



BlueShield
of Northeastern New York

Chiropractic Reference Manual



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This guide provides information about billing for chiropractic services and supplements the *Provider and Facility Reference Manual* available at bsneny.com. We will update this manual periodically and hope you will find it to be helpful.

Coverage decisions are subject to all terms and conditions of the patient's benefits, including exclusions and limitations. The details provided in this document do not constitute plan authorization, nor are they an explanation of benefits. Any additional questions or concerns regarding coverage or policies should be directed to the Provider Service Department at 1-800-444-4552 or (518) 220-5620.

Chiropractic Program Overview

The goal of the chiropractic program is to ensure our members receive the proper care. Inpatient or outpatient chiropractic services should be provided when medically appropriate and necessary, and within the scope of your license and practice.

Common conditions treated by chiropractors:

- Degenerative conditions of the joints
- Spondylolisthesis/spondylosis
- Sprains and strains
- Fibrositis
- Headaches (including tension headaches, migraines, and vertebrogenic-type headaches)
- Myalgia
- Myofibrositis
- Neuralgias
- Spinal facet syndromes
- Non-infectious inflammatory disorders of the joints, muscles, and ligaments of the spine and extremities
- Osteoarthritis
- Intervertebral disc disorders of the spine, such as disc protrusion, bulging, degeneration, and displacement
- Peripheral joint trauma
- Radiculopathies
- Repetitive motion injuries

Coding/Billing

New patients

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

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

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



New patient evaluation and management codes: 99201-99205

A new patient is defined as someone 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.

A new patient visit (99201–99205) can be billed along with a chiropractic manipulation visit (98940–98942). These coupled codes will be reimbursed every **three** years.

99201	<p>Office or other outpatient visit for the evaluation and management of a new patient, which requires three key components: a problem-focused history, a problem-focused examination, and 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.</p> <p>Physicians typically spend 10 minutes with the patient and/or family.</p>
99202	<p>Office or other outpatient visit for the evaluation and management of a new patient, which requires three key components: an expanded problem-focused history, an expanded problem-focused examination; and 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.</p> <p>Physicians typically spend 20 minutes with the patient and/or family.</p>
99203	<p>Office or other outpatient visit for the evaluation and management of a new patient, which requires three key components: a detailed history, a detailed examination, and 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.</p> <p>Physicians typically spend 30 minutes with the patient and/or family.</p>
99204	<p>Office or other outpatient visit for the evaluation and management of a new patient, which requires three key components: a comprehensive history, a comprehensive examination, and 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.</p> <p>Physicians typically spend 45 minutes with the patient and/or family.</p>
99205	<p>Office or other outpatient visit for the evaluation and management of a new patient, which requires three key components: a comprehensive history, a comprehensive examination, and 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.</p> <p>Physicians typically spend 60 minutes with the patient and/or family.</p>



Established patient evaluation and management codes: 99211-99215

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 that warrants further examination above and beyond what is included in **chiropractic** manipulative therapy (CMT) services.

Re-evaluations

It is appropriate to bill for the CMT and a re-evaluation if one of the following has occurred:

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

Codes 99211–99215 with a -25 modifier can be billed along with a chiropractic manipulation (98940–98942) every three months (or if the patient has a new complaint/exacerbation of their condition) for a total of four re-evaluations per year. CMT codes include a pre-manipulation patient assessment component for each visit, which must be supported by appropriate documentation. If billed inappropriately, the E&M service will be denied and the member cannot be billed.

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. Physicians typically spend five minutes face-to-face with the patient and/or family.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem-focused history, a problem-focused examination, and 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 two of these three key components: an expanded problem focused history, an expanded problem-focused examination, and 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 two of these three key components: a detailed history, a detailed examination, and 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 two of these three key components: a comprehensive history, a comprehensive examination, and 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.



