CareSource

REIMBURSEMENT POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Chiropractic Care-GA MP-PY-1446	01/01/2024-04/30/2025
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.
CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

This policy applies to the following Marketplace(s):				
☒ **Georgia**	☐ **Indiana**	☐ **Kentucky**	☐ **Ohio**	☐ **West Virginia**

Table of Contents

A. Subject....2
B. Background....2
C. Definitions....2
D. Policy....2
E. Conditions of Coverage....5
F. Related Policies/Rules....5
G. Review/Revision History....5
H. References....5

Archived

A. Subject
Chiropractic Care

B. Background
Reimbursement policies are designed to assist providers when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and office staff are encouraged to use self-service channels to verify member eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS/ICD-10 code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

C. Definitions
- **Chiropractor** – A Doctor of Chiropractic who is duly licensed and qualified to provide chiropractic services.
- **Chiropractic Therapy** – Therapy that focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments.
- **Manipulation Therapy** – Osteopathic/chiropractic therapy used for treating problems associated with bones, joints and the back.
- **Medically Necessary/Medical Necessity** – Health care services that a provider would render to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate in terms of type, frequency, extent, and duration.

D. Policy
I A covered chiropractic service that is legally performed will not be denied when such covered service is rendered by an in-network licensed chiropractor in the state that the covered service is performed.

II. All services are subject to member's share of cost (deductible, co-insurance and/or co-pays). This varies based on the member's plan enrolled at the time of service.

III. When manipulation services are provided in addition to an evaluation and management (E/M) office visit, modifier 25 should be appended to the E/M code. This distinguishes a significant, separately identifiable E/M office visit from the additional manipulation service.

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IV. Scope of practice
Chiropractors must follow a state's scope of practice. Any training or certification required by the state must be available to CareSource, upon request.

V. Chiropractic patients whose diagnosis is not within the chiropractic scope of practice, shall be referred, by the chiropractor, to a medical doctor or other licensed health practitioner for treatment of that condition.

VI. Manipulation therapy
- A. Includes chiropractic manipulation therapy used for treating problems associated with bones, joints and the back. Chiropractors would be limited to subluxations of the articulations of the human spine and the adjacent tissue.
- B. Annual benefit limits apply. It is the providers' responsibility to validate the available remaining quantity before rendering service. Manipulations performed will be counted toward any maximum for manipulation therapy services as specified in the member's Evidence of Coverage (EOC) or Schedule of Benefits regardless if:
  1. billed as the only procedure
  2. done in conjunction with an exam and billed as an office visit
- C. The member's plan does not provide benefits for manipulation therapy services provided in the home as part of Home Health Care Services.
- D. Modifier AT is required to be appended to any manipulation code.
- E. Claims should include a primary diagnosis of subluxation and a secondary diagnosis that reflects the patient's neuromusculoskeletal condition.

VII. All codes contained within this policy are not all inclusive but provide a general reference of covered codes based on what chiropractors are allowed to perform within their state. Codes contained within this policy that may or may not require a prior authorization should be confirmed by accessing the Provider Look-up Tool on the CareSource website (www.procedurelookup.caresource.com).

VIII. The following are a list of codes that may be covered and do not require a prior authorization:
- A. Evaluation and management (E/M) codes (99202-99204, 99211-99214)
- B. 98940 – Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
- C. 98941 – Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
- D. 98942 – Chiropractic manipulative treatment (CMT); spinal, 5 regions
- E. 98943 – Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions
- F. X-rays (radiologic examination (RE)) for diagnostic purposes:
  1. 72020 – RE, spine, single view, specify level
  2. 72040 – RE, spine, cervical; 2 or 3 views
  3. 72050 – RE, spine, cervical; 4 or 5 views
  4. 72052 – RE, spine, cervical; 6 or more views
  5. 72070 – RE, spine; thoracic, 2 views
  6. 72072 – RE, spine; thoracic, 3 views
  7. 72074 – RE, spine; thoracic, minimum of 4 views

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8. 72080 – RE, spine; thoracolumbar junction, minimum of 2 views
9. 72081 – RE, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g., scoliosis evaluation); one view
10. 72082 – RE, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g., scoliosis evaluation); 2 or 3 views
11. 72083 – RE, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g., scoliosis evaluation); 4 or 5 views
12. 72084 – RE, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g., scoliosis evaluation); minimum of 6 views
13. 72100 – RE, spine, lumbosacral; 2 or 3 views
14. 72110 – RE, spine, lumbosacral; minimum of 4 views
15. 72114 – RE, spine, lumbosacral; complete, including bending views, minimum of 6 views
16. 72120 – RE, spine, lumbosacral; bending views only, 2 or 3 views
17. 72170 – RE, pelvis; 1 or 2 views
18. 72190 – RE, pelvis; complete, minimum of 3 views
19. 72200 – RE, sacroiliac joints; less than 3 views
20. 72202 – RE, sacroiliac joints; 3 or more views
21. 72220 – RE, sacrum and coccyx, minimum of 2 views
22. 73000 – RE; clavicle, complete
23. 73010 – RE; scapula, complete
24. 73020 – RE, shoulder; 1 view
25. 73030 – RE, shoulder; complete, minimum of 2 views
26. 73050 – RE; acromioclavicular joints, bilateral, with or without weighted distraction
27. 73501 – RE, hip, unilateral, with pelvis when performed; 1 view
28. 73502 – RE, hip, unilateral, with pelvis when performed; 2-3 views
29. 73503 – RE, hip, unilateral, with pelvis when performed; minimum of 4 views
30. 73521 – RE, hips, bilateral, with pelvis when performed; 2 views
31. 73522 – RE, hips, bilateral, with pelvis when performed; 3-4 views
32. 73523 – RE, hips, bilateral, with pelvis when performed; minimum of 5 views
33. 73551 – RE, femur; 1 view
34. 73552 – RE, femur; minimum 2 views

IX. Codes that may be covered but require a prior authorization:
   A. 97010 – hot or cold packs
   B. 97012 – traction
   C. 97014 – electrical stimulation
   D. 97035 – ultrasound
   E. 97139 – unlisted therapeutic procedure
   F. 97140 – manual therapy technique

X. Exclusions/services not covered for Chiropractors:
   A. 20560 – needle insertion(s) without injection(s); 1 or 2 muscle(s)-dry needling
   B. 20561 – needle insertion(s) without injection(s); 3 or more muscles-dry needling

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1. CareSource follows the Center for Medicare and Medicaid (CMS) analysis stating that acupuncture includes dry needling.
2. Acupuncture is not a covered benefit.

E. Conditions of Coverage
NA

F. Related Policies/Rules
Modifier 25 Reimbursement policy
Marketplace Plan Georgia Evidence of Coverage

G. Review/Revision History

	DATE	ACTION
Date Issued	08/03/2022	New policy
Date Revised	09/27/2023	Policy number changed from PY-1358. Updated references. Approved at Committee
Date Effective	01/01/2024	
Date Archived	04/30/2025	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References
1. Definitions, GA CODE ANN. § 43-9-1 (2023).
2. National Coverage Analysis: Acupuncture for Chronic Low Back Pain CAG-00452N. Medicare Coverage Database. January 21, 2020. Accessed August 7, 2023. www.cms.gov.
3. Scope of Practice, GA CODE ANN. § 43-9-16 (2023).
4. *Use of the AT Modifier for Chiropractic Billing*. US Centers for Medicare and Medicaid Services; 2019. MLN Matters Number SE1602. Accessed August 7, 2023. www.cms.gov

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