

APPENDIX B

CHIROPRACTIC GUIDELINES

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NOTE: The revision date appears in the footer of the document. Links within the document are updated as changes occur throughout the year.

Chiropractic Manipulative Treatment (CMT)

BCBSKS expects the specific criteria identified for each code to be met and documented in the medical record when using a particular level of CMT code.

- **All manipulations must be coded separately.**

NOTE – Although a procedure/service has an assigned code that accurately defines the service, it doesn't guarantee the service is covered by BCBSKS.

For the majority of chiropractic office visits, the primary therapeutic procedure rendered is a spinal manipulation/adjustment. Please report manipulations using the appropriate CPT codes 98940-98942 (spinal) and 98943 (extraspinal).

Rehabilitation Services are covered only if they are expected to result in significant improvement in the Insured's condition. BCBSKS will determine whether significant improvement has, or is likely to occur.

Per CPT, Pre and Post Services are included in CMT Procedure Codes 98940 through 98943.

- **Per CPT, CMT Regions and Procedure Codes**
 - **E&M's are part of the manipulation**

 - **Regions of the Spine (for 98940 through 98942)**
 - ✓ Cervical (includes atlanto-occipital joint)
 - ✓ Thoracic (including costovertebral and costotransverse, excluding rib cage)
 - ✓ Lumbar
 - ✓ Sacral
 - ✓ Pelvic (sacro-iliac joint)

 - **Regions of the Extrapinal (98943)**
 - ✓ Head (including temporomandibular joint, excluding the atlanto-occipital)
 - ✓ Lower Extremities
 - ✓ Upper Extremities
 - ✓ Rib cage (excluding costotransverse and costovertebral)
 - ✓ Abdomen

 - **The procedure codes are**
 - 98940 1 to 2 regions of the spine manipulated
 - 98941 3 to 4 regions of the spine manipulated
 - 98942 5 regions of the spine manipulated
 - 98943 Extrapinal manipulated

Evaluation and Management (E&M) Codes

Chiropractors usually bill the first four levels of new and established office visit codes. BCBSKS uses the CPT definitions for new and established patients. If a provider has treated a patient for any reason within the past three years, the patient is considered an established patient.

[Policy Memo No. 2](#)

As a general rule, E&M codes should not be billed in conjunction with any manipulations. Routine use of E&M codes without sufficient documentation is not an appropriate billing practice.

E&M services can be reported separately for an initial exam of a new patient.

- **Selecting the Correct Level of E&M**

BCBSKS uses AMA-CPT codebook definitions for each level of E&M code as related to type of history, examination, and medical decision-making involved in the office visit. We expect the criteria identified for each code to be met and documented in the medical record when using a particular level of E&M code.

The following should be considered when making a decision as to what E&M procedure code is appropriate for a given date of service: The AMA-CPT book indicates the descriptors for the levels of E&M services recognize *seven* components, *six* of which are used in defining the levels of E&M services. These components are:

- *History*
- *Examination*
- *Medical decision-making*
- *Counseling*
- *Coordination of care*
- *Nature of presenting problem*
- *Time*

The *first three* of these components, history, examination and medical decision-making should be considered the **KEY COMPONENTS** in selecting the level of E&M service procedure code.

The *next three* components (counseling, coordination of care, and the nature of the presenting problem) are considered **contributory** factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided at every patient encounter.

The final component is time. Defined as the time the physician spends counseling (50 percent or more) face-to-face with the patient. The start and stop face-to-face time must be documented.

Coordination of care does not include time spent coordinating care within the physician's own office or clinic. Coordination of care does include time spent coordinating care outside of the physician's own office or clinic (i.e., other physicians, providers, hospitals, etc.)

Muscle and range of motion testing that are more in-depth than the routine tests performed on visit-by-visit basis can be coded separately if they meet the criteria outlined in the AMA-CPT book for each test and all criteria is met in the medical record.

Those tests not meeting the criteria are considered routine and are included in the E&M procedure code or the CMT/OMT procedure code.

E & M and CMT Coding

As stated previously, BCBSKS expects the specific criteria identified for each code to be met and documented in the medical record when using a particular level of CMT code.

- **New Patient**

You may bill a new patient E&M procedure code and a CMT procedure code on the same day.

- **Established Patient**

An E&M for an established patient will be considered content of service of the manipulation.

