BlueCross BlueShield of Texas

Reimbursement Policy

Policy Number: RP016	**Policy Title:** Chiropractic Care Services
Approval Date: July 20, 2026	**Effective Date:** July 24, 2026

Policy Disclaimer

If a conflict arises between a Reimbursement Policy and any Plan document under which a member is entitled to covered services, the Plan document will govern. If a conflict arises between a reimbursement policy and any provider contract pursuant to which a provider participates in and/or provides covered services to eligible member(s) and/or plans, the provider's contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, Benefit Booklets, Summary Plan Descriptions and other coverage documents. Blue Cross and Blue Shield of Texas may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable Plan documents.

Providers are responsible for submitting accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology (CPT®) Assistant, Healthcare Common Procedure Coding System, ICD-10-CM and ICD-10-PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare & Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services and procedures billed. Claim submissions are subject to claim review, including but not limited to, any terms of benefit coverage, provider contract language, medical policies and reimbursement policies, as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Description

The practice of chiropractic care services focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. These services are provided on an inpatient or outpatient basis, within the scope of licensure and practice of a chiropractor, to the extent services would be covered if provided by a Medical Doctor or Chiropractor.

Definitions

Chiropractic Manipulative Treatment - CMT procedures use high-velocity, short-lever, low-amplitude thrust by hand or instrument to remove structural dysfunction in joints and muscles that may be associated with neurologic or mechanical dysfunction of the spinal joints and surrounding tissue.

There are two types of CMT:

- Spinal: manipulative treatment of cervical, thoracic, lumbar, sacral, and pelvic regions
- Extraspinal: manipulative treatment of the appendicular skeleton

Chiropractic Maintenance Care – Maintenance care and supportive care are not eligible for reimbursement. A maintenance program consists of activities that preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur. Ongoing treatment after a condition has been stabilized or reached a clinical plateau (Maximum Therapeutic Benefit) is considered maintenance care. Supportive therapy also refers to therapy that is needed to maintain or sustain level of function.

Providers of Chiropractic Services – Qualified providers of chiropractic services acting within the scope of their license that is regulated by applicable law. Only those healthcare practitioners who hold an active license, certification, or registration with the applicable state board or agency may provide services under the direction and supervision of a chiropractor. The scope and extent of such services, when provided as part of a chiropractic treatment plan and billed by the chiropractor, may be regulated by the applicable state board responsible for the licensure of the chiropractor. Non-qualified personnel that do not meet the definition of qualified healthcare professionals are limited to non-skilled services. They may not bill any direct treatments, modalities, or procedures.

Date of Injury- The actual date of the current injury. This information is entered in Box 14 of the CMS-1500 claim form.

Durable Condition Specific Benefit- A measurable improvement in or restoration of a functional impairment that resulted from a specific disease, trauma, congenital anomaly, or therapeutic intervention; and able to be sustained long-term without significant deterioration.

Exacerbation - An increase in severity of the patient's condition or symptoms.

Qualified Healthcare Professional - Is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.

Initial Treatment Date - The date of the initial treatment (visit). This information is entered in Box 15 (other date) of the CMS-1500 claim form.

Therapeutic Procedure - A manner of affecting change through the application of clinical skills and/or services that attempt to improve function.

Reimbursement Information

Providers are to document and bill appropriately for all services submitted. The Plan reserves the right to request supporting documentation. Failure to adhere to coding and billing policies may impact claims processing and reimbursement.

Chiropractors may not bill for any chiropractic manipulative treatment, constant attendance modalities, or therapeutic procedures, unless the services were directly performed by the chiropractor.

Documentation Standards

Records must:

- Indicate the dates any professional services were provided.
- List the direct one-on-one contact time spent for each timed code per CPT nomenclature.
- Be legible in both readability and content.
- Contain only those terms and abbreviations easily comprehended by peers of similar licensure.
- Include documentation showing the members' need for chiropractic care and any changes since the last visit
- Contain pertinent subjective information from the member. This includes the following:
    - Chief complaint
    - Any changes in the member's condition
    - Member's response to care since the previous visit
    - Member's subjective progress relative to the outcome measures documented in the treatment plan.
- Contain pertinent objective data or examination findings from your exam of the member.
- Indicate the initial diagnosis.
    - Each daily visit must also include an assessment of the member's condition.

    - Include the diagnosis being managed on the visit and the assessment of the overall progress.
- Document the treatment details performed during the visit including the medical rationale.
- A written plan of treatment relating to the type, amount, frequency, and duration of care is required for all members.
    - The plan of care must be updated as the members' condition changes.
    - The goal of the treatment plan should be to achieve functional improvements in the member's condition.
    - Each complaint should be listed with selected treatment, duration, frequency, treatment goals, and objective measures to evaluate progress.
- It is essential for the provider to document clinical findings and justify the medical necessity of care.

