



Chiropractic Billing Guide

Independence Blue Cross (IBC) has created this 2006 Chiropractic Billing Guide Supplement in order to provide clear and helpful information about billing requirements for chiropractic services.

The following information is provided as a further supplement to the Billing Guide mailed to providers in September 2002 and July 2003. This guide applies only to services that are performed by chiropractic providers. *Individual member benefits must be verified.*

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.

Manipulations

For the majority of chiropractic office visits, the primary therapeutic procedure rendered is a spinal manipulation/adjustment. Please report manipulations using the appropriate CPT manipulation codes (98940-98942 [spinal] and 98943 [extraspinal]). As defined in the Current Procedural Terminology (CPT) Manual, the chiropractic manipulation treatment codes include a pre-manipulation patient assessment. Additional Evaluation and Management (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.

Physical Medicine Modalities

Below is a list of appropriate physical therapy modalities eligible to be reported by a chiropractor.

For most Health Maintenance Organization (HMO) products, physical medicine modalities are part of the Capitated Physical Therapy Program and are only reimbursable to Capitated Physical Medicine providers. In addition, a Primary Care Physician (PCP) referral is required for chiropractic services for most HMO products.

Modalities fall into two broad categories – supervised and constant attendance.

Supervised modalities:

- Do not require direct individual contact with the health care provider.
- Are eligible only once per date of service.

Constant attendance modalities:

- Are time-based.
- Require direct one-on-one individual contact with the health care provider.

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IBC offers products directly through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield – independent licensees of the Blue Cross and Blue Shield association.

Supervised Modalities

97010	Application of a modality to one or more areas; hot or cold packs
97012	Application of a modality to one or more areas; traction, mechanical
97014	Application of a modality to one or more areas; electrical stimulation
97016	Application of a modality to one 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
97024	Application of a modality to one or more areas; diathermy (e.g., microwave)
97026	Application of a modality to one or more areas; infrared
97028	Application of a modality to one or more areas; ultraviolet

Constant Attendance Modalities

97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to one or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to one or more areas; contrast baths, each 15 minutes
97035	Application of a modality to one or more areas; ultrasound, each 15 minutes
97036	Application of a modality to one or more areas; Hubbard tank, each 15 minutes
97039	Unlisted modality (specify type and time if constant attendance)

Therapeutic Procedures

Below is a list of therapeutic procedures eligible to be reported by a chiropractor.

Therapeutic procedures:

- Are time-based.
- Require direct one-on-one individual contact with the health care provider.

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

97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97139	Unlisted therapeutic procedure (specify)
97140	Manual therapy techniques (e.g. mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97532	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by the provider, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)

Note: IBC does not provide reimbursement for 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.

Decompression/Traction Devices

There are several computerized traction units that have been approved by the U.S. Food and Drug Administration (FDA) to be marketed as decompression devices.

Vertebral axial decompression (VAX-D) and similar devices such as the DRX9000™ (Axiom Worldwide, Tampa, FL) and Axiom 3XDActiveTrac™ should be reported using the procedure code S9090. It is not appropriate to use other CPT codes to represent these services.

Note: VAX-D is considered experimental/investigational based on Medical Policy #07.08.01a, Vertebral Axial Decompression Therapy. This policy can be accessed at www.ibx.com.

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CPT Definition of Modifier -59 (Distinct Procedural Service)

Under certain circumstances, a provider may need to indicate that a procedure or service was distinct or independent from other services that are performed on the same day. Modifier -59 is used to identify procedures or services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury) that is/are not usually encountered on the same day by the same provider.

Modifier -59 should only be used when there is no other modifier that describes the situation more accurately.

Use of Modifier -59

Physical medicine modalities that are performed solely to relax and prepare a patient for manipulation are considered inherent to the manipulation and are not eligible for separate reimbursement when they are reported on the same day as the manipulation. However, when services that are represented by codes **97010** (hot/cold packs), **97124** (massage), and/or **97140** (manual therapy) are performed on separate body regions unrelated to the manipulation procedure, these services may be eligible for separate reimbursement. In these cases, modifier -59 should be appended to the appropriate code. Documentation in the patient's medical record should support both medical/chiropractic necessity as a separate and distinct service.

Note: If modifier -59 is reported in conjunction with any other modifier, please ensure that modifier -59 is reported in the first position.

Tests and Measurements

- Are time-based.
- Require direct one-on-one individual contact with the health care provider.

Time-Based Procedures

Several CPT codes that are used for therapy modalities, procedures, test and measurements specify that the direct (one-on-one) time that is spent in contact with the patient is 15 minutes. Some procedures, by definition, include a reference to time allocation. If more than one CPT code is reported for a single date of service, the total number of units that can be reported is based on the total treatment time.

For any single CPT code, bill a single 15-minute unit as follows:

- 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

Example: If 24 minutes of **97112** and 23 minutes of **97110** were provided, the total treatment time was 47 minutes. Only three units should be billed for the treatment (2 units for **97112** and 1 unit for **97110**).