- **Re-Evaluations** will be considered content of service of the manipulation.

Radiology

Providers must bill diagnostic X-ray services using CPT radiology codes and adhere to the policies described in Policy Memo No. 7.

[Policy Memo No. 7: Radiology and Pathology](#)

Referring provider information should be submitted in the 2310A and/or 2420F loop.

Ordering provider information should be submitted in the 2420E loop

When filing on paper the information is reported in box 17B.

Pathology (Labs)

- All anatomic laboratory tests must be billed by the entity that performs the entire exam using CPT codes.
- Professional Services Coordinated with a Non-Contracting Provider
When a contracting provider uses a non-contracting provider (either in or out-of-state) to perform a portion of a professional service (e.g., professional component, technical component or other technology utilized in the performance of a service), the contracting provider must bill BCBSKS for all services. If the non-contracting provider bills the member or BCBSKS, the contracting provider will be required to hold the member harmless. [[Policy Memo No. 1](#), Section XIV, Page 13.]

[Policy Memo No. 7: Radiology and Pathology](#)

Referring provider information should be submitted in the 2310A and/or 2420F loop.

Ordering provider information should be submitted in the 2420E loop

When filing on paper the information is reported in box 17B.

Documentation Guidelines

The following information was communicated to Chiropractors via letter dated October 2009.

In 2006, chiropractors from the state of Kansas who do peer reviews for Blue Cross and Blue Shield of Kansas (BCBSKS) met and concurred that there was need for

BCBSKS-Business Procedure Manual

Appendix B: Chiropractic Guidelines

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NOTE: Codes published herein are current on the revision date and are subject to change.

Page B-5

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communication with their peers. The group's stated goals are to see chiropractors obtain appropriate compensation for the services provided and improve the process in performing reviews. A communiqué was sent to Kansas chiropractors, but concerns still remain. The purpose of this follow-up communiqué is to elaborate upon the two areas of concern. The two main concerns are:

- 1) **Documentation of medical necessity**
- 2) **Documentation of services provided**

DOCUMENTATION OF MEDICAL NECESSITY

Before BCBSKS can appropriately reimburse any eligible, professional provider for services, it must be determined if services are documented and can be supported by your records as being medically necessary. Medical necessity is a requirement of good stewardship of member premiums and is a standard of care that is supported by the chiropractic profession as well as all payer sources (see references). In many instances, this requires you to remit all appropriate and **legible** documentation for a claim in question.

When we request records from you, consider what documentation will support the need for the services you provided. Also, keep in mind that your documentation must allow a peer reviewer to discern the medical necessity for each service without knowing your patient as well as you do. Usually, your office must supply more documentation than just the day's chart note in question. For example, if a particular day's service is being considered which is in the midst of a series of treatments, it is necessary to supply the initial date of service notes, history, diagnostic tests, examination and radiology findings, etc. where specific details are documented. If the record supports the claim's billed services, without additional personal insight or knowledge, it should be adequate for review.

The importance of having the services you perform sufficiently documented cannot be over-emphasized.

DOCUMENTATION STANDARDS

The peer group agrees most travel cards **alone** provide insufficient medical detail from which to determine the medical necessity of care and treatment performed, especially in instances of extended care. The small entries, checkmarks, and commonly illegible notations seldom provide adequate information in a travel card format.

The chiropractic consultants firmly recommend that the content of the daily medical records contain the requirements detailed below. These requirements essentially mirror Kansas Board of healing Arts Regulation Section 100-24-1: Adequacy: minimal requirements.

The following medical record standards are **minimally** required; and if not met, may result in delay or denial of reimbursement as a **provider write-off**:

Records must:

