Alternative care overview

This section includes billing guidelines and treatment information for alternative care providers including:

- Acupuncturists/East Asian medicine practitioners
- Chiropractic physicians
- Licensed massage therapist
- Naturopathic physicians
- Nutritionists/dieticians

Additional information about provider types is available on our provider website at **regence.com**: Contracting and Credentialing>Provider Types.

Additional information about submitting all claims is available in the Claims Submission section on our website: Claims and Payment>Claims Submission.

The following treatment plan information applies to all alternative care provider types listed above:

Treatment plans

Treatment plans and progress notes may be requested for selected members. We reserve the right to review past records and claims submissions.

Fully documented treatment plans must include:

- Physician prescription or referral, if applicable
- Appropriate and legible chart note documentation
- Progress reports and/or notes which document the following:
    - Diagnosis or diagnoses must support the level of care provided.
    - Medical necessity of the care provided must be demonstrated and may be subject to review.
    - Procedures performed must be within the scope of license, as defined by either the Revised Code of Washington, Washington Administrative Code, or the governing quality assurance commission.

The guidelines in this section are subject to the employer group or Individual plan benefits and may not apply to every member. Please access the Availity Portal to obtain eligibility, benefit and claims information.

In this administrative manual, “Regence” refers to the following: Regence BlueShield of Idaho, Regence BlueCross BlueShield of Oregon, Regence BlueCross BlueShield of Utah, and Regence BlueShield (in select counties of Washington). When information does not apply to all these plans across the four states, then this administrative manual will identify the plan(s) or state(s) to which that specific information applies.

Acupuncturists/East Asian medicine practitioners

Billing guidelines

All claims must include the International Classification of Diseases, Tenth Revision (ICD-10) **and** CPT codes to ensure accurate processing. The diagnosis must match the diagnosis of the referring physician.

When billing for acupuncture services, please use:

- **CPT 97810** Acupuncture, one or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with patient
- **CPT 97811** Acupuncture, one or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with reinsertion of needle(s) (List separately in addition to code for primary procedure)
- **CPT 97813** Acupuncture, one or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with patient
- **CPT 97814** Acupuncture, one or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with patient, with reinsertion of needle(s) (List separately in addition to code for primary procedure)

CPT 97810 and 97813 will not be allowed when billed together for the same visit.

Only one unit of service for CPT 97810 and 97813 is allowed per date of service, up to the benefit maximum. CPT 97811 and 97814 must be explicitly denoted in the patient's medical record to be allowed.

Eight-minute rule for timed codes – one service

For services billed in 15-minute units, count the minutes of skilled treatment provided. Only direct, face-to-face time with the patient is considered for timed codes.

- 7 minutes or less of a single service is not billable.
- 8 minutes or more of a single service is billable as 1 unit or an additional unit if the prior units were each furnished for a full one.

15 minutes:

- 8-22 minutes = 1 unit
- 23-37 minutes = 2 units
- 38-52 minutes = 3 units

Note: Evaluation and management (E&M) codes cannot be used as a substitute for acupuncture treatments.

Chiropractic-only rehabilitation modalities and procedures

Rehabilitative medicine that is within the scope of license of a provider and provided independent of acupuncture services may be allowed in accordance with contract language and limitations specific to the member's rehabilitation benefit.

Acupuncture for the treatment of chemical dependency

A participating acupuncturist/east Asian medicine practitioner will be reimbursed for acupuncture services provided for chemical dependency treatment when the member's plan includes a benefit for both acupuncture services and chemical dependency treatment.

Acupuncture treatment for chemical dependency is covered in the following instances:

- When the member's plan covers acupuncture
- Diagnosis supports chemical dependency benefits
- When smoking cessation is covered under some plans
- If required by the member's plan, a referral by the member's primary care physician or by the contracted behavioral health department organization has been filed with Regence

Chiropractic physicians

Chiropractic care may include the following:

- E&M services
- Diagnostic radiology services
- Rehabilitation modalities and procedures
- Extraspinal manipulation (CMT, extraspinal)
- Spinal manipulations (chiropractic manipulative treatment [CMT], spinal)

Billing guidelines

Most products cover services performed by a chiropractor under the outpatient rehabilitation benefit. Therefore, these services are subject to the outpatient rehabilitation benefit contract requirements and limitations.