CMT Components

Pre-Service	A brief evaluation of the member's medical record documentation and chart review, imaging review, test interpretation, and care planning
Intra-Service	Treatment applied, Pre-manipulation (e.g., palpation, etc.), Manipulation, Post-manipulation (e.g., assessment, etc.)
Post-Service	Chart entry and documentation, including subjective, objective, assessment, plan consultation reporting

Diagnosis Codes

- ICD10-CM diagnosis codes are updated bi-annually in April and October.
- Some diagnosis codes require a 7th digit to code to the highest specificity.
- Update diagnosis and coding for every new episode, including a re-exam or an examination for a 'new' problem. Document any diagnosis coding change even if it is minor.
- Link the diagnosis to the service provided to support medical necessity and specificity. For example, when performing manual therapy with manipulation, the diagnosis pointer code(s) should point to the specific diagnosed condition that supports specific procedures billed. (Box 24E of the CMS-1500 claim form).

Evaluation and Management (E/M) Coding and CMT Codes

Billing an E/M code **with** a CMT code
To bill for an E/M service, the complete CPT guidelines must be met for each service. In general, it would be inappropriate to bill an office/outpatient E/M CPT code on the same encounter date as chiropractic manipulative treatments because CMT codes include a brief pre-manipulation assessment. There may be times when it would be appropriate, but it should not be routine.

Billing an E/M code **in place** of a CMT code
It would not be appropriate to bill an E/M code instead of a CMT code. It is required to bill the code that best describes the service rendered.

Chiropractic Manipulative Treatment (CPT codes 98940-98943)

Each CPT code reflects a specific number of regions, regardless of how many manipulations are performed in that region. For example:

- Chiropractic manipulation applied to C3 and C5 during the same visit represent treatment to only one region (cervical) and should be reported with CPT code 98940.

All CPT codes for CMT must have a supporting ICD-10-CM diagnosis code to justify the level of care provided. For example:

- When billing CPT code 98941, there must be ICD-10-CM codes that incorporate at least three different regions.

CPT Code	Description
98940	Chiropractic adjustment • 1-2 regions in the spinal region
98941	Chiropractic adjustment • 3-4 regions in the spinal region
98942	Chiropractic adjustment • 5 regions in the spinal region
98943	Non-spinal adjustment • 1 or more regions in the extraspinal regions

Additional Documentation

In addition to the documentation requirements listed above in the policy, documentation specific to billing CMT codes must include:

- Location of pain/condition for which treatment is being sought.
- The specific spinal regions adjusted, and the technique used.
- The response to the treatment/adjustment, including whether or not the pain/condition being treated increased, reduced, or eliminated the problem.
- Each manipulation reported must be related to the patient's complaints and a relevant symptomatic spinal or extraspinal level.

Diagnostic Imaging Services

The purpose of diagnostic imaging is to gain diagnostic information regarding the member in terms of diagnosis, prognosis, and therapy planning. Required standards for each imaging study must meet the following four standards:

- The study must be obtained based on clinical need.
- The study must be of sufficient diagnostic quality.
- There must be documented interpretation of the study to reach a diagnostic conclusion.
- The information from the study must be correlated with patient management.

The selection of patients for radiographic examination is based on the following criteria:

- The need for radiographic examination is based on history and physical examination findings.
- The potential diagnostic benefit of the radiographic examination is judged to outweigh the risks of ionizing radiation.
- Radiography is used to help the practitioner diagnosis pathology, identify contraindications to chiropractic care, identify bone and joint morphology, and acquire postural, kinematic, and biomechanical information.
- Routine radiography of patients as a screening procedure is not an appropriate practice except under public health guidelines.

Components of a Written Radiology Report

As a written record of the interpretive findings, the radiology report serves as an important part of the member's medical record and must contain the following items:

- Patient identification
- Location where studies were performed
- Study dates
- Types of studies

- Radiographic findings
- Diagnostic impressions
- Legible signature with professional qualifications included

Radiology reports may also include recommendations for follow-up studies and comments for further patient evaluation.

Additional Resources

Reimbursement Policy (formerly known as Clinical Payment and Coding Policy)

RP023 Modifier Reference Policy

CPCP024 Evaluation and Management Coding- Professional Provider

CPCP029 Medical Record Documentation

RP040 Physical Medicine and Rehabilitation Services

Medical Policy

THE803.010 Physical Therapy (PT) and Occupational Therapy (OT) Services

References

Policy History

Approval Date	Description
08/03/2018	New policy
06/25/2019	Annual Review
08/15/2019	Updated time-based codes verbiage due to regulatory changes.
09/25/2020	Annual Review, Disclaimer Update; Verbiage Update
12/16/2021	Annual Review
03/15/2023	Annual Review, Policy split, removed non-chiropractic services.
01/12/2024	Annual Review

06/13/2025	Annual Review; Grammatical and formatting updates; Sections revised- Documentation Standards: Bullet removed, and bullets revised; Coding Standards: Revised language; Diagnosis Codes: Additional month added; CPT Codes: E/M & CMT coding language; CMT code table added; Additional Resources and References updated.
07/20/2026	Annual Review