1. Be **legible** in both readability and content. If not readable, reimbursement will be denied.
2. Contain only those terms and abbreviations easily comprehended by peers of similar licensure. If a legend is needed to review your records, please submit it with your records. If needed and you have not submitted one, BCBSKS may request you provide a legend. If not supplied upon request, reimbursement will be denied.
3. Contain identification of the patient on every page (i.e. front and back). If not recorded, reimbursement may be denied.
4. Indicate the dates any professional service was provided. List start and stop times or total time on all timed codes per CPT nomenclature. If dates of service and/or start/stop time are not recorded, reimbursement will be reduced.
5. Contain pertinent and significant information concerning the patient's presenting condition (**subjective information and history**).
6. Reflect what examination or treatment was performed and physical area(s) treated, vital signs obtained and tests (lab, x-ray, etc.) performed and the findings of each (**objective data**).
7. Indicate the initial diagnosis and the patient's initial reason for seeking the provider's care. The **diagnosis is not just an ICD-10-CM billing code**, but a written interpretation of the patient's condition and physical findings. The diagnosis should be recorded in the record and reflected on the claim form. (**Assessment**)
8. Document the treatment performed (what treatment was done, why was it done, where it was done, and for how long). Treatment goals should be documented. (**Plan of Care**)
9. Document the patient's progress during the course of treatment as it relates to the plan of care and diagnosis.
10. Signature Requirements -- In the content of health records, each entry must be authenticated by the author. Authentication is the process of providing proof of the authorship signifying knowledge, approval, acceptance or obligation of the documentation in the health record, whether maintained in a paper or electronic format accomplished with a handwritten or electronic signature. Individuals providing care for the patient are responsible for documenting the care. The documentation must reflect who performed the service.
 - a. The handwritten signature must be legible and contain at least the first initial and full last name along with credentials and date. A typed or printed name must be accompanied by a handwritten signature or initials with credentials and date.
 - b. An **electronic signature** is a unique personal identifier such as a unique code, biometric, or password entered by the author of the electronic

medical record (EMR) or electronic health record (EHR) via electronic means, and is automatically and permanently attached to the document when created including the author's first and last name, with credentials, with automatic dating and time stamping of the entry. After the entry is electronically signed, the text-editing feature should not be available for amending documentation. Example of an electronically signed signature: **“Electronically signed by John Doe, M.D. on MM/DD/YYYY at XX:XX A.M.”**

- c. A digital signature is a digitized version of a handwritten signature on a pen pad and automatically converted to a digital signature that is affixed to the electronic document. The digital signature must be legible and contain the first and last name, credentials, and date.
- d. Rubber stamp signatures are not permissible. This provision does not affect stamped signatures on claims, which remain permissible.

It is essential for the chiropractor to document clinical findings and justify the medical necessity of care. It is strongly suggested this justification be documented via formal progress note using S.O.A.P. note format, which is considered a medical standard. The following elements should be present on **each initial and subsequent encounter/evaluation** regardless of the note format used.

S-SUBJECTIVE COMPLAINT should include the following:

◆ Initial Evaluation:

- Patient's reason for seeking care.
- History of complaint and/or nature of injury or accident
 - Include history of treatment by previous treators (chiropractic, MD, PT, OT, etc.)
 - Location of complaint
 - How long they've had complaint and what movement or motion aggravates it.
 - Description of pain.
 - * Quality (stabbing, pulling, throbbing, achy, etc.)
 - * Quantity (always there, only there during certain times of the day, certain positions, or while performing certain daily activity tasks)
 - * Severity (use pain scale to have patient describe the severity of the complaint).
- General health history and thorough systems review (**when clinically appropriate**).
 - Significant illnesses and medical conditions
 - Medication, allergies and adverse reactions
 - Past medical history of serious accidents, operations, hospitalizations, tumors
 - For children and adolescents (18 years and younger) past medical history of prenatal care, birth, operations and childhood illnesses
 - Social history, smoking, drinking, substance abuse, recreational activities as well as occupational history, living arrangements and activities of daily living (ADL).
 - Review of systems.

- ◆ **Subsequent Encounters:**
 - Follow-up documentation
 - Patient's perception of progress to date.
 - Perceived improvements in ADL.
 - Perceived improvements in pain quality, quantity and severity (pain scale).

O-OBJECTIVE FINDINGS should include the following:

- ◆ **Initial Evaluation:**
 - Functional and measurable data
 - Vital signs, height, weight, blood pressure, etc.
 - Orthopedic and neurological testing, laboratory studies and diagnostic imaging, i.e., x-ray finding, MRI, CT-scan, bone scan, etc. Include radiology or special diagnostic reports in patient record.
 - Visual observation
 - Inspection findings
 - Antalgia
 - Postural anomalies
 - Movement pattern deficits
 - Functional deficits
 - ADL deficits
 - Strength deficits, etc.
 - Physical examination findings, i.e.:
 - Static and motion palpation findings specific to region and/or specific spinal levels or extremity joints evaluated. May include muscle spasm/tightness, tenderness, trigger points, edema, strength and ROM deficits. Note that subluxations (spinal or extremity) need to be specifically identified objectively. Document the spinal segment or extremity joint involved along with its positional or functional deficit via your palpatory or x-ray analysis. **Example:**
 - * Decreased ROM Cervical right rotation 20° with joint lock at C2-3.
 - * Levorotatory lumbar curvature noted on x-ray. L2-3 fixation evident.
 - * Foraminal compression Cervical spine produces impingement at C5-6 on the right with cervicobrachial pain/paresthesia extending to the tip of the right index finger. Focal joint lock T8-9, L2 and Right ilium.
 - * Right Kemps test produces focal impingement L5-S1 ipsilateral.
- ◆ **Subsequent Encounters:**
 - Follow-up documentation
 - Improvement or decline in functional and measurable data as it relates to:
 - * Range of motion measurement (pre and post treatment)
 - * Strength measurement (pre and post treatment)
 - * Visual observation of movement patterns, palpatory findings, postural anomalies, etc.
 - * ADL's (able to comb hair, reach top cabinets, walk 10' longer without assistive device, etc.)

A-ASSESSMENT should include the following:

♦ **Initial Evaluation:**

- The DIAGNOSIS. The diagnosis is a written interpretation of the patient's condition, physical findings and should correlate with the objective data. **(It is not an ICD-10-CM billing code.) Examples:**
 - * Cervical sprain/strain with associated altered biomechanics at C4-5.
 - * Lumbar facet syndrome with associated lumbalgia, lumbar paraspinal myofasciitis and subluxations in the lumbar and sacroiliac region.
 - * Right sciatic neuralgia secondary to L5-S1 lateral disc protrusion.
 - * Right rotator cuff sprain/strain, grade 2 with AI luxation of humeral head.
 - * Plantar fasciitis secondary to acquired ankle pronation and luxation of the cubo-navicular complex.
- Long and short-term goals and expected functional outcomes. **Examples:**
 - Long-term goals:
 - * Patient able to sleep 8 hours without rising to apply heat or take medicines.
 - * Patient able to play golf in 4 weeks without pain.
 - * Patient able to vacuum house without back pain or rest breaks in 3 weeks, etc.
 - Short-term goals:
 - * Increase ROM cervical spine from 12° to 90°.
 - * Walk 10 ft. without crutches in 2 weeks with stand by assistance.
 - * Increase ROM in R shoulder so patient can wash hair without muscle spasm in trapezius.

♦ **Subsequent Encounters:**

- Follow-up documentation
 - Document appropriate changes in the diagnosis and the provider's evaluation of the patient's overall progress and prognosis with regard to the treatment plan. **Examples:**
 - * Improved ROM cervical spine to 45°, continue at same treatment frequency.
 - * Patient can now vacuum ½ her home without pain, but has low back fatigue. (ADL). Continue with work-hardening exercises at home & maintain treatment frequency at 2/wk to decrease rest breaks to 2.
 - * Patient improved and can play 9 holes of golf without pain. Decrease visits to two times per week and add home exercise program to increase stamina.

P-PLAN should include the following:

♦ **Initial Evaluation:**

- The initial visit would include the treatment plan as it relates to the complaint and diagnosis afforded the patient. The treatment plan should indicate each modality or therapeutic procedure/exercise to be provided, the frequency, duration, to what body area, and future plans for re-examination. Indicate plans for

anticipated discharge, prognosis, referral for consultations, and diagnostic testing.

- Treatment, therapy and procedures performed on the patient are recorded here. The services rendered should correlate with the CPT billing codes submitted for payment. **Example:**

- If physiotherapy is used, the type of modality or exercise must be identified as well as the body part treated, the length of time utilized, intensity settings, physiological reason for application and correlation with diagnosis. Medical reasoning for each treatment utilized must be documented when using multiple therapies. **Example:**

- * To reduce inflammation and edema at patient's cervical sprain area, use pulse ultrasound to C3-6 left facet/paraspinal region for 10 minutes at 50% pulse mode. Daily x3, then reduce to two times per week.

- * To reduce paraspinal and intercostals muscle spasms, use attended EMS HV therapy to the right thoracic T5-9 and corresponding right intercostal muscles for 15 minutes set at 145 volt tolerance. Daily x5 then reduce to 3 times per week.