Chiropractic manipulation treatment (CMT): 98940-98942

The primary therapeutic procedure rendered for the majority of chiropractic office visits is a spinal manipulation/adjustment. These treatment codes include a pre-manipulation patient assessment. Manipulations should be billed using the appropriate CPT manipulation codes: 98940–98942. **Do not use E&M procedure codes for manipulations.**

There are three CPT codes to assist you with accurately reporting manipulative treatment services. The work value (work per unit of time) of the codes includes both cognitive and technical components and is divided into three sections.

- 1. Pre-service** - includes documentation and chart review, imaging review, test interpretation, and care planning.
- 2. Intra-service** - includes pre-manipulation patient assessment (palpation, etc.), manipulation, and post-manipulation procedures (assessment, etc.).
- 3. Post-service period** - includes chart documentation, consultation, and reporting.

For the purposes of reporting CMT codes, there are five spinal regions:

- cervical (includes atlanto-occipital joint)
- thoracic
- lumbar
- sacral
- pelvic (sacroiliac joint)

98940	Chiropractic manipulative treatment (CMT); spinal, one or two regions. Documentation must include a validated diagnosis for one or two spinal regions and support that manipulative treatment occurred in one to two regions of the spine (region as defined by CPT).
98941	Chiropractic manipulative treatment (CMT); spinal, three or four regions. Documentation must support that manipulative treatment occurred in three or four regions of the spine (region as defined by CPT) and one of the following: validated diagnoses for three or four spinal regions or validated diagnoses for two spinal regions, plus one or two adjacent spinal regions with documented soft tissue and segmental findings.
98942	Chiropractic manipulative treatment (CMT); spinal, five regions. Documentation must support that manipulative treatment occurred in five regions of the spine (region as defined by CPT) and one of the following: validated diagnoses for five spinal regions or validated diagnoses for three spinal regions, plus two adjacent spinal regions with documented soft tissue and segmental findings or validated diagnoses for four spinal regions, plus one adjacent spinal region with documented soft tissue and segmental findings.



Physical medicine and rehabilitation services

Reimbursements of modalities and/or therapeutic procedures performed during an office visit are included in the payment of the chiropractic office visit.

Manual therapy: 97140

We will not reimburse providers for manual therapy services. Claims will deny as incidental (provider liability, regardless of a submission with a -59 modifier).

Non-reimbursable codes

HCPCS Codes	Description
76499	Unlisted diagnostic radiographic procedure
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
99090	Analysis of clinical data stored in computers (e.g., ECGs, blood pressures, hematologic data)
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
98943	Chiropractic manipulative treatment (CMT); extraspinal; one to five regions

Maintenance and wellness care: S8990

Maintenance and wellness care is elective health care that is typically long-term and not therapeutically necessary, but provided at intervals to prevent disease, prolong life, promote health, and enhance the quality of life. Ongoing care may include education, screenings to identify risk, a home exercise program, and lifestyle changes in the hope of promoting optimal health.

HCPCS Code	Description
S8990	Physical or manipulative therapy performed for maintenance rather than restoration



BlueShield
of Northeastern New York

Claims

Electronic billing

- BlueShield of Northeastern New York contracts with Administrative Services of Kansas, Inc. (ASK) for electronic billing. ASK will perform any necessary edits to ensure your claims meet regulatory and contractual requirements before transferring them to us for processing and payment.
- Submit claims electronically through your vendor or directly through ASK-EDI.

Non-electronic claim forms

Only if unable to submit electronically, submit CMS-1500 or UB-04 claim form to:

BlueShield of Northeastern New York
PO Box 80
Buffalo, NY 14240-0080

All required fields on the form must be completed or the claim may be returned.

Medical Necessity

When we request records from you, please keep in mind that your documentation must allow a peer reviewer to discern the medical necessity for each service without knowing your patient as well as you do.

Example: If a particular day's service (during a series of treatments) is being considered, it is necessary to supply the initial date of service notes, history, diagnostic tests, examination, and radiology findings, etc., where specific details are documented.

