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Chiropractic Reference Manual

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Overview

The practice of chiropractic focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. Doctors of Chiropractic recognize the value and responsibility of working in cooperation with other health care practitioners when in the best interest of the patient.

Chiropractic services are provided on an inpatient or outpatient basis when medically appropriate and necessary as determined by Blue Cross Blue Shield of North Dakota (BCBSND) and **within the scope of licensure and practice of a chiropractor, to the extent services would be covered if provided by a Physician.**

Benefits are not available for maintenance care which is **different than supportive care. Maintenance care, by definition is not therapeutically necessary**, but is provided at regular intervals. **Supportive care is therapeutically necessary**, and is provided for patients who have reached maximum therapeutic benefit, but who fail to sustain benefit and progressively deteriorate during period trials of treatment withdrawals.

Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and/or federal law. Policies contained in this document do not constitute plan authorization, nor are they an explanation of benefits. Contact Provider Service for specific coverage or policy information.

Definitions

Chiropractic Maintenance Care – Elective health care that is typically long-term, by definition not therapeutically necessary, but provided at preferably regular intervals to prevent disease, prolong life, promote health and enhance the quality of life. This care may be provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration, or it may be initiated with patients without symptoms in order to promote health and prevent future problems.

Chiropractic Manipulative Treatment (CMT) – CMT procedures (CPT® codes 98940-98943) use high-velocity, short-lever, low-amplitude thrust by hand or instrument to remove structural dysfunction in joints and muscles that may be associated with neurologic or mechanical dysfunction of the spinal joints and surrounding tissue. There are 2 types of CMT:

Spinal: manipulative treatment of cervical, thoracic, lumbar, sacral and pelvic regions

Extraspinal: manipulative treatment of the appendicular skeleton

Chiropractic Supportive Care – Long-term treatment/care that is therapeutically necessary. This is treatment for patients who have reached maximum therapeutic benefit, but who fail to sustain benefit and progressively deteriorate when there are period trials of treatment withdrawal. Supportive care follows appropriate application of active and passive care including rehabilitation and/or lifestyle modifications. Supportive care is appropriate when alternative care options, including home-based self-care or referral have been considered and/or attempted. Supportive care may be inappropriate when it interferes with other appropriate primary care or when risk of supportive care outweighs its benefit, i.e. physician/treatment dependence, somatization, illness behavior or secondary gain.

Date of Injury (DOI) – The actual date of the current injury. This information is entered in box 14 of the CMS-1500 claim form.

Dynamic Thrust – The therapeutic force or maneuver delivered by the physician during manipulation.

Exacerbation – An increase in severity of the patient's condition or symptoms.

Initial Treatment Date (ITD) – The first date the patient had the same or similar injury. This information is entered in box 15 of the CMS-1500 claim form.

Manipulation – An adjustment, skillful treatment or procedure involving the use of hands.

Modalities – Any physical agent applied to produce a therapeutic change to biological tissue; includes but is not limited to thermal, acoustic, light, mechanical, or electrical energy.

Supervised: Provider needs to watch over the application, though not necessarily at the patient's side. These are procedure/service based and units are always one (1).

Constant Attendance: Provider must be with the patient at all times. These are time-based, one unit = 15 minutes.

Subluxation – A subluxation is a complex of functional and/or structural and/or pathological articular changes that compromise neural integrity and may influence organ system function and general health. A subluxation is evaluated, diagnosed, and managed through the use of chiropractic procedures based on the best available rational and empirical evidence.

Therapeutic Procedure – A manner of affecting change through the application of clinical skills and/or services that attempt to improve function.

Documentation Guidelines

Daily Treatment Documentation

Chiropractic claims require proper documentation and appropriate billing of codes to receive accurate reimbursement. Documentation should be legible and intelligible and clearly identify medical necessity. Failure to meet these requirements may result in claim denial or claims returned for more information.

BCBSND accepts chiropractic documentation in the following formats:

- Dictated and transcribed
- Legibly handwritten
- Templates – must be filled out completely

Documentation for all patient services must be dated and signed. Whiteout and excessive pen marks should not be used to modify or delete documentation.

Use of standardized abbreviations can facilitate the documentation process. Non-standard abbreviations should be translated prior to submitting records to BCBSND. The most utilized and widely accepted method of record keeping is the SOAP format which records information about:

- S**-Subjective data
- O**-Objective data
- A**-Assessment
- P**-Plan of treatment

Subjective Data

This short statement describing the patient's symptoms can be expressed by the mnemonic O, P1, P2, Q, R, S, T.