- * To reduce inflammation noted over L3-5, place ice pack over lumbar spine wrapped in toweling for 10 minutes to patient tolerance. Daily x3 then have patient do themselves at home.

- * To restore normal biomechanics/juxtaposition, perform CMT to spinal regions C1, C4-5, T7 & L2. Re-evaluate after 10 visits.

- In the case of time-based modality/exercise, list start and stop times for each service provided. Services such as therapeutic procedures, neuromuscular re-education, manual therapy techniques, therapeutic activities, etc., require specific details about the services being performed to determine medical necessity and appropriateness. That detail includes, but is not limited to:

- Physiological reasoning for **each** service, especially if they are being performed in conjunction with other modalities/exercise procedures. **Each** service should provide a unique physiologic effect if they are to be used together; that effect needs to be documented.

- What **specific** exercise/procedure is being performed?

- The area being treated

- The number of repetitions if applicable

- * Statements that simply denote completion of activities is **not** adequate.

- ♦ **Subsequent Encounters:**

- Follow-up documentation:

- Follow-up visits document any appropriate changes in the diagnosis and/or treatment plan and why.

- At each patient encounter, a brief post-assessment of the treatment rendered should be performed and recorded. It is intended to evaluate the patient's response to the treatment for that day. This post-assessment is **not** considered a re-exam of the patient. **Example:**

- * Patient progressing well with home exercises for rotator cuff sprain. Will re-examine shoulder strength quantifiably at next visit. Follow-up 2 weeks.

- * Patient displays normal and pain-free ROM cervical spine with normal strength and stability displayed. Patient is discharged from care for cervical sprain/strain injury without limitations.
- * Patient is not responding as expected. Referring for MRI of lumbar spine to R/O underlying pathology.
- Document any patient instructions such as home care (ice/heat, belts/collars, exercises, work/home restrictions, etc.) or nutritional supplements recommended.
- Document any complications.
 - * Patient deaf and communication is difficult.
 - * Patient utilizes a walker and retains a forward flexed posture while weight bearing which complicates restoration of normal thoracic kyphosis and is delaying reduction of thoracic paraspinal myospasms.

CHIROPRACTIC DOCUMENTATION

RESPONSIBILITIES

It is imperative that you and your staff are fully aware of the professional, fiduciary, and legal standards/requirements of complete and thorough documentation. A BCBSKS professional relations representative is readily available to assist you. BCBSKS and chiropractic peer review consultants strive to provide you the information necessary to meet the requirements of documentation. Please refer to the important resources at the end of this document that will increase the successful and timely adjudication and remittance of payment for the valuable services you provide.

Please contact your BCBSKS professional relations representative should you have questions or require additional information.

RESOURCES

1. ACA Chiropractic Coding Solutions Manual 2000
2. Coulehan and Block, *The Medical Interview*, 4th Edition, F.A. Davis Company 1997.
3. National Chiropractic Mutual Insurance Company, *List of Some Simple Rules Regarding Responsible Record Keeping*.
4. Medicare documentation standards (<http://www.cms.hhs.gov>)
5. NCQA (national Committee for Quality Assurance) Guidelines.
6. American Chiropractic Association (<http://www.acatoday.org>)
7. BCBSKS *Ad Hoc Therapies-Documentation of Medical Services, Blue Shield Report*, MAC-01-05, pages 2-3.
8. Your BCBSKS contractual agreement, BCBSKS Policy Memo No. 1, XI, page 10
9. Kansas Statutes Annotated and Kansas Board of Healing Arts regulations (<http://www.ksbha.org/statsandregs.shtml>)

Maintenance Care

- BCBSKS considers Maintenance Care not medically reasonable or necessary, and is NOT payable, and will be denied not medically necessary. Ongoing physical medicine treatment after a condition has stabilized or reached a clinical plateau (maximum medical improvement) does not qualify as medically necessary, and would be considered "Maintenance Care." If a provider renders Maintenance Care, a conversation should take place with the patient before services are provided. This will allow the patient to decide if they want to assume financial responsibility.
- Maintenance Care is a provider write-off unless a [Limited Patient Waiver](#) is signed before performance of the service.
- Use modifier "GA" to demonstrate waiver on file.
- Applicable codes: 97001-97546 and 98940-98943.

