Chiropractic Services Professional Payment Policy

Applies to the following CarePartners of Connecticut products:

- ☒ CareAdvantage Premier
- ☒ CareAdvantage Prime
- ☒ CareAdvantage Preferred
- ☒ CarePartners Access

The following payment policy applies to providers who render chiropractic services to members of the CarePartners of Connecticut plans selected above.

In addition to the specific information contained in this policy, providers must adhere to the policy information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

Policy

CarePartners of Connecticut covers medically necessary chiropractic services, in accordance with the member's benefits.

General Benefit Information

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting CarePartners of Connecticut Provider Services at 888-341-1508.

Referral/Prior Authorization/Notification Requirements

Certain procedures, items and/or services may require prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Prior Authorization and Notification Policy.

No referrals, prior authorizations or inpatient notifications are required for in-network chiropractic services. Referrals are required for out-of-network services rendered for HMO members.

Billing Instructions

Unless otherwise stated, CarePartners of Connecticut follows industry-standard coding guidelines. Refer to current industry-standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

During the course of a single visit, submit the following procedure codes with manipulation treatment, an initial evaluation or an established patient visit, when appropriate.

Evaluation and Management Services

- 99202-99205: Office visit for initial evaluation and management (E&M) of a new patient

Chiropractic Manipulative Treatment (CMT)

- 98940: CMT, spinal, one to two regions
- 98941: CMT, spinal, three to four regions
- 98942: CMT, spinal, five regions

The AT modifier must be submitted to indicate active/corrective treatment has been performed; claims billed without the AT modifier will be considered maintenance therapy and will deny.

The primary diagnosis code must indicate the precise level of subluxation. The secondary diagnosis code(s) should indicate symptoms/conditions (i.e., the neuromusculoskeletal condition necessitating treatment).

Compensation/Reimbursement Information

Providers are compensated according to the applicable contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For more information, refer to the Professional Services and Facilities Payment Policy.

Chiropractic Manipulation and Evaluation and Management Services

Compensation for evaluation and management (E&M) services are included in chiropractic manipulation services; however, CarePartners of Connecticut will consider reimbursement for the E&M service if the appropriate modifier is appended to the procedure code to indicate that the service is distinct and separately identifiable.

X-Rays Taken in an Office Setting

Chiropractors may be eligible for compensation of medically necessary x-rays taken in their office. Prior to initiating x-ray services, verify the member's benefit specifics and refer to the provider's health services agreement for contracted radiology codes.

Additional Resources

- Evaluation and Management Services

Document History

- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- September 2020: Policy reviewed by committee; added existing AT modifier and required diagnosis billing instructions
- January 2019: Policy created

Audit and Disclaimer Information

CarePartners of Connecticut reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance. For more information about CarePartners of Connecticut's audit policies, refer to the CarePartners of Connecticut public Provider website.

This policy provides information on CarePartners of Connecticut claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.