Chiropractic Services

Reimbursement Policy ID: RPC.0052.5420

Recent review date: 01/2026

Next review date: 12/2026

Healthy DC reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Healthy DC may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy provides an overview of reimbursement limitations for chiropractic services based on plan coverage. Chiropractic care provides members with services for manual manipulation of the spine to correct a dislocation that has resulted in a neuromusculoskeletal condition.

Exceptions

N/A

Reimbursement Guidelines

Chiropractic manipulation (98940-98942) may be denied when billed without a primary diagnosis of vertebral subluxation and a secondary diagnosis for the symptoms associated with the diagnosis of subluxation. Chiropractic manipulative treatment (98940-98943) will be denied when billed more than once per day by any provider.

Per CPT guidelines, "Chiropractic manipulative treatment codes (98940-98942) include a pre-manipulation patient assessment. Additional evaluation and management (E/M) services may be reported separately using modifier 25, if the patient's condition requires a significant, separately identifiable E/M service, above and beyond the usual pre-service and post service work associated with the procedure." Refer to policy RPC.0009.5420 Significant, Separately Identifiable Evaluation and Management Service (Modifier 25).

CPT 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

Evaluation and Management Codes

CPT Code	Code Description
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99201	Office or other outpatient visit for the evaluation and management of a new patient, self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient, low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient, moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.

99204	Office or other outpatient visit for the evaluation and management of a new patient, moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
99205	Office or other outpatient visit for the evaluation and management of a new patient, moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.

Non-covered services include:

- Laboratory tests
- X-rays
- Physiotherapy
- Traction
- Supplies
- Injections
- Drugs
- EKGs or any diagnostic study
- Orthopedic devices
- Nutritional supplements/counseling
- Any service ordered by the chiropractor

Definitions

Vertebral subluxation
One or more vertebrae in the spine become misaligned, compressing spinal nerves and disturbing optimal nerve function.

Edit Sources

I. Current Procedural Terminology (CPT).
II. Healthcare Common Procedure Coding System (HCPCS).
III. International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM), and associated publications and services.
IV. Centers for Medicare and Medicaid Services (CMS).
V. District of Columbia Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

RPC.0009.5420 Significant, Separately Identifiable Evaluation and Management Service (Modifier 25)

Policy History

12/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of policy implemented by Healthy DC from Policy History section
01/2023	Template Revised • Revised preamble

	• Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section