Examples of Red Flags

- Duplicative services or physiologic effects
- Misuse of CPT codes
- Billing of units/treatment greater than BCBSKS policy allowable
- Upcoding
- Use of unlisted procedure and modality codes
- Continued use of modalities with no documented rationale and objective data to support patient improvement and ongoing treatment
- Lack of treatment plan documented in medical record.
- Vague diagnosis codes
- High utilization

Tiered Reimbursement

- See Policy Memo No. 1, Section XXV. Tiered Reimbursement and Provider Number Requirements.

[Policy Memo No. 1](#)

- Tiered reimbursement for chiropractors is defined in the 2016 Competitive Allowance Program (CAP) letter dated July 2015. Chiropractors are subject to 85 percent of the BCBSKS MAP.

Ineligible Providers

The following provider's are not considered eligible providers as defined in the local BCBSKS member contracts, or for the Federal Employee Program (FEP). Their services cannot be billed incident to an eligible provider if they provide services.

- Massage therapists, exercise physiologists, occupational therapy aides, physical therapy aides and chiropractic assistants.
- Services performed by these specialties are considered patient responsibility and should not be billed to BCBSKS.

Multiple Units of Physical Medicine Modalities and Procedures on Same Date of Service

BCBSKS has guidelines that require we review certain services when the units performed on a given date of service exceed the unit limitation placed on the particular physical medicine modalities and/or procedures, regardless of who performed the service.

These guidelines involve more than 4 physical medicine modalities and/or procedures being billed on one date of service; or the guidelines involve the BCBSKS daily unit limit being exceeded.

Units on Time-Based Physical Medicine Codes

All CPT time based codes require start and stop times or total time documented in the medical record

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers must use a single 15-minute unit for treatment greater than or equal to 8 minutes

through and including 22 minutes. Time intervals for 1 through 8 units are as follows:

- 1 unit: > 8 minutes through 22 minutes
- 2 units: > 23 minutes through 37 minutes
- 3 units: > 38 minutes through 52 minutes
- 4 units: > 53 minutes through 67 minutes
- 5 units: > 68 minutes through 82 minutes
- 6 units: > 83 minutes through 97 minutes
- 7 units: > 98 minutes through 112 minutes
- 8 units: > 113 minutes through 127 minutes

Note – If billing for more than one modality/therapy, time should not be combined to report units. Each unit for the modality/therapy is reported separately by code.

Physical Medicine Evaluation, Modalities and Therapeutic Procedures

At the end of this section there is a list of physical medicine evaluation, re-evaluation, modalities and procedures with their related unit limitations and guidelines; please refer to that chart for further information.

- **97010 through 97546; 97760 through 97799**
 - These codes must be billed separately.
 - If you deliver more than one unit of service the number must be recorded in the units field of the CMS 1500 claim form.
 - When the same modality is applied to two different locations on the same day, always identify the areas (i.e., right shoulder and left elbow) on claim attachment.
 - When two modalities are performed by one machine at the same time only one modality may be billed.

PLEASE REVIEW THE FOLLOWING GUIDELINES CAREFULLY

Physical Medicine Exams/Modality/Procedure Guidelines

~~More than four (4) modalities or procedures on the same day require medical records~~

Code	Description	Special Instructions
95831-95857	MUSCLE TESTING AND RANGE OF MOTION TESTING	Performing routine muscle testing and range of motion or muscle testing (i.e., tests that are an integral part of the assessment performed each visit to determine the patient's status from one visit to the next and to determine the level of care required for the current visit) are considered content of the evaluation or therapy billed that particular day and should not be billed separately.
97010	CRYOTHERAPY	Do not use procedure code 17340, as this is for direct application of chemicals to the skin.
97010	HOT OR COLD PACKS Unattended One or more areas is one unit of service	This code will deny content of service unless it is the only service provided on the date of service.
97012	TRACTION (MECHANICAL) Unattended One or more areas is one unit of service	This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated. Sending in medical records will not change the units reimbursed on this code.
97014	ELECTRICAL STIMULATION , INTERFERENTIAL THERAPY, HORIZONTAL THERAPY Unattended	This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated. Use this code for Horizontal Therapy. When electrical stimulation 97014 and ultrasound 97035 are performed at the same time using the same machine, only one modality should be billed. The electrodes and other supplies used to administer any modality are content of service of the modality.
97024	DIATHERMY (e.g., microwave)	This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated.
97026	INFRARED Unattended One or more areas is one unit of service	This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated.
97032	ELECTRICAL STIMULATION (MANUAL) Attended One or more areas 15 minutes is one unit of service	This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated. Billing of electrodes The electrodes and other supplies used to administer any modality are content of service of the modality.
97035	ULTRASOUND Attended One or more areas 15 minutes is one unit of service	This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated.
97039	ICE MASSAGE/ICE THERAPY UNLISTED MODALITY	This code is content of service unless it is the only service provided on that date. Specify type and time.
97039	MCCONNELL STRAPPING/TAPING	A description of "McConnell strapping" or "McConnell taping" needs to be indicated in the 2400 NTE segment or box 19. Includes reimbursement for the tape and the taping procedure. A separate charge may be billed for the evaluation or re-evaluation, if performed.

