Washington State Department of
Labor & Industries
*Workers' Compensation Services*

**Payment Policies for Healthcare Services**
**Provided to Injured Workers and Crime Victims**

# Chapter 7: Chiropractic Services

## Effective July 1, 2016

**Link:** Look for possible **updates and corrections** to these payment policies at:

www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2016/

## Table of contents

**Page**


**Definitions** ..... **7-2**

**Payment policies:**

Chiropractic care visits ..... **7-4**

Chiropractic evaluation and management (E/M) services ..... **7-8**

Chiropractic independent medical exams (IMEs) and impairment ratings ..... **7-11**

Chiropractic radiology services (X-rays) ..... **7-13**

Complementary & preparatory services, and patient education or counseling ..... **7-14**

Physical medicine treatment ..... **7-15**

**More info:**

Related topics ..... **7-17**


CPT® codes and descriptions only are © 2015 American Medical Association

## Definitions

- **Body regions:** One of the factors contributing to clinical decision-making complexity for chiropractic care visits. (See definition of **clinical decision-making complexity**, below.) Body regions include:
  - Cervical (includes atlanto-occipital joint),
  - Thoracic (includes costovertebral and costotransverse joints),
  - Lumbar
  - Sacral
  - Pelvic (includes sacroiliac joint),
  - Extra-spinal (considered one region), which includes
    - Head (includes temporomandibular joint; doesn't include atlanto-occipital), *and*
    - Upper and lower extremities, *and*
    - Rib cage (doesn't include costotransverse and costovertebral joints).

- **Chiropractic care visits:** Office or other outpatient visits involving subjective and objective assessment of patient status, management, and treatment.

- **Clinical decision-making complexity:** The primary component influencing the level of care for a chiropractic care visit. Clinical complexity is similar to established patient evaluation and management services, but emphasizes factors typically addressed with treating workers. Factors that contribute to clinical decision-making complexity for injured workers include:
  - The current occupational condition(s),
  - Employment and workplace factors,
  - Non-occupational conditions that may complicate care of occupational condition,
  - Chiropractic intervention(s) provided,
  - Number of body regions manipulated (see definition of **body regions**, above),
  - Care planning and patient management,
  - Response to care.

  The number of body regions being adjusted is only one of the factors that may contribute to visit complexity.

  L&I defines clinical decision-making complexity according to the definitions for medical decision-making complexity in the Evaluation and Management Services Guidelines section of the CPT® book.


CPT® codes and descriptions only are © 2015 American Medical Association

- **Complementary and preparatory services:** Interventions used to prepare a body region for or facilitate a response to a chiropractic manipulation/adjustment. The application of heat or cold is considered a complementary and preparatory service.

- **CPT® code modifiers mentioned in this chapter:**

  **–22 Unusual services**

  Procedures with this modifier may be individually reviewed prior to payment. A report is required for this review. Payment varies based on the report submitted.

  **–25 Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure**

  Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

- **Established patient:** One who has received professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

  L&I uses the CPT® definition for established patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

- **New patient:** One who hasn't received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

  L&I uses the CPT® definitions for new patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

CPT® codes and descriptions only are © 2015 American Medical Association

# Payment policy: Chiropractic care visits

(See definition of **chiropractic care visits** in Definitions at the beginning of this chapter.)

## Prior authorization

Prior authorization for all types of conservative care, including chiropractic, is required when billing for:

- More than 20 office visits, *or*
- Visits that occur more than 60 days after the first date you treat the worker (see WAC 296-20-03001(1)).

## Services that can be billed

Local codes **2050A**, **2051A**, and **2052A** can be billed. These codes account for both professional management (clinical complexity) and technical service (manipulation and adjustment). There are three levels of chiropractic care visits:

| The primary component is **clinical decision-making.** If it is… | and the typical **number of body regions** adjusted or manipulated is… | and typical **face-to-face time** with patient or family is… | Then the **appropriate billing code** and maximum fee is… |
|---|---|---|---|
| Straightforward | Up to 2 | Up to 10-15 minutes | **2050A** (Level 1) **$43.85** |
| Low complexity | Up to 3 or 4 | Up to 15-20 minutes | **2051A** (Level 2) **$56.17** |
| Moderate complexity | Up to 5 or more | Up to 25-30 minutes | **2052A** (Level 3) **$68.44** |

**Note:** See more information on **Clinical decision-making complexity** in Definitions (at the beginning of this chapter) and Examples of chiropractic care levels of complexity (below).


