HEALTH CHOICE GENERATIONS HMO SNP
CHIROPRACTIC SERVICES
FACT SHEET - 2018

The purpose of this document is to detail the difference between medical and supplemental chiropractic services and the billing required for payment.

HELPFUL CONTACTS

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Medicare allows only services that are medically necessary, except as mandated by statue. For chiropractic services, this means the patient must have a "significant" health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct, therapeutic relationship to the patient's condition and provide a reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine, as demonstrated by x-ray or physical exam.

Active treatment (Medical PA coding – Non-Supplemental):
Prior Authorization required for CPT/HCPCS codes with AT modifier:

- 98940
- 98941
- 98942

Supplemental Benefit allows for no more than one routine care visit per month. Routine chiropractic office visits are all inclusive of treatment modalities and x-rays. **No modifier or prior authorization required for supplemental benefit.**

Key Differences Between Medicare covered and Supplemental		
Topic	**Medicare-covered**	**Supplemental**
Covered Services	Medicare Part B (Medical Insurance) covers manual manipulation of the spine if medically necessary to correct a subluxation when provided by a chiropractor or other qualified provider. Maintenance care is not considered by Medicare to be medically reasonable and necessary, and is not reimbursable by Medicare. Only acute and chronic spinal manipulation services are considered active care and may, therefore, be reimbursable. Medicare doesn't cover other services or tests ordered by a chiropractor, including x-rays, massage therapy, and acupuncture.	Twelve routine care visits per year (one per month).
Non-Covered Services	All services other than manual manipulation of the spine for treatment of subluxation of the spine are excluded when ordered or performed by a doctor of chiropractic. Chiropractors are not required to bill these to Medicare. Chiropractic offices may want to submit charges to Medicare to obtain a denial necessary for submitting to a secondary insurance carrier. The following are examples (not an all-inclusive list) of services that, when performed by a Chiropractor, are excluded from Medicare coverage. • Laboratory tests • X-rays • Office Visits (history and physical) • Physiotherapy • Traction • Supplies • Injections • Drugs • Diagnostic studies including EKGs • Acupuncture • Orthopedic devices • Nutritional supplements and counseling • Medicare does not cover chiropractic treatments to extra spinal regions (CPT 98943), which includes the head, upper and lower extremities, rib cage, and abdomen.	The Plan excludes or limits the services and supplies listed below: • Any chiropractic services not listed as covered in this supplemental benefit plan and/or not provided by a Plan Chiropractor • Services not related to Neuromusculoskeletal Disorders • Physical therapy not related to a spinal or joint adjustment • Diagnostic scanning, including magnetic resonance imaging (MRI), CT scans and thermography • Hypnotherapy, behavior training, sleep therapy, or physical exercise training • Air conditioners, air purifiers, therapeutic mattress supplies, or any other similar devices or appliances • Vitamins, minerals, nutritional supplements, or other similar products
Required criteria	• Patient must require treatment by means of manual manipulation. • Manipulation services rendered must have direct therapeutic relationship to the patient's condition. • There must be a reasonable expectation of recovery or improvement of function resulting from the planned treatment.	None
Coverage Guidelines	For Medicare purposes, CR 3449 requires that every chiropractic claim (those containing HCPCS code 98940, 98941, and 98942) must include the Acute Treatment (AT) modifier if active/corrective treatment is being performed. The AT modifier must not be placed on the claim when maintenance therapy has been provided. Claims without the AT modifier will be considered as maintenance therapy and denied.	None

Key Differences Between Medicare covered and Supplemental		
Topic	**Medicare-covered**	**Supplemental**
Coding Guidelines	1. The precise level of subluxation must be specified on the claim and must be listed as the primary diagnosis. The neuromusculoskeletal condition necessitating the treatment must be listed as the secondary diagnosis. 2. All claims for chiropractic services must include the following information: • Date of the initiation of the course of treatment. Symptom/condition/Secondary diagnosis code(s) • Subluxation(s)/Primary diagnosis code(s) • Date of Service • Place of Service • Procedure Code • Failure to report these items will result in claim denial or delay.	
Prior Authorization	Authorization required.	No authorization required.
Costs	$0 if QMB; 20% of the Medicare-approved amount if non-QMB	No cost share.

