



Chiropractic and Osteopathic Manipulative Services

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PROVIDER/ENTITY IMPACTED

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
PROFESSIONAL	FACILITY	DME	AMBULATORY SURGERY	LAB	OTHER

LINES OF BUSINESS IMPACTED

<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
COMMERCIAL	BLUE MEDICARE ADVANTAGE	ACA QHP¹	SMALL GROUP ACA	JAA²	FEP³	DENTAL

¹ ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family ² JAA: Joint Administrative Account ³ FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.

Description/Application

Chiropractic services are a system of complementary medicine based on the diagnosis and manipulative treatment of misalignments of the joints.

Osteopathy is a system of healthcare that views the body as a connected whole, focusing on how the body's structure and function are interrelated

Policy

Chiropractic Service Providers

A provider rendering chiropractic services must be a licensed professional chiropractor, physical therapist, or physical therapy assistant.

Only licensed chiropractors may perform chiropractic manipulative treatments (CPT Codes 98940-98943).

Licensed massage therapists shall not charge, bill, or collect a fee for any service performed.

Spinal Manipulative Procedures

Chiropractic manipulative treatment (CMT) CPT codes 98940- 98942 are used to indicate the number of spinal areas manipulated.

The problem/complaint addressed, and precise level of each subluxation treated, must be specified in the medical record. The level of the subluxation must be specified on the claim and must be listed as the primary diagnosis.

Example:

98942 – Chiropractic manipulative treatment (CMT); spinal, 5 regions. Diagnosis should be specific to the location of the subluxation. CPT 98942 represents 5 different spinal regions; there must be a subluxation diagnosis to support each region.

Areas of treatment should be documented separately in spinal regions (e.g., cervical, thoracic, lumbar, sacrum and pelvic) and vertebral (C1-S5).

Using the term, all spinal regions, upper and lower spinal regions, and all affected regions, do not support the service performed to the degree of specificity required.

Acute Treatment

Chiropractors are required to use modifier AT on claims when providing active/corrective treatment for acute or chronic subluxation (98940, 98941, 98942).

Pre-manipulation Patient Assessment

The CPT (Current Procedural Terminology) manual says Chiropractic manipulative treatment codes (98940- 98943) are minor procedures and include an inherent E/M component to gauge the patient's overall health and the medical appropriateness of the service. Since the decision to perform a minor procedure is included in the payment — the relative value unit (RVU) includes pre-service work, intra-service time, and post-procedure time — it should not be reported separately.

Pre-Service work may include a review of:

- the patient's records
- diagnostic tests
- communication with other providers
- the actual preparations for care

Intra-Service work would include:

- discussion about the service with the patient
- a pertinent evaluation and assessment of the patient
- the procedure performed

Post-Service work includes:

- an evaluation and discussion with the patient about the effect of treatment
- arrangement of additional services or referral to another provider
- discussion of the patient's care with other providers
- review of literature about the patient's condition
- documentation of the service

Evaluation and Management (E/M) Services

It is only appropriate to report the E/M with modifier 25 if, in addition to the procedure, the physician performs an E/M service that is **beyond the usual pre-, intra-, and post-procedure associated care**. This tells the payer that a separate problem was addressed at the time of another service/procedure and the patient's condition required work above and beyond the other service provided or the usual care associated with the procedure performed.

Documentation must clearly demonstrate the E/M service is significant and separately identifiable from the procedure/s performed.

Maintenance Therapy

Blue KC pays only for medically necessary chiropractic services. When further improvement cannot be expected from continuing care, the services are considered maintenance therapy. Maintenance therapy is not medically necessary, and therefore not a covered service. Do not use modifier AT on a claim where maintenance therapy was provided

Osteopathic Manipulative Treatment

Osteopathic manipulative treatment (OMT) is a form of manual treatment applied by a physician or other qualified health care professional to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of over 20 different manual treatment techniques.

For osteopathic manipulation, the areas of treatment are identified by regions, extremities, and rib cage. Documentation must support the service performed by naming the region/s where the manipulation was performed.

- Head region
- Sacral region
- Cervical region
- Pelvic region
- Thoracic region
- Lower extremities (bilateral is one region)
- Abdomen/viscera region
- Upper extremities (bilateral is one region)
- Lumbar region
- Rib cage region

Documentation to support OMT

Ensure that you have thoroughly documented the history of the chief complaint, onset, frequency, duration, etc.