CPT® codes and descriptions only are © 2015 American Medical Association

## Services that aren't covered

CPT® chiropractic manipulative treatment (CMT) codes (**98940** – **98943**) aren't covered.

Instead of using CMT codes, L&I collaborated with the Washington State Chiropractic Association and the University of Washington to develop the local codes that can be billed for chiropractic care visits (see Services that can be billed, above).

## Requirements for billing

When billing **modifier –22** with chiropractic care visit local codes (**2050A-2052A**), submit a report detailing the nature of the unusual service and the reason it was required. The report will be reviewed individually, and payment will vary based on the review findings.

**Note:** See Payment limits for **modifier –22**, below.

## Payment limits

Only one chiropractic care visit per day is payable.

Evaluation and management (E/M) office visit CPT® codes (**99201-99204**, **99211-99214**) are payable in addition to chiropractic care visit codes only when all of the following conditions are met:

- The E/M service is for the initial visit on a new claim, *and*
- The E/M service is a significant, separately identifiable service (it goes beyond the usual pre- and post-service work included in the chiropractic care visit), *and*
- **Modifier –25** is added to the E/M code, *and*
- Supporting documentation describing both the E/M and the chiropractic care services is in the patient's record.

**Note:** See the Prior authorization requirements and Payment limits under the Chiropractic evaluation and management (E/M) services section of this chapter.

Extra-spinal manipulations aren't billed separately (extremities are considered to be one body region). (See definition of **body regions** in Definitions at the beginning of this chapter.)

**Modifier –22** isn't payable when used for non-covered or bundled services (for example, application of hot or cold packs).

CPT® codes and descriptions only are © 2015 American Medical Association

When a patient requires re-evaluation for an existing claim:

- An **established patient** E/M code is payable, *or*
- A chiropractic care local code (**2050A**, **2051A**, or **2052A**) is payable, *and*
- **Modifier –25** doesn't apply.

**Note:** See definition of **established patient** in Definitions at the beginning of this chapter.

## Examples of chiropractic care levels of complexity

These examples are for illustration only and aren't clinically prescriptive:

| **Level 1:** | **Straightforward clinical decision-making** (billing code **2050A**) |
|---|---|
| Patient | 26 year old male. |
| Cause of injury | Lifted a box at work. |
| Symptoms | Mild, low back pain for several days. |
| Treatment | Manipulation or adjustment of the lumbar region, anterior thoracic mobilization, and lower cervical adjustment. |

| **Level 2:** | **Low complexity clinical decision-making** (billing code **2051A**) |
|---|---|
| Patient | 55 year old male, follow-up visit. |
| Cause of injury | Slipped and fell on stairs while carrying heavy object at work. |
| Symptoms | Ongoing complaints of neck and low back pain. New sensation of periodic tingling in right foot. Two days off work. |
| Treatment | Discuss need to minimize lifting and getting assistance when carrying heavier objects. Five minutes of myofascial release prior to adjustment of the cervical, thoracic, and lumbar regions. |

| **Level 3:** | **Moderate complexity clinical decision-making** (billing code **2052A**) |
|---|---|
| Patient | 38 year old female, follow-up visit. |
| Cause of injury | Moved heavy archive boxes at work over the course of three days. |
| Symptoms | Headache, right anterior rib pain, low back pain with pain at the sacrococcygeal junction, pain in the sacroiliac regions, and right-sided foot drop. Obesity and borderline diabetes. Tried light-duty |


CPT® codes and descriptions only are © 2015 American Medical Association

| | |
|---|---|
| | work last week, but unable to sit for very long, went home. Tried prescribed stretching from last visit, but worker couldn't continue and didn't stretch because of pain. |
| Treatment | Review MRI report with the worker. 10 minutes of moist heat application, 10 minutes of myofascial work, and manipulation/ adjustment to the cervical and atlanto-occipital, thoracic, anterior rib area, lumbar, sacroiliac, and sacrococcygeal regions. |

CPT® codes and descriptions only are © 2015 American Medical Association

# Payment policy: Chiropractic evaluation and management (E/M) services

## Prior authorization

Prior authorization is required when billing for:

- More than 20 office visits, *or*
- Visits that occur more than 60 days after the first date you treat the worker (see WAC 296-20-03001(1)).

Chiropractic consultation requires prior notification to the department or self-insurer (see WAC 296-23-195).

