CPT Codes – 97010, 97012, 97014, 97032, 97035, 97110, 97124, 97140, 97530, 98940 – 98943, 99201 – 99205, 99211 – 99215

Sentinel has created this Chiropractic Billing Guide in order to provide clear and helpful information about billing requirements for chiropractic services.

This guide lists many procedures and codes. Not all of them are included in every benefit plan or are appropriate for all patients. Please check and verify individual member benefits to determine what services are covered. Also note that some codes or procedures may not be covered because of existing limitations, benefit contract exclusions, standard procedure code editing and medical necessity criteria.

Chiropractic services are considered medically necessary when all of the following criteria are met:

A. the member has a neuromusculoskeletal disorder; and,
B. the medical necessity of treatment is clearly documented; and,
C. improvement is documented within the initial 2 weeks of chiropractic care; and,
D. treatment is provided in accordance with an ongoing, written treatment plan that includes all of the following:
   • Specific modalities/procedures to be used in treatment; and,
   • Diagnosis; and,
   • Region treated; and,
   • Degree of severity (mild, moderate, severe); and,
   • Impairment characteristics; and,
   • Physical examination findings – x-ray or other pertinent findings; and,
   • Reasonable estimate of when goals will be reached (estimated duration of treatment, e.g., number of weeks); and,
   • Frequency of treatment (e.g., number of times per week); and,
   • Equipment and/or techniques utilized.

Chiropractic treatment is not considered medically necessary for any of the following, if:

1) No improvement is documented within initial 2 weeks unless treatment is modified; or,
2) No improvement is documented within 30 days despite modification of treatment; or,
3) The maximum therapeutic benefit has been achieved; or,
4) Patient is asymptomatic or without an identifiable clinical condition; or,
5) Patient’s condition is neither regressing nor improving; or,
6) Manipulation is performed repetitively to maintain level of function (this is considered maintenance therapy); or,
7) Manipulation is performed once every 2 – 4 weeks (this is considered maintenance therapy); or,
8) There is no written treatment plan established for conditions found on evaluation; or,
9) Treatment is for idiopathic scoliosis or scoliosis beyond early adolescence, unless the patient is exhibiting pain or spasm, or other medically necessary indication for manipulation.
The following chiropractic procedures are considered **experimental and investigational**:

- Active Release Technique
- Applied Spinal Biomechanical Engineering
- BioEnergetic Synchronization Technique
- Biophysics Technique
- Cranial manipulation
- Coccygeal meningeal stress fixation technique
- Directional non-force technique
- Manipulation for internal (non-neuromusculoskeletal) disorders (applied kinesiology)
- Manipulation under anesthesia
- Moiré contoururographic analysis
- Network technique
- Neural organization technique
- Sacro-occipital technique
- Upledger technique and craniosacral therapy
- VAX D (and similar devices such as DRX9000) – vertical axial decompression devices

The following diagnostic procedures are considered **experimental and investigational**:

- Thermography
- Paraspinal electromyography (EMG)/surface scanning EMG
- Spinoscopy (surface scanning and macro electromyography)
- Neurocalometer/nervoscope
- Pulstar FRAS System (Forced Recording and Analysis System) device that analyzes intervertebral resistance and also can be programmed to provide a low force mechanical thrust to the vertebrae
- Cineradiography/videoradiography (rapid sequence x-ray exam that films motion)
- Subtraction radiography or digital subtraction angiography
- Videofluoroscopy (recording on videotape images appearing on a fluoroscopic screen) - also referred to as dynamic motion imaging, dynamic motion x-rays, DMX imagining and/or digital motion x-rays.
- Xeroradiograph (system of developing images of specific areas of the body using x-rays)

**Manipulations** - For the majority of chiropractic visits, the primary therapeutic procedure rendered is a spinal manipulation/adjustment. Report manipulations using the appropriate CPT codes (98940-98942 [spinal] and 98943 [extra spinal]). As defined in the Current Procedural Terminology, chiropractic manipulation treatment codes include a pre-manipulation patient assessment.

**Evaluation and Management (E&M) Services** - Additional E&M services may be reported separately using modifier -25 but only if the patient’s condition requires a significant separately identifiable E&M service under the following circumstances:

a) initial exam of a new patient or condition; or,
b) acute exacerbation of symptoms or significant change in patient’s condition; or,
c) distinct different indications, which are separately identifiable and unrelated to the manipulation.

