Priority Health	BILLING POLICY No. 044
CHIROPRACTIC SERVICES	
Date of origin: Oct. 7, 2024	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise noted
- Medicaid follows MDHHS unless otherwise specified

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

Documentation requirements

Documentation to prove medical necessity may be requested from the rendering provider. This documentation should include:

- 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.

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

CHANGE / REVIEW HISTORY

Date	Revisions made