- O-onset. When and how did chief complaint start?
- P1-provocative. What makes the pain worse (sit, stand, cough, bend, sleep, etc.)?
- P2-palliative. What alleviates the symptoms (rest, meds, ice, heat, etc.)?
- Q-quality. Pain characteristics (sharp, dull, achy, numb, radiating, stiff, tingle, burn, etc.)
- R-radiation. Where does pain refer to (arm, leg, head, etc.)?
- S-severity. Has the intensity of the pain changed since the last visit?
- R-Ratio on 0-10 scale. 1=mild, 5=moderate, 10=severe; or % improvement on a 0-100% scale
- T-tendency. Is the pain frequent or constant? 25, 50, or 75% of the time?

Objective Data

This section records actual findings observed during the patient visit. Items in this section should include the following when appropriate:

- Observations, including postural evaluations
- Range of motion (ROM) of area of chief complaint
- Palpation findings including percussion, auscultation and motion palpation
- Orthopedic tests
- Deep tendon reflexes (DTRs), muscle tests, sensory exam
- Laboratory and diagnostic tests

Assessment

The physician interprets the subjective and objective data to draw a conclusion about the patient's current status. This section also includes the doctor's initial diagnosis, impressions of the patient's progress and evaluation of daily living activities.

Plan of Treatment

The patient's plan of treatment includes:

- Type of treatment provided which may include physical therapy. A brief description of techniques is also helpful.
- Prescribed exercises or rest.
- Home therapy recommendations.
- Recommended frequency and duration of treatment. This could also include additional documentation regarding services for re-evaluations, counseling and coordination of care with other practitioners.

Documentation for Initial/New Patient

The complexity of the problem ascertained in the history may help determine the type of examination provided and how many elements of the examination will be included. The elements of the objective portion in a new patient record may include:

Vital signs

- Height
- Weight
- Blood pressure (which can be age and/or condition dependent)
- Pulse
- Respiration (if indicated by symptoms)
- Temperature (if indicated by febrile symptoms)

Observation

Observations can be measured with an inclinometer, a goniometer, or visually.

- Auscultation (if indicated by symptoms)
- Percussion (if indicated by symptoms)
- Palpation
- Range of Motion (this can relate to active ROM, passive ROM, and active assisted ROM)

Examination

This may include deep tendon and pathological reflexes if indicated by symptoms.

- Vascular examination (if indicated by symptoms)
- Provocative orthopedic tests
- Neurological testing, which may include cranial nerves
- Station, gait, and balance
- Sensory examination
- Muscle testing using Grade 0 thru 5
- Use of various other types of instrumentation and objective measurement

Assessment

The initial new patient assessment is based on the subjective and objective data and the physician's interpretation of this data. An assessment of any risk factors inconsistent with the data should be included.

Diagnosis Codes

Proper coding is essential for correct reimbursement. Use the most current diagnosis codes related to the date of service.

ICD-10 Basics

- Purchase an ICD-10-CM coding book for guidelines and correct coding.
- Diagnosis coding under ICD-10-CM uses 3-7 digits instead of 3-5 digits.
- All providers subject to HIPPA regulations are required to use ICD-10 code sets for all outpatient claims starting with dates of service October 1, 2015.
- Claims for October 1, 2015 or later that do not contain ICD-10 diagnosis codes will not be processed by BCBSND and will be returned to providers.
- Handwritten claims will no longer be accepted by BCBSND starting on October 1, 2015.
- Claims cannot be submitted to BCBSND with both ICD-9 and ICD-10 codes. ICD-9 codes should be used for dates of service prior to October 1, 2015. ICD-10 codes should be used for all claims with dates of service October 1, 2015 or later.

Re-exam Coding

Update the diagnosis coding for every new episode, including a re-exam or an examination for a 'new' problem.

Primary ICD-10-CM Coding

Include at least one diagnosis code in box 21 of the CMS-1500 form (most current version 02-12). If there are more than 12 ICD-10-CM codes, include the additional codes in Box 19 of the CMS-1500 claim form.

Link the diagnosis to the service provided to support medical necessity and specificity. For example, when performing manual therapy with manipulation, the diagnosis code should point to the specific procedure that addresses the diagnosed condition. (Box 24E of the CMS-1500 claim form).