## Who must perform these services to qualify for payment

Only an L&I-approved chiropractic consultant can perform office consultation services to qualify for payment.

**Link:** For more information about consultations, a list of approved chiropractic consultants, and information about becoming a chiropractic consultant, go to: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/BySpecialty/ChiroSvcs.asp

## Services that can be billed

### Case management services

Codes and billing instructions for case management services telephone calls, team conferences, and secure email can be found in the Case management services section of Chapter 10: Evaluation and Management. These codes may be paid in addition to other services performed on the same day.

### Chiropractic consultations

Approved consultants may bill the first four levels of CPT® office consultation codes.


CPT® codes and descriptions only are © 2015 American Medical Association

### Chiropractic office visits

Chiropractic physicians may bill the first four levels of office visit codes for new and established patients.

**Note:** For complete code descriptions, definitions, and guidelines, refer to a CPT® book.

**Link:** Fees appear in the Professional Services Fee Schedule available at: http://feeschedules.Lni.wa.gov

## Payment limits

A **new patient** E/M office visit code is payable only once for the initial visit. (See definitions of **new patient** and **established patient** in Definitions at the beginning of this chapter.)

An **established patient** E/M office visit code isn't payable on same day as a new patient E/M.

**Modifier –22** isn't payable with E/M office visit codes for chiropractic services.

For follow-up visits, E/M office visit codes aren't payable in addition to L&I chiropractic care visit codes.

Chiropractic E/M office visits are only payable on the same date as a chiropractic care visit when all of the following are met:

- It is the first visit on a new claim, *and*
- The E/M service is a significant, separately identifiable service (it goes beyond the usual pre- and post-service work included in the chiropractic care visit), *and*
- **Modifier –25** is added to the E/M code, *and*
- The patient's record contains supporting documentation describing both the E/M and the chiropractic care services.

**Note:** Refer to the Chiropractic care visits section of this chapter for policies about the use of E/M office visit codes with L&I codes for chiropractic care visits.

CPT® codes and descriptions only are © 2015 American Medical Association

## Additional information: Chiropractic consultations

L&I periodically publishes:

- A policy on consultation referrals, *and*
- A list of approved chiropractic consultants.

**Link:** For more information on this topic, including current policy, a list of approved consultants, and information on how to become an approved chiropractic consultant, go to:

www.Lni.wa.gov/ClaimsIns/Providers/AuthRef/SecondOpinion.asp.


CPT® codes and descriptions only are © 2015 American Medical Association

# Payment policy: Chiropractic independent medical exams (IMEs) and impairment ratings

## Prior authorization

Prior authorization is only required when an IME is scheduled. To get prior authorization for claims that are:

- **State Fund**, use L&I's secure, online Claim & Account Center to see if an IME is scheduled. To set up an account, go to: www.Lni.wa.gov/ORLI/LoGon.
- **Self-Insured**, contact the self-insured employer (SIE) or their third party administrator (TPA). For a list of SIE/TPAs, go to: www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/.
- **Crime victims**, call **1-800-762-3716**.

## Who must perform these services to qualify for payment

Only an L&I-approved IME examiner can perform chiropractic IMEs or impairment ratings to qualify for payment.

For an impairment rating, an attending chiropractic physician may:

- Perform the rating on their own patients if the physician is an approved IME examiner, *or*
- Refer to an approved IME examiner for a consultant impairment rating.

**Link:** For more information, see Chapter 12: Impairment Rating Services

## Services that can be billed

Use the CPT® codes, local codes, and the payment policy for IMEs described in Chapter 13: Independent Medical Exams (IME).

CPT® codes and descriptions only are © 2015 American Medical Association

## Additional information: Becoming an approved IME examiner

To apply for approval, chiropractic physicians must complete:

- Two years as an approved chiropractic consultant, *and*
- Impairment rating course approved by the department.

The department approved impairment rating course and the Chiropractic Consultant Seminar are offered as part of the Chiropractic Consultation Program.

**Links**: For more information, refer to:

- L&I's Chiropractic Consultation Program webpage, *and*
- IME and impairment rating guidelines, sample reports, and billing procedures as explained in the **Medical Examiners' Handbook** (publication F252-001-000), available at: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1668.


CPT® codes and descriptions only are © 2015 American Medical Association

# Payment policy: Chiropractic radiology services (X-rays)

## Prior authorization

**Required:**

X-rays after the initial study require prior authorization.