Code	Description	Special Instructions
97110	THERAPEUTIC PROCEDURE Attended One or more areas <i>15 minutes is one unit of service</i>	
97112	NEUROMUSCULAR REEDUCATION Attended One or more areas <i>15 minutes is one unit of service</i>	
97124	MASSAGE Attended One or more areas <i>15 minutes is one unit of service</i> This service requires direct contact of the clinician.	97124 WILL DENY CONTENT OF SERVICE.
97140	MANUAL THERAPY TECHNIQUES Attended One or more areas <i>15 minutes is one unit of service</i> APPLIED KINESIOLOGY	97140 WILL DENY CONTENT TO THE MANIPULATION. May be medically justified with appropriate documentation.
97530	THERAPEUTIC ACTIVITIES Attended <i>15 minutes is one unit of service</i>	
S8948	APPLICATION OF A MODALITY TO ONE OR MORE AREAS Requires constant provider attendance Low level laser Each 15 minutes	No MAP set, by report
S9090 National S Code	VERTEBRAL AXIAL DECOMPRESSION THERAPY <i>Per session</i> This service is provided on mechanical traction machines, with provider intervention as appropriate. Some of the brand names for these machines are: VaxD; IDD; DR 5000; DR 9000; DRX 9000; SpinaSystem	This code is per session, regardless of time spent or areas treated. Submitting medical records will not change the unit limit for this code.

Nerve Conduction Studies and Related Services

- **Out-of-State Vendors**

It is in violation of your contract with BCBSKS to use the services of an out-of-state vendor to conduct or read nerve conduction studies, diagnostic ultrasound, or any other related service since your contract indicates you must use the services of a contracting provider when referring services. BCBSKS does not contract with out-of-state vendors for these services.

[Policy Memo No. 1](#)

- **Certification for In-State Providers**

- Reimbursement guidelines are based on the certification of the performing provider.
- For more information see Policy Memo No. 1.

[Policy Memo No. 1](#)

- **Medical Policy**

To review medical necessity guidelines visit our website and the Medical Policy section.

[Policy Memo No. 1](#)

NON-COVERED PROCEDURES

- The following services are non-covered on the majority of policies.
 - **Acupuncture**
 - **Foot Orthotics**
 - **Vitamins and Nutritional Supplements**
- Please verify each specific policy – call the CSC Provider Benefits Only Line (800-432-0272 or 785-291-4183) to determine coverage or the BCBSKS website at www.bcbsks.com

- A non-covered service does not need to be submitted to BCBSKS. The patient may be billed direct.
- When covered, you should use the appropriate procedure code from the AMA-CPT codebook.

NOT MEDICALLY NECESSARY

- Rollerbed Services (code 97012) are considered not medically necessary. When billing for this service, have the patient sign the [Limited Patient Waiver](#) and use modifier "GA" to demonstrate waiver on file.

EXPERIMENTAL/INVESTIGATIONAL

- The following procedures are considered experimental/investigational and are a provider write-off unless a Limited Patient Waiver is signed before performance of the service.

[Limited Patient Waiver](#)

Use modifier "GA" to demonstrate waiver on file

Anodyne Therapy

- This service should be coded using 97799 with a description of "anodyne therapy" submitted in the 2400 NTE segment or box 19. It should not be confused with Infrared Therapy that is coded 97026.

Anti-Gravity Lumbar Traction-Reverse (Inversion)

- Use 97139.

