



Chiropractic Manipulative Treatment Reimbursement Policy

Policy Number	0045	Annual Approval Date	04/2020	Approved By	Optum Reimbursement and Technology Committee Optum Quality and Improvement Committee
----------------------	------	-----------------------------	---------	--------------------	---

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. Optum reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. 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 only as a general reference resource regarding Optum's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, Optum may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to Client enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the provider contracts, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by Optum due to programming or other constraints; however, Optum strives to minimize these variations.

Optum may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

**CPT® is a registered trademark of the American Medical Association*

Application

This policy applies to all products, all network and non-network rehabilitation providers. This includes non-network authorized, and percent of charge contract providers.

Fee schedule/provider contract/client contract may supersede

Policy

Overview

This policy describes Optum's requirements for reimbursement of CPT codes 98940, 98941, 98942 (Spinal Chiropractic Manipulative Treatment) and 98943 (Extraspinal Chiropractic Manipulative Treatment).

The purpose of this policy is to ensure that Optum reimburses for services that are billed and documented, without reimbursing for billing submission or data entry errors or for non-documented services.

Reimbursement Guidelines



Spinal Manipulation

Optum will align reimbursement values with CPT definition. One spinal CMT procedure code is reimbursable per date of service.

Extraspinal Manipulation

Optum will align reimbursement values with CPT definition. One extraspinal CMT procedure code is reimbursable per date of service.

Manipulation + Evaluation and Management

The CMT codes include a premanipulative patient assessment. Additional Evaluation & Management (E/M) services may be reported separately using 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.

Extraspinal Manipulation + Spinal Manipulation

Modifier -51 (Multiple Procedures) is not required to be appended to the extraspinal CMT procedural code (98943), when billed on the same date of service as a spinal CMT code (98940-98942).

Manipulation + Manual Therapy

CPT code 97140 (Manual therapy techniques) may be billed on the same date of service as a CMT code when the manual therapy service is provided to a different **noncontiguous** body region than the CMT. When these procedures are billed together, modifier -59 or the appropriate -X modifier, is required to be appended to CPT code 97140 to delineate that an independent procedure was performed.

CMS has established the following four HCPCS modifiers (referred to collectively as -X{EPSU} modifiers) to define specific subsets of the -59 modifier:

- XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter,
- XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure,
- XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner, and
- XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.

Current Procedural Terminology (CPT) instructions state that modifier 59 should not be used when a more descriptive modifier is available. Providers should utilize the more specific -X modifier when appropriate.

Background Information

There are four CPT codes (98940, 98941, 98942, and 98943) that 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.

According to CPT, the complete CMT service requires preservice and intra-service work that is included as part of the service. [CPT Assistant 2018 (Nov.)]

The preservice work includes:

- Physician review of the patient's records to establish a treatment plan and to familiarize himself or herself with the previous treatment
- The review of prior imaging, test interpretation, and test results
- Consideration of the range of potential manipulative treatments that may be performed in the appropriate number of body regions for the current date of service
- The explanation of the potential procedures to the patient and obtaining verbal consent
- Answering any additional questions, comments, and/or concerns.

The intra-service work includes:

- Performing a pre-manipulation patient assessment, which includes:
 - an assessment of the patient's pain level;
 - evaluation of interval changes in objective signs;
 - and evaluation of functional changes that may include:
 - identifying asymmetry,
 - assessing segmental mobility,
 - evaluating changes in tissue and tone in the affected regions.
- A treatment procedure that best fits the patient's condition is finalized that day.

The post-service (after the patient leaves) period includes:

- Chart documentation
- Follow-up consultation e.g., arrangement of additional services or discussion/referral to another provider
- Reporting e.g., written and telephonic communications with the patient, family, and other providers [Beck, 2007]

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.