**Not required:**

X-rays are allowed without prior authorization when:

- Medically necessary, *and*
- Performed immediately prior to and following the initial chiropractic adjustment.

## Who must perform these services to qualify for payment

Chiropractic physicians in the network may bill for radiographs taken as allowed under their license. It is required that a written x-ray report of radiologic findings and impressions be included in the patient's chart.

Only chiropractic physicians on L&I's list of approved radiological consultants may bill for X-ray consultation services. A chiropractic physician must be a Diplomat of the American Chiropractic Board of Radiology and must be approved by L&I to become an approved radiological consultant.

## Services that can be billed

Chiropractic physicians must bill diagnostic X-ray services using CPT® radiology codes and the Requirements and Payment limits described in Chapter 26: Radiology Services.

CPT® codes and descriptions only are © 2015 American Medical Association

# Payment policy: Complementary & preparatory services, and patient education or counseling

(See definition of **complementary & preparatory services** in Definitions at the beginning of this chapter.)

## Payment limits

Chiropractic physicians aren't paid separately for:

- Complementary and preparatory services, *or*
- Patient education or counseling.

## Example of complementary & preparatory services

The application of heat or cold is an example of a complementary and preparatory service.

## Examples of patient education or counseling services

Patient education or counseling includes discussing or providing written information about:

- Lifestyle, *or*
- Diet, *or*
- Self-care and activities of daily living, *or*
- Home exercises.


CPT® codes and descriptions only are © 2015 American Medical Association

# Payment policy: Physical medicine treatment

**Note:** Includes powered traction devices.

## Services that can be billed

Use local code **1044M** for physical medicine modalities or procedures (including the use of traction devices) by attending provider not board certified/qualified in Physical Medicine and Rehabilitation (PM&R).

**Link**: For more information, see Chapter 25: Physical Medicine Services

## Services that aren't covered

CPT® physical medicine codes (**97001** – **97799**) aren't payable to chiropractic physicians.

## Requirements for billing

Documentation of the visit must support billing for local code **1044M**.

## Payment limits

Local code **1044M** is limited to six units per claim, except when the attending provider practices in a remote location where no licensed physical therapist is available.

After six units, the patient must be referred to a licensed physical or occupational therapist, or physiatrist for such treatment except when the attending provider practices in a remote location. (Refer to WAC 296-21-290 for more information.)

Only one unit of the appropriate billing code will be paid per visit, regardless of the length of time the treatment is applied.

The insurer won't pay any additional cost when powered traction devices are used. This policy applies to all FDA-approved powered traction devices.

**Note**: Published literature hasn't substantially shown that powered traction devices are more effective than other forms of traction, other conservative treatments, or surgery. Powered traction devices are covered as a physical medicine modality under existing physical medicine payment policy. When powered traction is a

proper and necessary treatment, the insurer may pay for powered traction therapy administered by a qualified provider.

**Link:** For additional information, see powered traction therapy in Chapter 25: Physical Medicine Services.


CPT® codes and descriptions only are © 2015 American Medical Association

## Links: Related topics

| If you're looking for more information about… | Then go here: |
|---|---|
| **Administrative rules** for physical medicine | Washington Administrative Code (WAC) 296-21-290: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-21-290 |
| **Becoming an L&I provider** | L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/ |
| **Billing** instructions and forms | Chapter 2: Information For All Providers |
| **Chiropractic Services** including Industrial Insurance Chiropractic Advisory Committee, practice, training, consultation resources | L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/BySpecialty/ChiroSvcs.asp |
| **Fee schedules** for all healthcare professional services (including chiropractic) | L&I's website: http://feeschedules.Lni.wa.gov |
| Payment policies for **case management services** | Chapter 10: Evaluation and Management Services |
| Payment policies for **diagnostic X-ray services** | Chapter 26: Radiology Services |
| Payment policies for **durable medical equipment (DME)** | Chapter 9: Durable Medical Equipment |
| Payment policies for **IMEs** | Chapter 13: Independent Medical Exams (IMEs) |
| Payment policies for **impairment ratings** | Chapter 12: Impairment Rating Services |
| Payment policies for **physical medicine treatment** or **powered traction therapy** | Chapter 25: Physical Medicine Services |
| Payment policies for **supplies** | Chapter 28: Supplies, Materials, and Bundled Services |

- **Need more help?** Call L&I's Provider Hotline at **1-800-848-0811**

CPT® codes and descriptions only are © 2015 American Medical Association