Dynamic Chiropractic

BILLING / FEES / INSURANCE

Insurance Waivers and Maintenance Treatment

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Q: I have a patient whose insurance carrier placed a waiver on their "spine" due to prior treatment the patient had received in this office. My concern is that my current treatment is not for a specific condition, but simply maintenance, and as my patient puts it, to "feel good." This patient requested an adjustment about two times per month and I never had a specific diagnosis other than simple misalignment. I wrote to the carrier on the patient's behalf and stated that he did not have any spine or back conditions that required a diagnosis and simply was getting treatment for maintenance. The insurer contented that his treatment, as I reported under the manipulation code 98942, was for a back condition. I further disputed it, but to no avail. Is there a code or a way to be sure my treatment is reflected as maintenance? I have looked in all my coding references and found nothing.

A: Waivers are certainly a consumer problem that is at the forefront of the current health insurance reform debates, and a practice that certainly limits individuals who have non-coverage for specific conditions or body parts. On the positive side, since the implementation of HIPAA, waivers are essentially not allowed when the insured is part of a group - an employer-sponsored health plan or other group plan. Your patient almost certainly has an individual health plan, which means the insurer can place waivers for past health conditions.

As part of the underwriting process, an individual plan insurer will request records from all the doctors the potential insured has seen. In this case, your records reflected chiropractic manipulation of the patient on a regular basis. This treatment, in the insurance company's opinion, was deemed reflective of a pre-existing back condition.

Your 98942 coding is a correct code for spinal manipulation for all five spine regions. It indicates specific chiropractic treatment and is the code to use when billing insurance for a diagnosed condition. The insurance company interprets its use for the correction of a specific problem and not for maintenance, as you noted. There is a HCPCS (Healthcare Common Procedure Coding System) code specific to services that are not for correction, but for maintenance. The code is S8990 and is defined as "physical or manipulative therapy done for maintenance and not correction." Therefore, use of this code instead of a CMT directly indicates there was no treatment for a diagnosed condition, but rather that the treatment was for maintenance only.

When coding in the file and on the patient receipt, use this code, as it clearly indicates per the coding nomenclature that the services were maintenance. Using your normal CMT code of 98940-98942 does not do this.

Additionally, I would be sure the chart notes specifically indicate the maintenance nature of the treatment in a clear manner so the insurer does not misinterpret it as something other than a service of convenience and comfort. Another potential positive use of the S8990 code and service is that it is a different service from a CMT provided for correction, allowing a provider to offer a different or reduced price from their normal CMT treatment cost, since it is a different service and code. This could allow patients greater access to regular chiropractic, because it could be more affordable when they choose to get manipulation not to treat a specific problem, but rather to

potentially prevent one from manifesting.

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