Modifiers

Commonly used modifiers	
RT	Right side (used to identify procedures performed on the right side of the body)
LT	Left side (used to identify procedures performed on the left side of the body)
TC	Technical component of a procedure
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service. Modifier 25 indicates that the patient's condition requires a significant separate identifiable E&M service above and beyond the usual pre-service and post-service work associated with the CMT service.

26	Professional component. Modifier 26 is used when the professional component of a procedure is reported separately.
52	<p>It is not appropriate to use modifier 52 with any of the CMT codes or timed therapy codes.</p> <ul style="list-style-type: none"> • Modifier 52 identifies a reduced service but should not be used to identify another procedure if there is a specific CPT[®] code for the reduced service. • Codes for spinal manipulations (98940 – 98942) are specific to the number of regions treated. If only two regions are treated, 98940 should be used instead of 98941–52. • Modifier 52 should not be used for therapy services less than 15 minutes. At least eight minutes of a physical therapy timed service must be provided in order to use a therapy procedure code (i.e. 97140 – manual therapy techniques, one or more regions, each 15 minutes). If the therapy service is less than eight minutes, it is not billable as those codes require a minimum of eight minutes. Procedure code 97140 can be submitted with one unit for services that span 8-22 minutes. An additional 8 minutes must be provided beyond the 15-minute increment to submit a second unit. If 12 minutes of 97140 is provided, it is not appropriate to append modifier 52. • Modifier 52 should not be used to identify reduced charges. It should only be used to identify a service or procedure that has been reduced or eliminated at the provider's discretion.
59	Identifies procedures and services, other than E&M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support the separate and distinct procedures i.e., location (different region), procedure description (technique) and time.
76	Repeat procedure or service by same physician
77	Repeat procedure or service by another physician

Evaluation and Management Services

When submitting an Evaluation and Management (E&M) service (CPT® codes 99201-99215), the following documentation must be included in the medical record:

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

Note: These are not time-dependent; they are based on the complexity of the case. BCBSND may audit medical records on a prepayment or retrospective basis to verify that documentation supports the claim submitted.

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.

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. The established patient must have a new condition, new injury, aggravation, or exacerbation which warrants further examination above and beyond what is included in CMT services.

New Patient Evaluation & Management Codes	
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers 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.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 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 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 20 minutes face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a detailed history; a detailed examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers 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 evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers 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 evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers 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 Evaluation & Management Codes	
99211	Office or other outpatient visit for the evaluation and management 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 visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers 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.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers 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 visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers 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 25 minutes face-to-face with the patient and/or family.

99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers 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 40 minutes face-to-face with the patient and/or family.
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Evaluation & Management and CMT (CPT® codes 99201–99215 with 98940–98943)

E&M is necessary when performing the initial exam. An E&M service may once again be necessary if there is a change in condition or treatment protocol.

It is not appropriate to bill for routine scheduled E&M service (every 12 days of treatment).

Use modifier 25 to identify the E&M service separately when performed with CMT.

Documentation must be complete as to the level of E&M services provided according to CPT® guidelines.

CMT codes include a pre-manipulation patient assessment component for each visit, which must be supported by appropriate documentation. Therefore, it is not appropriate to bill an E&M service with each CMT service. If billed inappropriately, the E&M service will be denied as provider liable.

It is appropriate to bill for the CMT and E&M service if one of the following has occurred:

- A new patient visit
- An established patient visit. The established patient must have a new condition, new injury, aggravation, or exacerbation which warrants further examination above and beyond what is included in CMT services.
- Periodic re-evaluation to determine if a change in the treatment plan is necessary

Documentation of Evaluation & Management Services

The physician must choose the level of detail contained in the documentation, which will also determine the code, whether the patient is new or established, and the level of complexity. The requirements for proper coding of evaluation and management codes will be determined according to how many elements of the history are utilized. The physician must determine whether it is necessary to include all of the following elements in the records of patients with less severe problems. The elements of the subjective portion of the clinical record could include the following:

History of the present illness: (HPI)

These factors are used to complete the history of the present illness. The mnemonic O, P1, P2, Q, R, S, T, U can also be used:

- History of trauma or incident
- Description of the chief complaint(s)
- O-Onset of symptoms
- P1-Palliative factors
- P2-Provocative factors

- Q-Quality of pain which can include burning, numbness, and tingling, etc.
- R-Radiation of pain
- S-Severity of pain on a scale from 0-10
- T-Timing or frequency of complaint
- U-Previous episodes of chief complaint.