- All services performed during an encounter must be billed.
- E&M codes are not allowed as a substitute for rehabilitation modality and procedure CPT codes.
- E&M and other CPT codes are not allowed as a substitute for spinal or extraspinal manipulation codes when spinal or extraspinal CMT is performed.
- All licensed providers must bill for any and all services they perform under their own name. A chiropractor may not submit claims for services performed by another licensed provider.
- Procedures performed must be within the scope of license, as defined by either the Revised Code of Washington, Washington Administrative Code or the governing quality assurance commission.

Diagnosis codes

The diagnosis must be as specific as possible and must be substantiated by the patient's medical records. We require diagnosis codes that correspond to each spinal and extra-spinal region billed. For example, if you bill CPT 98941 with CPT 98943, we require separate diagnosis codes that correspond to the specific regions billed. Documentation must support each region billed.

Evaluation & management (E&M) services

An initial office visit can be billed in addition to the chiropractic treatment when the member is seen for the first time.

Documentation must support a significant and separately identifiable E&M service; that is, the E&M procedure must be distinct and independent of the additional or other services.

Medical records to support the additional E&M services may be requested.

The appropriate modifier (25) must be used if the patient's condition requires a significant separately identifiable E&M service. View the policy about this modifier on our website: Library>Policies and Guidelines.

According to the *Coding Guidelines in the Current Procedural Coding Expert* manual, the Instructions for Selecting a Level of E&M Service section states in part:

> The descriptions of the levels of E&M services recognize seven components, six of which are used in defining the levels of E&M services. These components are:
>
> - History
> - Examination
> - Medical decision making
> - Counseling
> - Coordination of care
> - Nature of presenting problem
> - Time
>
> The first three of these components (history, examination and medical decision making) should be considered the key components in selecting the level of E&M services.

We review documentation sent by a provider for the existence of these components in conjunction with the requirements for the specific E&M code that was billed.

Note: E&M codes or any other CPT codes **are not** to be used as a substitute for manipulation codes.

Chiropractic manipulative treatment (CMT)

For spinal and extra-spinal manipulations, use the following codes below:

- **CPT 98940** Chiropractic manipulative treatment; spinal, one to two regions
- **CPT 98941** Chiropractic manipulative treatment; spinal, three to four regions
- **CPT 98942** Chiropractic manipulative treatment; spinal, five regions

Extra-spinal manipulations (manipulations of extremities): Use CPT 98943 Chiropractic extra-spinal manipulation. If CPT 98943 is billed in conjunction with any other chiropractic manipulation code, it will be reduced by 50 percent.

The Current Procedural Coding Expert manual states:

> Form of manual treatment performed to influence joint/neurophysical function. The following five extra-spinal regions:
>
> - Abdomen
> - Upper extremities
> - Lower extremities
> - Rib cage, not including costotransverse/costovertebral joints
> - Head, including temporomandibular joint, excluding atlanot-occipital region

We will allow one of the above spinal CMT services and/or one extra-spinal CMT service per encounter. CMT codes include the pre-manipulation assessment and post treatment evaluation.

<u>Eight-minute rule for timed codes – one service</u>

For services billed in 15-minute units, count the minutes of skilled treatment furnished. Only direct, face-to-face time with the patient is considered for timed codes. When billing greater than 1 unit, total time or service duration is required to be noted in the visit documentation.

- 7 minutes or less of a single service is not billable.
- 8 minutes or more of a single service is billable as 1 unit or an additional unit if the prior units were each furnished for a full 15 minutes.

15 minutes:

- 8-22 minutes = 1 unit
- 23-37 minutes = 2 units
- 38-52 minutes = 3 units

Note: The level of manipulative treatment must support the diagnosis.

Maintenance therapy

Maintenance therapy means a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life or therapy that is performed to maintain or prevent deterioration of a chronic condition. Once the maximum therapeutic benefit has been achieved for a given condition, any additional therapy provided is considered maintenance therapy.