- Document somatic dysfunction

- Detail the regions treated with OMT (to support the CPT codes reported)
- Include all techniques used and describe how the patient tolerated the treatment
- Document functional improvement or decline, especially in patients seen repeatedly over an extended period

Documentation

Each visit must have its own documentation to support services performed that day. Referring to older notes such as “manipulation done in same areas previously documented” will not be accepted as supporting documentation.

Modifier GP

Beginning 2/1/2025, chiropractors will be required to use the "GP" modifier when submitting codes that are considered “sometimes therapy” or “always therapy”.

This is to indicate that the service provided is considered "physical therapy" even though chiropractors aren't typically classified as physical therapists. This ensures proper claim processing and potential secondary insurance payments.

The following chiropractic billing codes require a GP physical therapy modifier, as appropriate.

CPT	Description
97012	Application of a modality to 1 or more areas; traction, mechanical
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes (if covered under subscribers’ benefits)
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes

Non-Covered Services

There will be no additional reimbursement for:

- There will be no additional reimbursement for the use of mechanical or electrical devices during manipulations or other treatment modalities, or for the device itself.
- Manual therapy techniques (i.e., CPT 97140) when performed on the same date, and in the same region(s) as spinal manipulation (98941-98943) will not be paid separately when the same practitioner performs both services.
- Hot/cold pack therapy
- Massage therapy

For information on medical necessity for manipulations and chiropractic care, please see Blue KC Medical Policy 2.01.500 Manipulations and Chiropractic Care.

Coding

CPT Code	Description
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions

98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions

References and Resources

Blue KC Provide Reference Guide
Centers for Medicare and Medicaid Services
American Medical Association CPT Manual

Related Documents

N/A

Revision History

Version	Date	Summary of Revisions
001	12/1/2020	Original
002	1/14/2021	Added to policy, Licensed chiropractors may only perform Certain services (Chiropractic Manipulative treatments 98940-98943)
003	3/11/2021	Under noncovered changed language to say "Mechanical or electrical devices used in the same region as manipulations "
004	3/24/2021	Added under "Timed Therapeutic Exercises" please see Timed Therapeutic Procedures Payment Policy POL-PP-114 for additional documentation requirements. Also added link to policy. Added beginning 2/1/2025 modifier GP will be required on sometimes and always therapy codes. (list provided).
005	3/26/2021	2021Removed - When billing both mechanical traction and spinal manipulation on the same date of service, in the same spinal region(s), spinal manipulation will be paid, and mechanical traction denied as redundant. Added under Non-covered - Manual therapy techniques (i.e., CPT 97140) when performed in the same region(s) as spinal manipulation
006	8/16/2021	Added language on Osteopathic Manipulative Treatment
007	12/1/2021	Annual review, no updates, or changes were made to the policy
008	12/28/2021	Update -Formatting changes
009	3/29/2022	Update - changed language for the use of mechanical/electrical devices to match medical policy - There will be no additional reimbursement for the use of the mechanical or electrical devices during manipulations or other treatment modalities, or for the device itself

010	5/5/2022	Update - Added E/M levels 4 and 5 require significant additional work and would seldom be appropriate when billing both a manipulative treatment code and an evaluation and management service. When a high-level E/M is submitted (99214, 99215, 99204, 99205), documentation will be requested for review to support the service
011	8/4/2022	Update - Modified 2 nd bullet under Noncovered services to say, " Manual therapy techniques (i.e., CPT 97140) when performed on the same date, and in the same region(s) as spinal manipulation (98941-98943) will not be paid separately when the same practitioner performs both services.
012	12/1/2022	Annual review, no updates, or changes were made to the policy
013	9/11/2023	Update - Removed The presence of the AT modifier alone does not indicate the service is reasonable and necessary. Claims without modifier AT will be considered maintenance therapy.
014	12/1/2023	Annual review. Added for information on medical necessity please see Medical Policy 2.01.500 Manipulations and Chiropractic Care.
015	1/29/2024	Update - Example of Spinal Manipulative Procedure 98942 and required diagnosis.
016	12/1/2024	Annual review removed information on timed therapeutic procedures and added link to payment policy. Information added saying beginning 2/1/2025 chiropractors must use modifier GP on "always "therapy codes.
017	12/1/2025	Annual review – Clarification on the appropriate use of modifier 25 for E/M service with chiropractic procedures