Past History

- Prior major illnesses and injuries
- Prior operations
- Prior hospitalizations
- Current medications
- Allergies to food or drug
- Age appropriate immunization status
- Age appropriate feeding and dietary status
- Current vitamin and mineral usage including herbs and homeopathy

Social History

- Current employment
- Occupational history
- Use of drugs, alcohol, or tobacco
- Relevant social factors

Family History

Any significant health factors that may be congenital or familial in nature.

Review of Systems (ROS)

The following areas relate to a review of systems:

- Constitutional symptoms (fever, weight loss/gain, or fatigue, etc.)
- Eyes
- Ears, nose or throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integument which includes skin or breast
- Neurological
- Psychiatric
- Endocrine
- Hematology and lymphatic
- Allergies and immunologic

Physical Medicine

Commonly Used Physical Medicine Codes	
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	Application of a modality to 1 or more areas; traction, mechanical
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes)
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)

Eight-Minute Rule

Providers should not bill for services if less than a total of eight minutes is spent with the patient.

- One Unit ≥ 8-22 minutes
- Two Units ≥ 23-37 minutes
- Three Units ≥ 38-52
- Four Units ≥ 53-67
- Five Units ≥ 68-82
- Six Units ≥ 83-97

Ultrasound/Electric Muscle Stimulation Combination Therapy

- When performing ultrasound (CPT[®] 97035) and electric muscle stimulation, constant, attended (CPT[®] 97032) the services are duplicate and therefore only the higher reimbursed code is allowed to represent the total service
- 97035 and 97032 should not be billed together
- Ultrasound/electric muscle stimulation is billed appropriately with CPT[®] 97035

Chiropractic Manipulative Treatment (CMT)

Chiropractic Manipulative Treatment (CMT) Codes	
98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions
98941	Chiropractic manipulative treatment (CMT); spinal, three to four regions
98942	Chiropractic manipulative treatment (CMT); spinal, five regions
98943	Chiropractic manipulative treatment (CMT); extraspinal, one or more regions

Chiropractic manipulative treatment procedures (CPT[®] codes 98940-98943) use high-velocity, short-lever, low-amplitude thrust by hand or instrument to remove structural dysfunction in joints and muscles that may be associated with neurologic or mechanical dysfunction of the spinal joints and surrounding tissue. These procedures are specifically and primarily used by chiropractors to mobilize, adjust, manipulate, apply traction, massage, stimulate or otherwise influence the spine and paraspinal tissues to affect the patient's health.

Each CPT[®] code reflects a specific number of regions, regardless of how many manipulations are performed in that region. For example, chiropractic manipulation applied to C3 and C5 during the same visit represent treatment to only one region (cervical) and should be reported with CPT[®] code 98940.

All CPT[®] codes for CMT must have a supporting ICD-10-CM diagnosis code to justify the level of care provided. For example, when billing CPT[®] 98941, there must be at least three ICD-10-CM codes indicating the three different regions treated. If the proper diagnosis code is not provided to support each CPT[®] code, claims will be returned to the provider for correction.

CMT Components

Pre-Service	A brief evaluation of the patient documentation and chart review, imaging review, test interpretation and care planning
Intra-Service	Treatment applied Pre-manipulation (e.g., palpation, etc.) Manipulation, Post-manipulation (e.g., assessment, etc.)
Post-Service	Chart entry and documentation, including subjective, objective, assessment, plan consultation reporting

The CPT[®] code includes a "work per unit of time" which is reflected in the Relative Value Units (RVUs). The RVUs take into consideration the work expense (work unit), practice expense, and malpractice expense. The reimbursement amount is calculated by multiplying the RVU times the conversion factor. The conversion factor is a base dollar amount that applies to all physician codes with RVUs. Since RVUs can change from year to year, the conversion factor is recalculated annually to remain budget neutral for total physician payments.

Spinal Manipulative Treatment

Spinal manipulative treatment body regions include:

Cervical	All manipulations performed to the atlanto-occipital joint, and C1 through C7
Thoracic	All manipulations performed to T1 through T12, including the posterior ribs (costotransverse and costovertebral junctions)
Lumbar	All manipulations performed to L1 through L5
Sacral	All manipulations performed to the sacrum, including the sacroccygeal junction
Pelvic	All manipulations performed to the sacroiliac joint and other pelvic articulations

Extraspinal Manipulative Treatment (CPT® code 98943)

Manipulative treatment of the appendicular skeleton should be billed with CPT® code 98943 regardless of how many individual extraspinal manipulations are performed. CPT® code 98943 can be billed alone or in conjunction with a spinal CMT code.