CPT/HCPCS CODES		
Supplemental Plan-Covered CPT/HCPCS	**Description**	**Frequency limitations**
HCPCS S8990	Chiropractic adjustments	No more than once per month
99201; 99205	New Patient; Office or other outpatient visit for the evaluation and management of a new patient	No more than once per 12 months
99211; 99215	Established Patient; Office or other outpatient visit for the evaluation and management of an established patient	No more than once per month
98940 (with no AT modifier)	Chiropractic manipulative treatment (CMT); spinal, one to two regions	No more than once per month
98941 (with no AT modifier)	Chiropractic manipulative treatment (CMT); spinal, three to four regions	No more than once per month
98942 (with no AT modifier)	Chiropractic manipulative treatment (CMT); spinal, five regions	No more than once per month
98943 (with no AT modifier)	Chiropractic manipulative treatment (CMT); extra spinal, one or more regions	No more than once per month
97012	Modalities (Supervised); traction, mechanical	No more than once per month
97014	Modalities (Supervised); electrical stimulation (unattended)	No more than once per month
97032	Modalities (Constant Attendance); Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	No more than once per month
97035	Modalities (Constant Attendance); ultrasound, each 15 minutes	No more than once per month
72010	Diagnostic Imaging - Spine; Radiologic examination, spine, entire, survey study, anteroposterior and lateral	No more than once per 6 months
72020	Diagnostic Imaging - Spine; Radiologic examination, spine, single view, specify level	No more than once per 12 months
72040	Diagnostic Imaging - Spine; Radiologic examination, spine, cervical; two or three views	No more than once per 12 months
72050	Diagnostic Imaging - Spine; minimum of four views	No more than once per 12 months
72052	Diagnostic Imaging - Spine; complete, including oblique and flexion and/or extension studies	No more than once per 12 months
72069	Diagnostic Imaging - Spine; Radiologic examination, spine, thoracolumbar, standing (scoliosis)	No more than once per 12 months

CPT/HCPCS CODES		
Supplemental Plan-Covered CPT/HCPCS	**Description**	**Frequency limitations**
72070	Diagnostic Imaging - Spine; Radiologic examination, spine, thoracic, two views	No more than once per 12 months
72072	Diagnostic Imaging - Spine; thoracic, three views	No more than once per 12 months
72074	Diagnostic Imaging - Spine; thoracic, minimum of four views	No more than once per 12 months
72080	Diagnostic Imaging - Spine; thoracolumbar, two views	No more than once per 12 months
72090	Diagnostic Imaging - Spine; scoliosis study, including supine and erect studies	No more than once per 12 months
72100	Diagnostic Imaging - Spine; Radiologic examination, spine, lumbosacral; two or three views	No more than once per 12 months
72110	Diagnostic Imaging - Spine; minimum of four views	No more than once per 12 months
72114	Diagnostic Imaging - Spine; complete, including bending views	No more than once per 12 months
72120	Diagnostic Imaging - Spine; Radiologic examination, spine, lumbosacral, bending views only, minimum of four views	No more than once per 12 months
72170	Diagnostic Imaging - Spine; Radiologic examination, pelvis; one or two views	No more than once per 12 months
72190	Diagnostic Imaging - Spine; Radiologic examination, pelvis; one or two views	No more than once per 12 months
72200	Diagnostic Imaging - Spine; Radiologic examination, sacroiliac joints; less than three views	No more than once per 12 months
72202	Diagnostic Imaging - Spine; three or more views	No more than once per 12 months
72220	Diagnostic Imaging - Spine; Radiologic examination, sacrum and coccyx; minimum of two views	No more than once per 12 months