Services are medically necessary when:

1. The member has a neuromusculoskeletal disorder;
 2. The necessity for treatment is clearly documented; **and**
 3. Objective functional improvement — including pain scales, range of motions, etc. — is documented within the initial two weeks of care.
- If no improvement is documented within the initial two weeks, additional treatment is considered not medically necessary unless the treatment is modified.
 - If no improvement is documented within 30 days despite the modification of treatment, continued treatment is considered not medically necessary.
 - After the maximum therapeutic benefit has been reached, continuing chiropractic care is considered not medically necessary.
 - Chiropractic manipulation in asymptomatic persons without an identifiable clinical condition or symptoms is considered not medically necessary.

Chiropractic care for those whose conditions are neither regressing nor improving — and who have reached their maximum therapeutic benefit — is considered not medically necessary. Please refer to Maintenance and Wellness Care section for additional information.

Clinical Practice Guidelines: Adolescent/Adult

McKesson InterQual® Chiropractic Clinical Practice Guidelines are used for the chiropractic program. A copy of the guidelines and additional administrative policies are available by contacting the BlueShield Provider Relations Department.

Experimental/investigational medical policy

- Vertebral Axial Decompression: Review Corporate Medical Protocol: 80309
- Low-Level Laser Therapy: Review Corporate Medical Protocol: 20156
- Manipulation under Anesthesia: Review Corporate Medical Protocol: 80140
- Transcutaneous Electrical Nerve Stimulation (TENS): 10109

Corporate Medical Protocols are available on our provider website under *Policies & Guidelines*.

BlueShield considers the following procedures/services experimental, investigational and not reimbursable:

- Work-hardening programs
- Back schools
- Vocational rehabilitation programs and any program with the primary goal of returning an individual to work
- Services for the purpose of enhancing athletic performance or for recreation

The following procedures/techniques are considered investigational:

- Applied spinal biomechanical engineering
- BioEnergetic synchronization technique
- Chiropractic biophysics technique
- Coccygeal meningeal stress fixation technique
- Cranial manipulation
- Directional non-force technique
- dry hydrotherapy
- Manipulation for internal (non-neuromuscular) disorders (applied kinesiology)
- Manipulation under anesthesia
- Moire contourographic analysis
- Network technique
- Neural organizational technique
- Neurocalometer/Nervo-Scope
- Paraspinal electromyography (EMG)/ surface scanning EMG
- Sacro-Occiptal technique
- Spinoscopy
- Thermography
- Thermomechanical massage (e.g., Spinalator, Hill Anatomotor, Chattanooga Ergowave)
- Upledger technique and craniosacral therapy
- Wobble chair



Contraindications

Dynamic thrust is the therapeutic force or maneuver delivered by the physician during a manipulation. A relative contraindication is a condition that adds a significant risk of injury to the patient from dynamic thrust but does not rule out the use of it. The doctor should discuss this risk with the patient and record this in the chart.

The following are relative contraindications to dynamic thrust:

- Articular hypermobility and circumstances where the stability of the joint is uncertain
- Severe demineralization of bone
- Benign bone tumors (spine)
- Bleeding disorders and anticoagulant therapy
- Radiculopathy with progressive neurological sign

Dynamic thrust is absolutely contraindicated near the site of demonstrated subluxation and proposed manipulation in the following:

- Acute arthropathies characterized by acute inflammation and ligamentous laxity and anatomic subluxation or dislocation, including acute rheumatoid arthritis and ankylosing spondylitis
- Acute fractures and dislocations or healed fractures and dislocations with signs of instability
- An unstable os odontoideum
- Malignancies that involve the vertebral column
- Infection of bones or joints of the vertebral column
- Signs and symptoms of myelopathy or cauda equina syndrome
- For cervical spinal manipulations, vertebrobasilar insufficiency syndrome
- A significant major artery aneurysm near the proposed manipulation



Utilization Management

Preauthorization requirements

Preauthorization is required for members with contractual chiropractic visit limitations. Verify eligibility and benefits prior to rendering services by calling Provider Service at 1-800-444-4552 or (518) 220-5620.