When an extraspinal region manipulation (98943) is performed on the same patient on the same day as a spinal manipulation (98940, 98941, 98942), reimbursement for the extraspinal manipulation will not be reduced. Reimbursement will be based on the full Physician fee schedule amount for spinal and extraspinal manipulations when billed together.

Extraspinal manipulative treatment body regions include:

Head	All manipulations performed to the head, including the TMJ, excluding the atlanto-occipital joint
Lower extremities	All manipulations performed to the hip, leg, knee, ankle and foot
Upper extremities	All manipulations performed to the shoulder, arm, elbow, wrist and hand
Rib cage	All manipulations performed to the anterior rib cage, including the costosternal junction
Abdomen	All manipulations performed to the abdominal area

Manual Therapy Performed with CMT (CPT® codes 97140 and 98940-98943)

Manual therapy techniques (CPT® 97140) may be performed in addition to CMT when a separate therapeutic benefit is being achieved. However, manual therapy should only be performed when necessary. Some indications for utilization of manual therapy may include, but are not limited to, limited range of motion, muscle spasm, pain, scar tissue or contracted tissue and/or soft tissue swelling, inflammation or restriction, etc.

Manual therapy includes, but is not limited to, connective tissue massage, joint mobilization, manual traction, passive range of motion, soft tissue mobilization and manipulation, and therapeutic massage. The code descriptor states this is a manual hands-on administration. CMT is the use of a high-velocity, short-lever, low-amplitude thrust by hand or instrument which will remove structural dysfunction in the joints and muscles that may be associated with neurological or mechanical dysfunction of the joint and its surrounding tissues.

CPT® code 97140 is reported for each 15 minutes of manual therapy technique provided to one or more regions. Manual therapy is not a mutually exclusive procedure when it is billed for different body regions separate from CMT codes 98940 - 98943. Medical documentation may be requested to review appropriateness. **When manual therapy is performed to the same region as the CMT with similar outcomes, it will not be reimbursed separately.**

When manual therapy is performed on the same date of service as CMT and is separate from the CMT procedure, a separate diagnosis related to the treatment must be identified by a specific ICD-10-CM diagnosis code; CPT® code 97140 must be billed with modifier 59.

Radiology Services

Radiology Codes	
72010	Radiologic examination, spine, entire, survey study, anteroposterior and lateral
72020	Radiologic examination, spine, single view, specify level
72040	Radiologic examination, spine, cervical; 2 or 3 views
72050	Radiologic examination, spine, cervical; minimum of 4 views
72052	Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies
72069	Radiologic examination, spine, thoracolumbar, standing (scoliosis)
72070	Radiologic examination, spine; thoracic, 2 views
72072	Radiologic examination, spine; thoracic, 3 views
72074	Radiologic examination, spine; thoracic, minimum of 4 views
72080	Radiologic examination, spine; thoracolumbar, 2 views
72090	Radiologic examination, spine; scoliosis study, including supine and erect studies
72100	Radiologic examination, spine, lumbosacral; minimum of 2 or 3 views
72110	Radiologic examination, spine, lumbosacral; minimum of 4 views
72114	Radiologic examination, spine, lumbosacral; complete, including bending views
72120	Radiologic examination, spine, lumbosacral, bending views only, minimum of 4 views

Proper billing

The number of units on the claim is based on the code description, not the number of views taken. The code description provides the number of views taken.

- Example: 71010 (chest x-ray, single view) - Units should be 1
71020 (chest x-ray; 2 views) - Units should be 1
- CPT® code must be billed with supporting ICD-10-CM codes

CPT® code 76140 (Consultation on X-ray examination made elsewhere, written report)

- CPT® code 76140 should only be used when a provider requests the opinion or advice of another provider to interpret and consult on a radiograph image
- Requires a written report

Radiology Documentation

Effective communication is a critical component of diagnostic imaging. Tips to consider and remember when documenting and communicating any type of diagnostic imaging result:

- Quality patient care can only be achieved when study results are given in a timely manner to those responsible for the treatment decisions.
- An official interpretation (final report) should be completed following any examination, procedure or consultation regardless of the performance site (hospital, physician office, mobile unit, imaging center, etc.).
- Final reports are the definitive means of communicating to the referring physician(s).
- Documentation of radiological studies should be completed on the day the image is read.
- Radiology reports become part of the patient's permanent medical record.

