480-5-5-.18 **CHIROPRACTIC SERVICES**.

(1) **Initial Evaluation**

(a) An evaluation shall be performed to determine if a patient will benefit from chiropractic services.

(b) When a chiropractor examines a patient and an evaluation for chiropractic services is performed, the billing of the office visit shall include the initial evaluation.

(c) For acute cases, up to three (3) visits during the certification process may be allowed after the initial evaluation, if same day certification cannot be obtained. If subsequent pre-certification results in an adverse determination, reimbursement shall be allowed for the initial evaluation and up to three visits during the certification process, if medically necessary and the treatment is for a compensable injury.

(2) **Qualifications for Reimbursement**

(a) The patient's condition shall have the potential for restoration of function.

(b) The chiropractic care shall be specific for the improvement of the patient's condition.

(c) The chiropractic care shall be provided under a current written plan of care.

(3) **Plan of Care**

(a) A plan of care shall be developed and filed with the URE or employer/agent.

(b) The plan of care content, at a minimum, shall include, but may not be limited to, the following:

1. The potential degree of restoration and measurable goals;

2. The specific services to be provided including the estimated frequency and estimated duration of each; and

3. The estimated duration of the treatment regimen.

(c) The chiropractor shall be responsible for providing documentation of medical necessity to the URE or employer/ agent when there are questions regarding the extent of chiropractic services being provided or appropriateness of the treatment regimen.

(d) The plan of care shall be updated at least every
30 days, if goals and objectives as set out in the treatment plan are not being met, and the revised plan is approved by the URE or employer/agent.

(e) The appropriate CPT-4 procedure code shall be used when billing for an initial evaluation.

(4) **Manipulations**

(a) Definition of body areas for workers' compensation:

1. The "spine" shall be the posterior region of the trunk including the cervical, thoracic, lumbosacral, and sacroiliac areas;

2. The "upper extremity" shall be the upper limb including the shoulder, upper arm, elbow, forearm, wrist and hand; and

3. The "lower extremity" shall be the lower limb including the hip, thigh, knee, leg, ankle and foot.

(b) Billing for workers' compensation:

1. The appropriate CPT-4 procedure code shall be used when billing for a manipulation of one area; and

2. The appropriate CPT-4 procedure code shall be used when billing for manipulation of each additional area.

3. Manipulation codes may be billed at each visit but may not be billed in conjunction with an office visit or any other evaluation and management code.

4. The appropriate CPT procedure code may be used to bill for an office visit, but may not be used in conjunction with manipulation codes.

(c) Reimbursement:

1. No more than one visit per day for the purpose of manipulation(s) is recommended without prior certification;

2. Reimbursement for manipulation(s) is limited to two body areas (a combination of the spine and one extremity, or two extremities); and

3. Reimbursement for manipulation(s) shall be limited to the Maximum Fee Schedule for Chiropractors or mutual agreements pursuant to Code of Alabama, 1975, §25-5-314 for each area.

(5) **Modalities and Procedures**

(a) The following three body areas, or any portions thereof, shall be recognized for the provision of modalities and procedures:

1. The "trunk" shall be the entire body including the spine, excluding the head and limbs (Synonym: Torso); or

2. Any two extremities:

(i) An "upper extremity" shall be the upper limb including the shoulder, upper arm, elbow, forearm, wrist and hand.

(ii) A "lower extremity" shall be the lower limb including the hip, thigh, knee, leg, ankle and foot.

3. The head.

(b) Billing:

1. Single Modality/Procedure.

(i) The appropriate CPT-4 procedure code and the unique descriptor for each shall be used when billing for a single (one) modality or procedure to a single body area.

(ii) Billing for a single therapeutic procedure shall presume up to 15 minutes.

(iii) Physical medicine modalities that do not require direct (one-on-one) patient

contact by the provider are not billed and reimbursed on a time-oriented basis.

(iv) Medical necessity and actual treatment time shall be documented in the patient's record.

2. Multiple Body Areas

(i) When chiropractic services are billed for more than one body area, there shall be more than one diagnosis code and descriptor in Element 23 and the reference numbers 1, 2, 3, etc., shall be listed in 24D of the HCFA 1500.

(ii) When chiropractic services are provided to more than one body area, modifier-51 shall be added to the procedure code(s) billed for the additional body area.

(iii) Reimbursement

(I) No more than one visit per day for the purpose of chiropractic service is recommended without prior certification.

(II) Reimbursement for additional time shall be in accordance with the appropriate CPT-4 procedure code for each body area treated regardless of the procedure codes used for orthotics training, prosthetic training, therapeutic activities requiring direct patient contact by the provider or training in activities of daily living.

(III) Reimbursement for chiropractic services to a single body area shall be limited to the Maximum Fee Schedule for Chiropractors for the applicable procedure code or mutual agreement pursuant to Code of Alabama, 1975, §25-5-314.

(IV) Reimbursement for chiropractic services shall be limited to two body areas.

(V) The URE or employer/agent shall compare the billing with the plan of care to ensure that only the services that are itemized in the plan of care are reimbursed.

(VI) The CPT-4 procedure code for Hubbard Tank shall not be reimbursed unless full body immersion chiropractic service is medically necessary and prescribed.

(VII) All chiropractic care is subject to peer clinical review (Third Level Clinical Review) by a chiropractor, trained in utilization review principles, as specified in Rule 480-5-5-.06.

(6) **Re-evaluation**

(a) A re-evaluation of an established patient shall be reimbursed in addition to physical medicine only when:

1. There is a definitive change in the patient's condition;

2. The patient fails to respond to treatment;

3. The patient reaches maximum medical improvement or is ready for discharge; or

4. It is medically necessary to provide evaluation services over and above those normally provided during therapy services.

(b) The provider shall submit documentation with the HCFA 1500 to substantiate the medical necessity for the services over and above the evaluative services normally performed during chiropractic treatments.

(c) The appropriate CPT-4 procedure code shall be used when billing for a re-evaluation.

(7) **Tests and Measurements**

(a) Extremity Testing, Muscle Testing and Range of Motion Measurements shall be reimbursed only once in a 30-day period for the same body area.

(b) When two or more extremity testing, muscle testing and range of motion procedures are performed on the same day, reimbursement shall not exceed the Maximum Fee Schedule for Physicians for the procedure code for total evaluation of the body, including hands.

(c) The appropriate physical performance test or measurement procedure code shall be used when a physical performance test or measurement is performed by means of mechanical equipment.

(d) The physical performance test or measurement procedure code includes a printout of test results and separate reimbursement shall not be made under procedure code for analysis of information data stored in computer.

(8) **Diagnostic Imaging**

(a) A decision on whether or not to use diagnostic imaging studies shall be made following a carefully performed history, physical and regional evaluation, and consideration of cost/benefit/radiation exposure ratios. The decision shall be based on sound clinical reasoning and the likelihood that significant information may be obtained from the study regarding diagnosis, prognosis and therapy and shall be consistent with the pre-certification requirements of Rule 480-5-5-.08.

Author: Workers' Compensation Division
Statutory Authority: Code of Alabama, 1975, §25-5-293
History: Effective September 12, 1996