Priority Health	BILLING POLICY No. 044
CHIROPRACTIC SERVICES	
Date of origin: Oct. 7, 2024	**Review dates: 2/2025, 2/2026, 3/2026, 4/2026**

DEFINITION
This policy outlines proper billing and coding for chiropractic care.

MEDICAL POLICY

- Rehabilitative & Habilitative Medicine Services (#91318)

POLICY SPECIFIC INFORMATION
Spinal manipulations are the only chiropractic treatment that will be considered for coverage. Coverage is limited to the number of visits deemed medically necessary by Priority Health or the number of visits outlined in the member's schedule of visits, whichever is less.

- **98940**: Chiropractic manipulative treatment; spinal, one or two regions
- **98941**: Chiropractic manipulative treatment; spinal, three to four regions
- **98942**: Chiropractic manipulative treatment; spinal, five regions

Not covered:

- **98943**: Chiropractic manipulative treatment; extraspinal, one or more regions

Diagnosis codes:
Diagnosis codes should be coded at the highest level of specificity. The primary diagnosis should be coded as the precise level of subluxation.

- M99.00 Segmental and somatic dysfunction of head region
- M99.01 Segmental and somatic dysfunction of cervical region
- M99.02 Segmental and somatic dysfunction of thoracic region
- M99.03 Segmental and somatic dysfunction of lumbar region
- M99.04 Segmental and somatic dysfunction of sacral region
- M99.05 Segmental and somatic dysfunction of pelvic region

To support appropriate coding, the complaint or related codes should be listed as secondary diagnosis codes.

Note: Some plans allow for a chiropractic rider that may be less restrictive of diagnosis or frequency.

Documentation requirements
Documentation to prove medical necessity may be requested from the rendering provider. This documentation may include but are not limited to:

- The precise area and condition being treated.
- Proof of meaningful improvement throughout the course of treatment (within 90 days), including improved mobility and ability to perform activities of daily living.
- One set of diagnostic x-rays (up to three views) performed by a chiropractor annually 72010, 72020, 72040, 72050, 72052, 72069, 72070, 72072,72074, 72080, 72090, 72100, 72110, 72114, 72120, 72170, 72190, 72200, 72202, 72220
    - X-rays of the area of chief complaint may be taken at the start of treatment.

- Follow-up x-rays should be performed within 90 days for acute conditions and within 365 days for chronic conditions.

Evaluation and management

New patient visits (if applicable) or established patient visits are reimbursed once every 12 months for chiropractic providers.

Modifiers

- **AT**: Required when condition is considered acute for codes 98940, 98941, and 98942.

Chiropractic codes without the AT modifier will be considered maintenance services and may not be covered based on specific plan benefits.

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added “Disclaimer” section
Feb 2026	Under “Documentation Requirements” changed “This documentation should include” to “This documentation may include but are not limited to” for clarity
March 2026	Added compliant or related condition with secondary diagnosis section
April 2026	Clarification on secondary diagnosis