Note: Most products exclude coverage for maintenance therapy.

Accidental injury

Injury claims must include the following:

- Date of injury
- Cause or source of injury
- Where the injury took place
- Whether the injury is related to an auto accident or employment

Supplies

The following supplies to be used outside the treatment session may be paid according to the member's benefits.

- Use a valid CPT/HCPCS code for supplies
- Document the type of supply, quantity purchased and the cost of the supply
- If there is no HCPCS code that adequately describes the supply, please use the appropriate unlisted HCPCS code(s) with a specific description of the supply included on the claim.

Diagnostic radiology services

Radiology films must be of sufficient diagnostic quality with a legible and permanently documented report. Radiographic findings (presence of subluxation or fracture, etc.) must be separately identified. All radiographic services must meet the WAC 246-808-565 radiographic standard.

Chiropractic clinical record

The chiropractic clinical record requires the following specific documentation:

1. **Member intake form** states the chief complaint or reason for the visit, including the description of the accident, injury or other cause
2. **Exam forms** or notes for each exam performed for which an E & M code is billed. The record should support the level of the E&M code billed
3. **Daily chart notes** must include any changes in the care or progress of the member:
    - **Initial visit**
        - History
        - Diagnosis
        - Chief complaint

        - Date of the visit
        - Treatment plan:
            - Treatment goals
            - Anticipated duration of treatment
            - Measures to evaluate effectiveness
            - Documentation of treatment provided
        - Physical examination of the area(s) related to the diagnosis:
            - Objective, measurable findings
            - Location, limitations, severity and frequency of impeded function
    - **Subsequent visits**
        - Documentation of treatment given
        - History, including the chief complaint
        - Physical examination of area(s) related to the diagnosis:
            - Assessment of the patient's condition
        - Specific elements of the manipulative service for each day of service:
            - Reason that the service was necessary that day
            - Type, location and response to treatment given on the day of service
4. Treatment plan includes all of the following:
    - Frequency and duration of care and the anticipated discharge date
    - Short- and long-term functional goals including instruction in home care exercises, strengthening and functional abilities (e.g., sitting, standing, walking)

Each identified problem must have a specific care plan. The chiropractor evaluates the effectiveness of the management care plan at each visit.

Services not covered

- Clean up
- Record keeping
- Report writing costs
- Treatment preparation
- Member transportation
- Patient care conferences
- Associated post-service work
- Application of hot and cold packs
- Pre-manipulation member assessments
- Routine supplies and materials provided by the chiropractor and used during the therapy session are not covered. These are considered part of your operational overhead.
- Dietary advice and recommendations on nutritional supplements is considered part of the treatment plan and not separately reimbursed

Licensed massage practitioners (LMPs)

Billing guidelines

For care to be covered under the member's benefit, a physician must diagnose a medical condition, which has resulted in functional loss, for which rehabilitation therapy is prescribed. The LMP will be reimbursed for services currently covered under the member's rehabilitation or neurodevelopmental benefit.

In addition to any prescription and/or required referral, coverage for the services of a LMP is subject to applicable member contract limitations. When the treating LMP submits a claim, it is not necessary to include the patient's prescription. We require the prescription to be on file in your office.

Most products cover services performed by a LMP under the outpatient rehabilitation benefit. Therefore, these services are subject to the outpatient rehabilitation benefit contract requirements and limitations.

When billing for massage therapy services, please use the current appropriate CPT codes for all services rendered. Additional billing information is listed below:

- Units of service must be included on the claim.
- Chiropractic manipulation codes are only payable to chiropractors.
- Osteopathic manipulation codes are only payable to MDs, DOs, ARNPs and NDs.
- CPT codes, such as E&M codes, are not payable to physical, occupational, speech or licensed massage practitioners.
- A total of four units of modalities/procedures per date of service are accepted.
    - If no units are listed on the claim, we will assume one unit of service was performed.
- All licensed providers must bill for any and all services they perform under their own name. LMPs may not submit claims for services performed by another licensed provider.