- A Chiropractic Treatment Request (CTR) form is available in the *Tools & Resources* section of our provider website for these members.
 - If a preauthorization is required, complete and fax a CTR form along with any additional information to 1-716-887-7913.
- Notification for approvals and denials are made to the member and the member's health care provider, by telephone and in writing.
- If additional visits are required, submit an additional CTR form as well as documentation from the last eight office visits.

Retrospective medical record review

Retrospective audits for medical necessity can occur after each member's 14th office visit. Each chiropractor's performance will be monitored on an individual basis. You must comply with your contractual obligations with BlueShield of Northeastern New York. Data will be maintained and reviewed by the Credentials Committee for re-credentialing purposes.

Clinical measures - sources of information may include, but are not limited to utilization management reports, medical record reviews, and focused quality of care reviews.

Service measures - sources of information may include, but are not limited to information from grievances filed, member complaints, and member satisfaction surveys.

Medical Claims Review

Medical claims review staff review for medical appropriateness and adverse determinations for the following types of claims:

- Outpatient procedures and services
- Inpatient level of care
- Durable medical equipment
- Professional claims for inpatient and outpatient services
- All services where medical necessity determinations are to be made

The reviews are performed by health care professionals and administrative personnel, who determine:

- Contract eligibility
- Medical appropriateness
- Whether provider and member education is needed

Information regarding medical appropriateness review, adverse medical determinations, appeals process, retrospective medical claims review, and the special investigations unit are located in Section 5 of the BlueShield Provider and Facility Reference Manual.

Documentation

Patient charts

Proper documentation is your responsibility and extends beyond an internal office communication. Any similarly 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.

Documentation for all patient services must be dated and signed. Whiteout and excessive pen marks should not be used to modify or delete documentation. Notes should be legible and clearly substantiate medical necessity. If a legend is needed to review your records, please submit it with your records. If not supplied upon request, reimbursement will be denied for lack of medical necessity.

BlueShield **does not** consider travel cards as appropriate documentation. Most travel cards provide insufficient medical detail from which to determine the medical necessity of care and treatment performed.

Failure to meet these requirements may result in claim denial or claims returned for more information.

The following medical record standards are minimally required; and based on the National Committee for Quality Assurance requirements and if not met, may result in delay or denial of reimbursement as a provider write-off. Additional information regarding NCQA can be found at ncqa.org/homepage.aspx.

Each of the following components should be documented in the patient's chart.

- Demographics
 - Name/ID number: Every page of the medical record
 - Date of birth
 - Current address
 - Home and work telephone numbers
 - Emergency phone number
 - Employer and work phone number
 - Marital status
- Records documented in the Subjective, Objective, Assessment Plan (SOAP) format (additional information below)
- Related problem list
 - List all significant illnesses and active medical conditions pertinent to the patient's health care or "no problems"
- Allergies/adverse reactions
 - Medication allergies and adverse reactions or NKDA/NKA must be recorded in a prominent location

- Relevant past history
 - Includes serious accidents, operations, and physical and psychological conditions pertinent to the patient's care
- Current medications/nutritional/herbal supplements or no medications
- History of presenting complaint
 - List presenting symptom(s), potential triggering events, assessment of severity amount of pain and/or interference with daily activities, irritating/relieves symptoms, relation to activity, and previous treatment
- Pain chart completed by the patient
- Examination
 - Vital signs: blood pressure, pulse, temperature, and respiratory rate
 - Neurological exam
 - Documented for at least the initial visit. The record should indicate that at least 80% of the pertinent examination has been recorded, and the follow-up neurological examinations are performed as clinically indicated.
 - Orthopedic examination
 - Orthopedic exam should be documented for at least the initial visit. The record should indicate that at least 80% of the pertinent examination has been recorded, and the follow-up orthopedic examinations are performed as clinically indicated.
- Imaging studies/laboratory studies
- Differential diagnosis and/or clinical impression
 - Indicate the diagnosis/condition reflective of patient's evaluation
- Treatment plan
 - Number of treatments and intervals between visits (reasonable based on standards)
 - Date and time frame for follow-up visits and discharge date
- Continuity of care between chiropractor and primary care provider or other referring specialist when indicated
 - Written communication and/or documentation of telephone communications
 - Need to include presenting symptom, likely diagnosis, and a treatment plan
- All entries in the medical record are signed and include dates for each visit.



