

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

Providers are responsible for submission of accurate claims requests. This reimbursement policy is intended to ensure that you are reimbursed based on the code that correctly describes the procedure performed. This and other reimbursement policies may use CPT, CMS or other coding methodologies from time to time. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

Coding methodology, clinical rationale, industry-standard reimbursement logic, regulatory issues, business issues and other input is considered in developing reimbursement policy.

This information is intended to serve as a resource regarding the reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly we may use reasonable discretion in interpreting and applying this policy to services being delivered in a particular case. Further, the policy does not cover all issues related to reimbursement for services rendered to enrollees as legislative mandates, the provider contract documents, and the enrollee's benefit coverage documents, may supplement or in some cases supersede this policy. Finally, systems logic or set up may prevent the loading of this policy onto different claims platforms in exactly the same way; however, we strive to minimize these variations.

ACN Group Inc., (OptumHealth Physical Health), may modify this policy from time to time by publishing a new version of the policy on its Website; however, the information presented in this policy is believed to be accurate and current as of the date of publication.

Chiropractic Manipulative Treatment Policy

Type	Reimbursement	
Number	0045	
Approved by		Approval Date
Reimbursement and Technology Committee Quality Improvement Committee		February 8, 2007 April 12, 2007

Description

This policy describes OptumHealth Physical Health methodology and requirements for reimbursement of CPT codes 98940, 98941, 98942 (Spinal Chiropractic Manipulative Treatment) and 98943 (Extraspinal Manipulative Treatment).

Audience

Targeted Population	This policy applies to all products, all network and non-network chiropractors. This includes non-network authorized, percent of charge contract, and flat rate/per diem contract chiropractors.* <i>*Fee schedule/provider contract/client contract may supersede</i>
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Policy

Overview	<p>Spinal Manipulation OptumHealth Physical Health will align Maximum Frequency in Combination per Day (MFCD) reimbursement values with CPT definition. That is, the total of spinal chiropractic manipulative treatment (CMT) CPT codes (98940-98942) will hold an MFCD value of one. Only a single spinal CMT procedural code is reimbursable on any one date of service.</p> <p>Extraspinal Manipulation If the extraspinal CMT procedural code is billed without an accompanying spinal CMT code for any date of service, then the total of 98943 will hold an MFD value of one.</p> <p>Extraspinal Manipulation + Spinal Manipulation The extraspinal CMT code, 98943, must be accompanied by the modifier -51, when billed on the same date of service as a spinal CMT code (98940-98942). An extraspinal manipulation CPT code accompanied by modifier -51 billed in conjunction with a spinal manipulation CPT code is allowable on the same date of service. MFD and MFCD values apply.</p>
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Edit Sources

OptumHealth Physical Health sources its Physical Medicine and Rehabilitation and Chiropractic CPT code payment policy methodology to methodologies used and recognized by third party authorities. The sources used to determine if a CPT code is reimbursable are:

Current Procedural Terminology book (CPT) from the American Medical Association (AMA)

Centers for Medicare and Medicaid (CMS) National Coverage Policy and current Centers for Medicare and Medicaid (CMS) Policy Manual(s) <http://www.cms.hhs.gov>

ChiroCode DeskBook, 18th ed., 2010. <http://www.chirocode.com>

Background Summary

There are four CPT codes, which have been developed to assist chiropractic providers with accurately describing and reporting their manipulative treatment services. The work value of the CMT codes includes both cognitive (clinician judgment) and technical (skill) components. The work value or “work per unit of time” is divided into three sections: preservice, intraservice, and postservice.

The *preservice* (before patient arrives) includes: documentation and chart review, imaging review, test interpretation, and care planning. The *intraservice* (face-to-face time with patient) comprises: the premanipulation patient assessment (palpation, etc.), manipulation, and postmanipulation procedures (assessment, etc.). The *postservice* (after the patient leaves) period includes: chart documentation, consultation, and reporting.

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

regions.

The *Spinal* regions are: cervical (includes atlanto-occipital joint); thoracic (includes costotransverse and costovertebral joints); lumbar, sacral; and pelvic (sacroiliac joint). The *Extraspinal* regions are: head (including temporomandibular joint, excluding the atlanto-occipital joint); lower extremities; upper extremities; rib cage (excluding costotransverse and costovertebral joints); and abdomen.

Regardless of how many segments are manipulated in any defined spinal region, it counts as one region under the CMT codes. The CMT code 98943 applies to one or more extraspinal regions, where manipulation is performed.

As described above, the CMT codes include a premanipulative patient assessment. Additional Evaluation & Management services may be reported separately using the modifier -25, if the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the procedure.

The 97140 manual therapy CPT code may be billed on the same date of service as a CMT code when the manual therapy service is provided to a different body region than the CMT. When these procedures are billed together, modifier -59 is required to be appended to the 97140 CPT code in order to delineate that an independent procedure was performed.

Documentation Requirements

General Guidelines

All ICD-9-CM diagnosis codes and CPT treatment and procedure codes must be validated in the patient chart and coordinated as to the diagnoses and treatment code descriptors. A valid diagnosis is the most appropriate ICD-9-CM code that is supported by subjective symptoms, physical findings, and diagnostic testing/imaging (if appropriate)..

Documentation should be recorded on the day of the patient visit and include all of the following:

1. a subjective record of the patient complaint i.e., location, quality, and intensity
2. physical findings to support manipulation in a region or segment e.g., regional/segmental asymmetry or misalignment, range of motion abnormality, soft tissue tone and/or tenderness characteristics
3. assessment of change in patient condition, as appropriate
4. a record of the specific segments manipulated

98940 Chiropractic manipulative treatment (CMT); spinal, one to 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 to four regions

Documentation must support that manipulative treatment occurred in three to four regions of the spine (region as defined by CPT) and one of the following:

1. validated diagnoses for three or four spinal regions
2. 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:

1. validated diagnoses for five spinal regions
2. validated diagnoses for three spinal regions, plus two adjacent spinal regions with documented soft tissue and segmental findings
3. validated diagnoses for four spinal regions, plus one adjacent spinal region with documented soft tissue and segmental findings

98943 Chiropractic manipulative treatment (CMT); extraspinal, one to five regions

Documentation must support that manipulative treatment occurred in one or more extraspinal regions (as defined by CPT), and there is a validated diagnosis for one or more extraspinal regions for which manipulation has been shown to be both safe and efficacious per appropriate OptumHealth Physical Health medical policy.

Definitions

Maximum Frequency per Day (MFD) Value	The maximum frequency per day (MFD) value is the number of units automatically allowed for a service on a single date of service by OptumHealth Physical Health.
Maximum Frequency in Combination per Day (MFCD) Value	The maximum frequency in combination per day (MFCD) value is the number of units automatically allowed for a combination of services on a single date of service by OptumHealth Physical Health.

References and Resources

References

1. American Medical Association, *Current Procedural Terminology (CPT), Professional Edition 2010*
2. Centers for Medicare and Medicaid Services (CMS), *Medicare Benefit Policy Manual, Chapter 15* <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>
3. American Chiropractic Association (ACA), Professional Resources, Clinical (Medical) Documentation: The Key to Reimbursement for Chiropractic Claims http://www.amerchiro.org/content_css.cfm?CID=1080
4. 2009 Chiropractic Coding Solutions Manual. American Chiropractic Association; Arlington, VA
5. ChiroCode DeskBook, 18th ed., 2010. <http://www.chirocode.com>

History/Updates

Approval Date: 4/12/07	Revision History: 7/31/08, 2/26/09, 4/8/10
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