutual.com/For-Providers/Policies-and-Standards/CorporateMedicalPolicies.aspx

Applicable Code(s):	
CPT:	**97140, 98940, 98941, 98942, 98943, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215**
HCPCS:	N/A
ICD10 Procedure Codes:	N/A

Revised:
05/15/2022 Policy created.