PROVIDER REIMBURSEMENT GUIDANCE			
Chiropractic Services			
Original Date Approved	**Effective Date SCO/ICO**	**Effective Date MAPD***	**Revision Date**
8/18/2020	9/1/2020	01/01/2022	10/25/2021

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options (MA)
☒ One Care (MA)
☒ CCA Medicare Preferred – (PPO) MA*
☒ CCA Medicare Value - (PPO) MA*
☒ CCA Medicare Preferred – (PPO) RI*
☒ CCA Medicare Value - (PPO) RI*
☒ Medicare Maximum – (HMO DNSP) RI*

PAYMENT POLICY SUMMARY:

Commonwealth Care Alliance © (CCA) reimburses medically necessary Chiropractic Manipulative Treatment (CMT). CMT is defined by AMA CPT as a form of manual treatment to influence joint and neuro-physical function. CMT is performed for treatment of misalignments, subluxations, or segmental joint dysfunction.

REIMBURSEMENT REQUIREMENTS:

CCA will reimburse medically necessary CMT services until the maximum therapeutic benefit has been achieved.

CCA does not cover spinal manipulation services for the treatment of non-musculoskeletal disorders including but not limited to Rheumatoid Arthritis, Muscular Dystrophy, Multiple Sclerosis, Pneumonia, and Emphysema.

Spinal manipulation for the treatment of chronic conditions or for maintenance care without objectively measurable improvement is considered not medically necessary and not covered.

CMT services are payable to Chiropractors as well as Community Health Centers when the services are provided by a CHC employed Chiropractor or contracted Chiropractor.

SCO/One Care: Radiology services are reimbursed when the services are needed to confirm neuromusculoskeletal conditions that require treatment.

PRIOR AUTHORIZATION/REFERRAL REQUIREMENTS:

SCO/One Care: Authorization is required after 36 CMT visits. For more information, please see the Provider Manual Section 4.

Medicare Advantage: Prior Authorization is required.

BILLING AND CODING GUIDELINES:

CCA will use current industry standard procedure codes throughout their processing systems. The Health Insurance Portability & Accountability Act (HIPAA) Transaction and Code Set Rule requires providers to use the code(s) that are valid at the time the service is provided. Providers must only use industry standard code sets and must use specific HCPCS and CPT codes when available.

CCA reimburses for the Chiropractic procedure codes as below:

CPT Code	Description
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
98940*	Chiropractic Manipulation Services (CMT), spinal, one to two regions
98941*	Chiropractic Manipulation Services (CMT), spinal, three to four regions
98942*	Chiropractic Manipulation Services (CMT), spinal, five regions
72020**	Radiologic examination, spine, single view, specify level
72040**	Radiologic examination, spine; cervical, two or three views
72070**	Radiologic examination, spine; thoracic, two views
72080**	Radiologic examination, spine; thoracolumbar, two views
72100**	Radiologic examination, spine; lumbosacral, two or three views

* Medicare Advantage Plans require addition of the AT (acute treatment) Modifier to the appropriate CMT code to support medical necessity.

**Medicare Advantage Plans do not reimburse for chiropractic x-rays.

DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to plan policies and procedures and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

Reimbursement is provided for all medically necessary covered services when the medical criteria and the guidelines for medical necessity are met. CCA reserves the right to request preauthorization or to complete a retrospective review of services provided. In some instances, medical records may be requested for determination of medical necessity. When medical records or clinical information is requested, all supporting documentation to support medical necessity should be included for clinical review.

REFERENCES:

CMS Website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-MedicaidCoordination.html

CCA Website: http://www.commonwealthcarealliance.org

Healthcare Administrative Solutions Website: https://www.hcasma.org

Food and Drug Administration Website https://www.fda.gov/drugs

National Correct Coding Initiative:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

Chiropractor Manual: https://www.mass.gov/lists/chiropractor-manual-for-masshealth-providers

POLICY TIMELINE DETAILS

1. Drafted July 2020
2. Effective 09/01/2020
3. Approved August 2020
4. Updated for MAPD Oct. 2021