Electrical Stimulation Procedures (unattended)

G0281	Electrical stimulation, (unattended), to one or more areas, for chronic Stage III and Stage IV pressure ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days conventional care, as part of a therapy plan of care
G0282	Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281
G0283	Electrical stimulation (unattended), to one or more areas for indications other than wound care, as part of a therapy plan of care

E&M

Generally, *E&M codes should not be billed in conjunction with any manipulations*. Routine use of E&M services without justification, as well as reporting E&M services when other services are being performed, is not an appropriate billing practice and is subject to post-payment review. E&M services should be reported separately only in the following circumstances.

- Initial examination is for a new patient or new condition.
 - Most E&M services for new patients are generally reported with code **99203**.
- There is an acute exacerbation of symptoms or a significant change in a patient's condition.
- There are distinctly different indications which are unrelated to the manipulation.

As defined in the current CPT Manual, the chiropractic manipulation treatment codes include a pre-manipulation patient assessment. 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.

For your reference, a list of the most commonly reported E&M codes is enclosed.

Commonly Reported CPT E&M Procedure Code Definitions

New Patient:

A new patient is 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.

99201

Office or other outpatient visit for the E&M of a new patient, which requires these three key components:

- a problem-focused history
- a problem-focused examination
- straightforward medical decision-making

Counseling and/or coordination of care with other providers and/or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

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99202

Office or other outpatient visit for the E&M of a new patient, which requires these three key components:

- an expanded problem-focused history
- an expanded problem-focused examination
- straightforward medical decision-making

Counseling and/or coordination of care with other providers and/or agencies are provided consistent with the nature of problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

99203

Office or other outpatient visits for the E&M of a new patient, which requires these three key components:

- a detailed history
- a detailed examination
- medical decision-making of low complexity

Counseling and/or coordination of care with other providers and/or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99204

Office or other outpatient visit for the E&M of a new patient, which requires these three key components:

- a comprehensive history
- a comprehensive examination
- medical decision-making of moderate complexity

Counseling and/or coordination of care with other providers and/or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of 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 E&M of a new patient, which requires these three key components:

- a comprehensive history
- a comprehensive examination
- medical decision-making of high complexity

Counseling and/or coordination of care with other providers and/or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Established Patient

An established patient is 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.

99211

Office or other outpatient visits for the E&M of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

99212

Office or other outpatient visits to the E&M of an established patient, which requires at least two or these three components:

- a problem-focused history
- a problem-focused examination
- straightforward medical decision-making

Counseling and/or coordination of care with other providers and/or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minute face-to-face with the patient and/or family.

99213

Office or other outpatient visits for the E&M of an established patient, which requires at least two of these three components:

- an expanded problem-focused history
- an expanded problem-focused examination
- medical decision-making of low complexity

Counseling and/or coordination of care with other providers and/or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99214

Office or other outpatient visits for the E&M of an established patient, which requires at least two of these three components:

- a detailed history
- a detailed examination
- medical decision-making of moderate complexity

Counseling and/or coordination of care with other providers and/or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99215

Office or other outpatient visits for the E&M of an established patient, which requires at least two of these three key components:

- a comprehensive history
- a comprehensive examination
- medical decision-making of high complexity

Counseling and/or coordination of care with other providers and/or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

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General Information

Sessions

A therapy session is usually up to one hour on any given day.

Maintenance Therapy

The continuation of care and management of the patient when the therapeutic goals of a treatment plan have been achieved, no additional functional improvement is apparent or expected to occur, the provision of services for a condition ceases to be of therapeutic value, and the service is no longer medically appropriate/necessary.

Reporting/Documentation of Diagnosis

The primary diagnosis should be reported in the first diagnosis field as the principal diagnosis.

Multiple diagnosis codes may be reported. Documentation in the patient's medical record should support the diagnosis reported.

Copayment Applications

Only one co-payment per date of service will be applied.

Documentation

Proper documentation is the provider's responsibility and extends beyond an internal office communication. Documentation should be made available for review upon request from the plan. Specifically, any trained clinician should be able to review a chart and be able to understand the status of the patient on a visit-to-visit basis, patient diagnosis, treatment plans, therapeutic goals, medical necessity or appropriateness of the treatment being rendered, and expected outcome from the prescribed plan of care. National and regional documentation standards and plan requirements exist and are in effect. For example: Standard documentation of an office visit uses the acronym "SOAP" to include the following elements in the office note: (S) Subjective, (O) Objective, (A) Assessment, and (P) Plan.

For more information, please refer to the 2006 CPT Manual or to the CMS billing guidelines for chiropractic documentation available at www.hgsa.com/professionals/bguides/chiro.shtml.

Please Note:

Manipulations should be reported using the appropriate CPT manipulation codes **(98940-98943)**.

Do not use E&M procedure codes to report manipulations.

All services are subject to post-payment review and audit procedures.

In addition, please remember that although a service has a code which accurately defines a service being performed, it does not imply that the service is covered by the Company. All services are subject to existing limitations, benefit contract exclusions, standard procedure code editing, and medical necessity criteria. Individual member benefits *must* be verified.

If you have any questions regarding the reporting of chiropractic services, please contact your network coordinator.

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