Recommended documentation components for radiology reports:

Demographics:

- Patient's name and personal identifier
- Date and time of service
- Name/type of examination
- Facility or location where study was performed
- Name(s) of referring physician(s)
- Name and signature of interpreting provider
- Inclusion of the following additional items is encouraged:
 - Dictation date
 - Date and time of transcription
 - Birth date and/or age
 - Gender

Clinical Information:

- Indication(s) for examination: reason why the study is being performed.
- Procedures performed/materials used: description of the studies and/or procedures performed and any contrast media (including concentration, volume and administration route), medications, catheters or devices used.
- Views taken
- Findings:
 - Appropriate anatomic, pathologic and radiologic terminology should be used to describe findings
 - Indication of study quality, i.e. if results are unable to be obtained due to inadequacy of image(s)
 - Pertinent positive findings and/or pertinent negative findings
 - Impression (conclusion or diagnosis):
 - A precise diagnosis should be given when possible
 - If appropriate, a differential diagnosis should be rendered
 - Significant patient reaction or complication, if applicable
 - The radiological findings can be listed using the mnemonic "A, B, Cs":
 - Alignment
 - Bone
 - Cartilage
 - Soft tissue
- Recommendations: Follow-up or additional studies needed should be indicated when applicable.

Medical Policy

[Low-level Infrared Therapy](#)

[Vertebral Axial Decompression](#)

[Physical Therapy](#)

Non-covered Services

Hydrobed

The use of a hydrobed should be billed using 97039 (Unlisted modality [specify type and time if constant attendance]) and modifier GA. This service is considered non-covered and cannot be billed interchangeably with CPT® 97022 (Application of a modality to one or more areas; whirlpool). Whirlpool treatment involves immersing the body or limb into heated water. The heated water facilitates tissue debridement, wound cleaning, and/or exercise. This definition does not describe the use of a hydrobed.

Laser Therapy

- Modality which requires constant attendance
- Often incorrectly coded with CPT® code 97026 (Infrared therapy)
- Supervised therapy vs. constant attendance required for laser therapy
- Bill CPT® code 97039 (unlisted therapy) with notation of laser therapy
- Procedure is currently investigational and member liable

Maintenance Care

All services performed for a maintenance care visit are non-covered and are benefit exclusions. When submitting a claim for chiropractic maintenance care use HCPCS code S8990 (Physical or manipulative therapy performed for maintenance rather than restoration).

Hot and Cold Packs

Hot and cold packs are considered integral to other modalities and procedures provided. The application of hot or cold packs when used alone is not covered.

After Hours

CPT® codes 99050 – 99058 (for after hours services) are valid codes when used in addition to another basic service code; they should never be submitted alone. BCBSND does not reimburse these adjunct codes. When the service is billed by a participating provider, it is considered to be a provider discount.

Mechanical/Vibratory Massage

- Massage therapy (CPT® 97124) is a therapeutic procedure requiring constant attendance.
 - Procedure may be applied to one or more areas
 - Timed in 15-minute increments
 - Common procedures are effleurage, petrissage and tapotement
- It is appropriate to bill CPT® 97124 for the G-5 massager
- A mechanical vibratory device such as a mechanical chair or table does not require constant attendance and would be incorrectly coded using 97124

Corrective Action Policy

A [corrective action plan](#) (CAP) is a formally defined disciplinary process, intended to direct a Health Care Provider back into compliance with the performance standards, during which, for a specified period of time, practice restrictions can be imposed and/or payment for care administered by a Health Care Provider can be denied, restricted or reduced for all or certain services.

Claim Information

Deleted and Returned Claims

Claims are commonly deleted and returned to providers as a result of the following errors:

- CPT[®] code does not match ICD-10-CM code
- Invalid procedure and diagnosis code
 - Deleted HCPCS, CPT[®] or diagnosis code
 - Diagnosis code without correct number of digits
- Missing provider information
- Invalid benefit plan number

Claim Adjustments

Providers may request an adjustment to the original claim submitted (i.e., billed in error, procedure codes, diagnosis codes, dollar amount, provider information, etc.). Claim adjustment requests must be received within 180 days from the remittance date.

Claim adjustments may be submitted:

- Online through THOR.
- Using Claim Adjustment forms available at www.bcbsnd.com.

Appeals

An appeal is a request for claim review of denied services. Send all documentation for the episode to Provider Service. For appeals related to a Coordinated Treatment Plan, send all documentation for the episode to Provider Service. Additional information is available at www.bcbsnd.com/providers

Contact Information

Provider Service Call Center:

800-368-2312

FEP Service Call Center:

800-548-4026