SOAP notes

Please follow the SOAP format when documenting an office visit. The SOAP format includes:

Subjective data

This short statement describing the patient's symptoms can be expressed by the mnemonic O, P1, P2, Q, R, S, and 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 used is also helpful.
- Prescribed exercises or rest.
- Home therapy recommendations.
- Recommended frequency and duration of treatment. This could also include additional documentation regarding services referrals and coordination of care with other specialists.

All notes should be signed and dated by the clinician performing the services. At minimum, a legible first initial and last name is required; otherwise, the reimbursement will be denied. A stamped signature is not acceptable.

Radiology

X-rays

You may order medically necessary radiology services, as permitted through scope of practice. Radiology codes 72100–72052 should be billed once per treatment period. If additional codes are billed, these services will be subject to medical review for documentation of medical necessity.

Services billed for consultation on X-ray exams performed elsewhere (CPT 76140) are not covered, as we already reimburse for both the professional and technical component of most radiology services. Re-interpretation of films is a duplication of these other components.

MRI/CT scans

National Imaging Associates manages the preauthorization process for MRI/MRA and CT scans for all BlueShield lines of business (unless specified per the member's contract). To obtain a preauthorization for these services, you may submit your requests 24 hours a day, seven days a week at radmd.com or contact their provider call center at 1-800-642-7820. This center is staffed with physicians, on call from 8 a.m. to 8 p.m. EST, Monday through Friday.

Other services

Nerve conduction study/electromyography

We provide coverage for nerve conduction studies and electromyography only when performed by chiropractors who have completed post-graduate studies in one or more of the following:

- Diplomate of International Academy Chiropractic Neurology (DIACN)
- Diplomate of International Board of Electrodiagnosis (DIBE)
- Diplomate of the American Board Chiropractic Neurology (DACNB)
- Completion of postgraduate program associated with a chiropractic college with current CCE accreditation consisting of at least 150 hours of focused study on electrodiagnosis

To bill BlueShield of Northeastern New York for nerve conduction and electromyography studies:

- Your name must appear on the list of certified neurologists at iacn.org or acnb.org, or
- You must provide evidence of certification of program completion with requirements as listed above

If your name does not appear on the IACN/ACNB website, or your certificate is not on file with BlueShield, you may not bill for these services.

Laboratory services

Referred laboratory services provided to our HMO, POS, EPO, and PPO members **must** be performed by a provider participating with our laboratory network (includes commercial labs and specific participating hospitals). Please refer to the most recent participating lab location guide on our website.

Chiropractic Advisory Committee

The BlueShield of Northeastern New York Chiropractic Advisory Committee (CAC) assists in the development and future direction of the Chiropractic Program. The committee's purpose is:

- To ensure continuing access to high quality, medically appropriate evidence-based, cost-effective chiropractic care for our members.
- To guide us in maintaining a consistent and clinically appropriate approach in the administration of chiropractic care, including development of its clinical practice guidelines.
- To assist us with the development of clinically integrated programs and quality incentive programs.
- To aid in the development of coverage criteria, review of coverage decisions, and technology assessments.
- To review administrative rules pertaining to health care issues that may be related to the delivery of high quality chiropractic care.

The CAC has a maximum of 14 members, with a minimum of eight doctors of chiropractic being and the remaining committee members being BlueShield employees. Members serve two-year terms with a term limit of no more than three consecutive terms.

Questions and concerns

If you have any questions regarding this information, please contact your Provider Relations and Contracting account specialist at (518) 220-5601.

This billing guide is not all-inclusive and does not contain all components of the BlueShield of Northeastern New York Chiropractic Program.



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