Aqua Massage Therapy

- This service should be coded using 97039 with a description of "aqua massage therapy" submitted in the 2400 NTE segment or box 19. It should not be billed using 97124.

Cold Laser Therapy/Soft Laser Therapy/ Low-Level Laser Therapy

- This service should be coded using 97039. It should not be confused with Infrared Therapy that is coded 97026.
- When using an unspecified code (97039) a description of the service must be submitted in the 2400 NTE segment or box 19.
- Low-level laser therapy should be coded S8948.

Kinesio Taping

- This service should be coded as 97039 with the description of "Kinesio taping" box19 or the electronic narrative.
- It is considered experimental/investigational and is a provider write-off unless a [Limited Patient Waiver](#) is signed before performance of the service.
- Limited Patient Waiver
 - Use modifier "GA" to demonstrate a waiver is on file.

Posture Pump

- This service should be coded 97139 with a description of "posture pump" submitted in the 2400 NTE segment or box 19.

Sympathetic Therapy

- This service should be coded using 97799 with a description of "Sympathetic therapy" submitted in the 2400 NTE segment or box 19.

REVISIONS

1/01/2014	Changed revision date in footer from July 2013 to January 2014. Updated CPT copyright to 2014.
	Page B-5 Deleted verbiage to using modifier "22," submitting medical records to support medical necessity and Two CMTs on the SAME DAY under the Established Patient heading under E & M and CMT Coding.
	Page B-6 Deleted link to 2013 Lab Fee Schedule for Professional Providers.
	Page B-12 Added BCBSKS Policy Memo No. 1, XI, page 10 to 8. under the RESOURCES heading.
	Page B-16 Deleted references to modifier "22" and unit limit chart under the Physical Medicine Evaluation, Modalities and Procedures heading.
	Page B-16 Added Applied Kinesiology section.
	Page B-17 Deleted references to modifier "22" and to more than one unit of service on a given date requiring medical records under the Ice Massage/Ice Therapy heading.
	Page B-23 Deleted reference to code 97039 and box 19, then added Applied Kinesiology verbiage under Kinesio Taping heading.
	Page B-24 Deleted reference to modifier "22" under Code 97022
	Page B-25 Deleted reference to modifier "22" under Codes 97033, 97036, 97039 and 97110. Deleted i.e. Aqua Massage, Cold Laser, etc., under Code 97039.
	Pages B-26, B-27 and B-28 Deleted references to modifier "22."
03/12/2014	Page B-8 – Added Section on signature requirements.
12/03/2014	Page B-8 – Bolded "electronic signature."
	Page B-14 – Added "Examples of Red Flags."
	Page B-16 – Moved "Physical Medicine Exams/Modality/Procedure Guidelines" grid to "Multiple Units of Physical Medicine Modalities and Procedures on Same Date of Service" section. Revised grid.
10/13/2015	Pages B-8, 11 – Added "ICD-10-CM" reference.
11/09/2015	Pages B8, 15 – Added "or total time" reference.
	Pages B-8, 11 – Removed "ICD-9-CM" reference.
	Page B-13 – Added "Chiropractic Documentation" link.
	Page B-14 – Removed "Provider Documentation Reference List".
	Page B-14 – Added "High utilization" reference.
	Page B-15 – Removed list of codes.
Page B-17 – Removed "97140" from Applied Kinesiology listing.	
02/16/2016	Page B-14 – Removed reference to roller bed services.
	Page B-20 – Added verbiage for intersegmental tractions.
05/10/2016	Page B-17 – Removed 97010 cryotherapy for redundancy.
	Page B-20 – Added "Not Medically Necessary Procedures"
06/24/2016	Pages B-16-17 – Added codes and descriptions 97012 and 97124.
07/08/2016	Page B-20 – Added code for low-level laser therapy.

REVISIONS

07/25/2016	Page B-16 – Clarified roller bed billing.
09/01/2016	Page B-2 – Moved Maintenance Care to B-13
	Page B-13 – Created Maintenance Care section with updates.
	Page B-15 – Added note regarding multiple units.
	Page B-16 – Removed Rollerbed billing.
	Page B-17 – Moved Applied Kinesiology to code 97140.
	Page B-19 – Added Rollerbed Services as NMN.
	Page B-21 – Corrected 97040 to 97140.