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Coding Guidance

Chiropractic Manipulative Treatment

Introduction
The American Chiropractic Association (ACA) receives numerous requests for clarification regarding chiropractic manipulative treatment (CMT). In response to common questions, this guidance addresses key concepts related to CMT coding. This information is for educational purposes only, and the application may vary from one third-party payer to another. Providers should consider any laws, regulations, payer-specific policies, or contractual obligations that apply to each individual encounter.

Definition
Chiropractic manipulative treatment (CMT) describes a variety of manual treatment techniques that are performed to influence joint and neurologic function.[13,14,15,17] These manual treatments may involve the assistance of a hand-held device.[12,14,15,16]

In addition to the manipulation, the CMT codes include other preservice, intraservice, and postservice work.[4,7,17] For example, the CMT codes may include the review of prior records, an assessment of current levels of pain and function, explaining the procedure to the patient, and obtaining informed consent.[7]

For coding purposes, CMT can be performed in five spinal regions and five extraspinal regions. [14,15,17]

Spinal CMT Regions	Extraspinal CMT Regions
Cervical (including the atlanto-occipital joint)	Head (including temporomandibular joint, excluding atlanto-occipital)
Thoracic (including the costovertebral and costotransverse joints)	Rib cage (excluding costotransverse and costovertebral joints)
Lumbar	Lower extremities
Sacral	Upper extremities
Pelvic (sacro-iliac joint)	Abdomen

Application
Code Selection
While third-party payer policies regarding code selection may differ, four CPT codes are generally used to report CMT.[17]

Code	Code Description
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions
98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions

Both spinal and extraspinal manipulation may be billed on the same visit when appropriate.

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Providers should only bill one spinal CMT code (98940-98942) per encounter. Spinal CMT code selection is based on the number of regions receiving CMT during the encounter. [5] The number of spinal regions treated on each visit often varies throughout a single episode of care since changes in the patient's clinical presentation impact clinical decision making at each encounter. The documentation and diagnosis codes should support the medical necessity for CMT in all billed regions on each date of service.

It is important to recognize that the number of regions treated may differ from the number of motion segments adjusted. For example, CMT applied to C3. C4, T3, T4, and T6 involves the manipulation of five different vertebral motion units but only affects two spinal regions (cervical and thoracic). Since manipulation to those five segmental levels is only performed in two regions, the appropriate CPT code for CMT is 98940 (Chiropractic manipulative treatment (CMT); spinal, 1-2 regions).[5]

Extraspinal CMT (98943) is billed once per encounter regardless of how many extraspinal joints or regions are treated during the encounter. Medicare does not cover extraspinal CMT. [9, 12,13,14,15] Also, the AMA's CPT Assistant clarifies that modifier 51 should not be appended to extraspinal CMT.[6]

Common CMT Modifiers

Modifiers are two-character codes that are appended after a CPT or HCPCS code to respond to payment policies or to report that a service or procedure has been altered but not changed by some specific circumstance.[17] The following modifiers that are commonly used with CMT codes:

Modifier	Description	Additional Information
AT	Acute treatment (this modifier should be used when reporting service 98940, 98941, 98942)[1,10,11,13,14]	For Medicare and some other payers, chiropractors must append modifier AT to a CMT code when providing active/corrective treatment.[10,11, 12,13,14,16]
GA	Waiver of liability statement issued as required by payer policy, individual case[1,8,10,11]	For Medicare, providers should append modifier GA when they issue a valid ABN to inform the beneficiary that Medicare does not cover maintenance CMT. Providers do not need to send the ABN with the claim, but they must keep it on file and provide it if requested.[8,10,11]
GZ	Waiver of liability statement issued as required by payer policy, individual case[1,8,10,11]	Providers should append modifier GZ to CMT codes when they expect Medicare to deny maintenance CMT and they did not issue an ABN as required. [8,10,11]

Maintenance CMT

Medicare policies state, "Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy."[13,14,16]

While third-party payer coding requirements and definitions of maintenance CMT may vary, there are two common ways to code for maintenance CMT:

- HCPCS Level II code S8990 represents "Physical or manipulative therapy performed for maintenance rather than restoration". [1] Providers should not use S8990 on Medicare claims since it is a "non-Medicare" code.[1]
- For Medicare claims for maintenance CMT, providers can utilize 98940-98942 but should not append modifier AT. [10,11, 12,13,14,16] Providers should instead append modifier GA or GZ to indicate if an ABN was issued as required for maintenance CMT.[10,11]

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Other Key Concepts

- While chiropractic manipulation using a hand-held instrument may still be reimbursable by third-party payers, payers generally do not provide additional reimbursement for the devices. [12,13 ,16]
- Third-party payers may classify some CMT treatment techniques as non-covered services if the payer deems them to be experimental or investigational.
- While the CMT codes include a pre-manipulation patient assessment, additional evaluation and management (E/M) services may be separately reported if they are significant and separately identifiable from the CMT service. [7,17] The significant and separately identifiable E/M service may be related to the same symptoms that prompted the CMT treatment on that visit and may be billed for the same diagnosis code.[17] When appropriate, providers may use modifier 25 to indicate that the patient's condition required this significant and separately identifiable E/M service that exceeded the usual preservice and post-service work associated with the CMT.[7,17] ACA members can find additional information on the use of modifier 25 in the ACA coding guidance on CMT and E&M Reimbursement Solutions.
- Manual therapy (97140) is not separately reimbursable when performed in the same body area as CMT. When appropriate, modifier 59 or XS can be appended to the manual therapy code to indicate that the provider performed CMT and manual therapy in separate body areas.[2,3,5] ACA members can find additional information on billing CMT and manual therapy on the same date in the ACA coding guidance on the CPT® Position on the Proper Use of Procedure Code 97140 and Procedure Code 97140.

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