<u>Eight-minute rule for timed codes – one service</u>

For services billed in 15-minute units, count the minutes of skilled treatment provided. Only direct, face-to-face time with the patient is considered for timed codes.

- 7 minutes or less of a single service is not billable.
- 8 minutes or more of a single service is billable as 1 unit or an additional unit if the prior units were each furnished for a full one.

15 minutes:

- 8-22 minutes = 1 unit
- 23-37 minutes = 2 units
- 38-52 minutes = 3 units

Supplies

Supplies and materials are not separately reimbursed. Supplies provided by the LMP and used during the therapy session are not covered. These are considered part of the provider's operational overhead.

Services not covered

- Supplies
- Clean-up
- Record-keeping
- Report-writing costs
- Treatment preparation
- Member transportation
- Patient care conferences
- Application of hot and cold packs

Note: E&M services performed by an LMP are not covered.

Maintenance therapy

Maintenance therapy means a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. Once the maximum therapeutic benefit has been achieved for a given condition, any additional therapy provided is considered maintenance therapy.

Note: Most products exclude coverage for maintenance therapy.

Accidental injury

Injury claims must include the following:

- Date of injury
- Cause or source of injury
- Where the injury took place
- Whether the injury is related to an auto accident or employment

Naturopathic physicians
Naturopaths as PCPs

Primary care providers (PCPs) have agreed to supervise, coordinate and provide initial and basic care to our members, to initiate their referrals when medically necessary and to maintain continuity of member care.

Naturopaths as specialists

Our plans may also cover naturopathic physician services as specialists.

Billing guidelines

- Chiropractic manipulation codes are only payable to chiropractors.
- Osteopathic manipulation codes are only payable to MDs, DOs, ARNPs and NDs.
- Medications and supplies that are available over the counter (OTC) are not covered.
- As stated in your participating agreement, a preferred laboratory must perform all laboratory services.
- E&M codes are not allowed as a substitute for rehabilitation modality and procedure codes or other medical procedure codes.
- Naturopathic physicians are included in the list of providers to whom female members may self-refer for covered women's health care services.
- All licensed providers must bill for any and all services they perform under their own name. A naturopath may not submit claims for services performed by another licensed provider.
- Physical therapy modalities and procedures are subject to the member's outpatient rehabilitation benefit, including any limitations or exclusions. When billing for physical therapy modalities or procedures, the naturopath should follow the therapy billing guidelines. These guidelines are listed in the Therapy Guidelines section of this manual.

Note: The member must sign a non-covered member consent form acknowledging they will be responsible for any non-covered charges **prior** to services rendered at any non-participating laboratory or for any non-covered laboratory services. Specific information must be on the form, including:

- Date of service
- Condition/diagnosis
- Estimated cost of service
- Services/supplies requested
- Signature of member or legal guardian of member

A sample form is available on our website: Library>Forms.

Nutritionists and dieticians

Billing guidelines

For care to be covered under the member's benefit, a physician or other prescribing provider must diagnose a covered medical condition. The nutritionist or dietician must keep the prescription on file.

When billing for medical nutrition therapy please use the following code(s):

- **CPT 97802** Medical nutrition therapy, initial assessment
- **CPT 97803** Medical nutrition therapy, re-assessment and intervention
- **HCPCS G0270** Medical nutrition therapy, re-assessment and subsequent interventions

- **HCPCS G0108** Diabetes outpatient self-management training services, individual, per 30 minutes

Services not covered

- **CPT 97804** Medical nutrition therapy, group, each 30 minutes
- **HCPCS G0271** Medical nutrition therapy, group reassessment
- **HCPCS G0109** Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes

Use the most appropriate CPT code to describe the service(s). E&M codes are not appropriate CPT codes and will not be allowed.

Services are subject to the member's contract benefits and limitations and may be subject to review. For example, if the services are part of a weight loss program, depending on the member's contract, such services may be denied as non-covered obesity treatment.

With the exception of the guidelines stated above, any other services will be included in the allowance for medical nutrition therapy and will be denied as provider write-off.