CPT describes the application of modifier -25 when E/M services are reported in conjunction with CMT procedural codes (98940-98943). "The chiropractic manipulative treatment codes include a pre-manipulation patient assessment. Additional evaluation and management services ... may be reported separately using modifier 25 if the patient's condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and post-service work associated with the procedure. The E/M service may be caused or prompted by the same symptoms or condition for which the CMT service was provided. As such, different diagnoses are not required for the reporting of the CMT and E/M service on the same date." [Chiropractic Manipulative Treatment. CPT Assistant Newsletter 2018 (Nov.); FAQs:12.]

Modifier -51 (Multiple Procedures) does not need to be appended to the extraspinal CMT code (98943), when billed in conjunction with chiropractic manipulative treatment (CMT) codes (98940- 98943). According to "The CPT® Assistant" [December 2013], these are separate and distinct procedures and the use of modifier 51 does not apply.

The National Correct Coding Initiative (NCCI) Edits – developed by the CMS – provides guidance in the application of modifier -59. "Use of modifier -59 to indicate different procedures/surgeries does not require a different diagnosis for each HCPCS/CPT coded procedure/surgery. Additionally, different diagnoses are not adequate criteria for use of modifier -59. The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters...

From an NCCI perspective, the definition of different anatomic sites includes different organs or different lesions in the same organ. However, the treatment of contiguous structures in the same organ or anatomic region does not constitute treatment of different anatomic sites.[NCCI, 2017] For example, Optum considers...

- the treatment of myofascial structures using manual therapy techniques in the same organ (spine), where CMT was performed and are contiguous (cervical and thoracic), does not constitute treatment of different anatomic sites.
- the treatment of myofascial structures using manual therapy techniques in the same organ (spine), where CMT was performed and are not contiguous (cervical and lumbar), does constitute treatment of different anatomic sites.
- the treatment of the cervical spine and a shoulder joint does constitute treatment of different anatomic sites.

Documentation Guidelines

General Guidelines

All ICD-10-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-10-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 Optum medical policy.

97140: Manual therapy techniques (e.g. mobilization, manipulation, manual lymphatic drainage, manual traction) one or more regions, each 15 minutes.

When reporting the CPT code 97140 in conjunction with CMT codes, there are six criteria that must be documented to validate the service:

1. Manipulation was not performed to the same anatomic region or a contiguous anatomic region e.g., cervical and thoracic regions are contiguous; cervical and pelvic regions are noncontiguous
2. The clinical rationale for a separate and identifiable service must be documented e.g., contraindication to CMT is present
3. Description of the manual therapy technique(s)
4. Location e.g., spinal region(s), shoulder, thigh, etc.
5. Time i.e., number of minutes spent in performing the services associated with this procedure meets the timed-therapy services requirement
6. CPT code 97140 is appended with the modifier -59 or the appropriate -X modifier

Resources

- American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services
- Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
- Centers for Medicare and Medicaid Services



- The Medicare National Correct Coding Initiative (NCCI). Modifier 59 article. 2017; Accessed 2/15/18: <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/modifier59.pdf>
- Chiropractic Manipulative Treatment. CPT Assistant Newsletter 2018 (Nov.); FAQs:12.
- Beck DE, Margolin DA. Physician coding and reimbursement. Ochsner Journal 2007; 7(1): 8–15. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3096340/>

History / Updates

04/12/2007	New
07/2008	Annual review and update
02/2009	Annual review and update
04/2010	Annual review and update
04/2011	Annual review and update
04/2012	Annual review and update
04/2013	Annual review and update
04/2014	Annual review and revision; Included current NCCI edits describing the application of modifier -59; Added explicit documentation criteria for reporting CPT code 97140 in conjunction with CMT codes; Deleted required use of modifier -51 when extraspinal CMT is billed in conjunction with spinal CMT
04/2015	Annual review and revision; added new CMS modifier –X detail
04/2016	Annual review and update
04/2017	Annual review and update
04/2018	Annual review and update
04/2019	Annual review; Updated Background Information (CPT Assistant Nov. 2018); Clarified postservice work
0/2020	Annual review and update

Proprietary information of Optum
Copyright 2020 Optum