When reporting E&M services, the level reported should be consistent with the complexity of the history, physical and medical decision making involved in the patient encounter. Documentation in the medical record should include the components of the separate and distinct E&M service as well as the reasons for performing the separate service. Report E&M services using the appropriate CPT codes (99201 – 99205 [new patient] 99211-99215 [established patient]).
Adjunctive Physical Therapy Modalities - Adjunctive physical modalities and/or therapeutic procedures are defined as services rendered in conjunction with or concurrent to the primary treatment – chiropractic manipulative treatment.

There is no documentation in medical literature to suggest that use of physical modalities will produce a difference in clinical outcomes. The use of physical modalities in chiropractic practice is unique and distinct from the practice of physical therapy, because physical modalities and procedures are rendered concurrent to or in conjunction with chiropractic manipulative treatment. As a result of this, the clinical rationale used by physical therapists for physical modalities and procedures is not logically transferred to chiropractic practice and the use of these physical modalities and procedures must be viewed for the value that they offer the patient as an adjunct to manipulative treatment.

The purpose for delivering adjunctive physical modalities and procedures is to improve the clinical efficacy and affect application of manipulation in the presence of factors that may impair its effect.

Factors that may impair the delivery include initial patient fear of the manipulation and/or extreme pain and associated physical concomitants such as muscle spasm. Other factors are muscular de-conditioning (strength/endurance), muscular imbalance and/or ligamentous instability. Physical modalities and procedures are only considered adjunctive to the effect of the manipulation when there is an established therapeutic value to their use and this value is measurable and includes a defined outcome.

For these reasons, the use of adjunctive physical modalities and procedures in conjunction with chiropractic manipulative treatment may be considered medically necessary when:

1) only 1 or 2 adjuncts is/are used (1 unit only for time based modalities and procedures); and,
2) only for a period of time during which the factors complicating the delivery of manipulative therapy can reasonably exist – limited to the first 2 months of care.

Physical modalities fall into 2 broad categories – supervised and constant attendance.

Supervised modalities:

do not require direct individual contact with the health care provider; and
are eligible only once per date of service.

Contact attendance modalities and procedures:

are time-based; and
require direct one-on-one individual contact with the health care provider.

For time based procedures increments are in 15 minute intervals with billing for multiple units based on:

1 unit = greater than 8 minutes and less than or equal to 23 minutes
2 units = greater than 23 minutes and less than or equal to 38 minutes
3 units = greater than 38 minutes and less than or equal to 53 minutes
4 units = greater than 53 minutes and less than or equal to 68 minutes

Below is a list of appropriate physical modalities to be reported by a chiropractor along with manipulation treatment within the 1st 60 days of treatment based on proper documentation for medical necessity.
Supervised Modalities –

97010 Hot or cold packs
97012 Traction, mechanical
97014 Electrical stimulation

Constant Attendance Modalities and Procedures (each per 15 minutes) –

97032 Electrical stimulation (manual)
97035 Ultrasound
97110 Therapeutic exercise

97124 Massage
97140 Manual Therapy Joint Mobilization

97530 Therapeutic Activities

Physical modalities that are performed solely to relax and prepare the patient for manipulation (application of hot or cold packs (97010), massage (97124) and joint mobilization (97140)) are considered an inherent part of manipulation. These services are not eligible for separate payment when reported on the same day as manipulation unless performed on separate body regions unrelated to the manipulation procedure. In these cases modifier -59 should be appended to the appropriate code. Documentation in the patient’s record should support both medical/chiropractic necessity as a separate and distinct service. NOTE: Most plans do not cover services that are performed by a massage therapist. This applies to independently practicing massage therapists as well as those who are employed and supervised by an eligible health care professional.

Physical Modalities and Procedures are not considered medically necessary, if:

1) administered without manipulation, or after the manipulation benefit has been exhausted;
2) administered after the initial 2 months of manipulation care;
3) more than 2 different modalities are performed at one visit;
4) more than 2 units of a time based modality are administered as the only modality for visit; or, more than 1 unit of a time based modality is administered in combination with another adjunct modality procedure.

Policies are designed to provide medical guidelines that are applicable for the majority of individuals with a particular disease, illness, or condition. In addition, policies are designed to supplement the medical necessity terms as defined in the member's Policy or Benefit Plan. Therefore, sMed policies alone cannot override specific Policy or Benefit plan language regarding coverage, limitations and exclusions. In the event of conflict, the Policy or Benefit Plan shall govern. Any sMed policies included herein do not constitute medical advice or the practice of medicine. Rather, they are intended only to establish general guidelines. Application of a sMed policy to determine medical necessity in an individual instance is not intended, implied or construed to take priority over the professional judgment of a treating provider. In all situations, the treating provider must use professional judgment to provide the care believed to be in the best interest of the patient, and the provider and patient remain responsible for all treatment decisions.

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