Alternative Care

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 **asuris.com**: Contracting & Credentialing>Provider Types.

Additional information about submitting all claims is available in the Claims Submission section on our website: Claims & 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:

- A physician prescription or referral may be required to meet state requirements (These do not need to be submitted to Asuris)
- 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 Availity Essentials to obtain eligibility, benefit and claims information at **availity.com**.

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.

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 Asuris

Chiropractic physicians

Chiropractic care may include the following:

- Problem-focused E&M services
- Traditional X-ray films
- Extraspinal manipulation (chiropractic manipulative treatment [CMT], extraspinal)
- Spinal manipulations (CMT, spinal)

Billing guidelines

- All services performed during an encounter must be billed.
- 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 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.

E&M services

Low-complexity periodic examinations are typically performed to formally assess the patient's response to treatment, their progress or to make necessary changes to the treatment plan.

An exacerbation or new problem may also warrant a follow-up E&M service.

E&M levels 4 and 5 require significant additional work and would seldom be appropriate when billing both a manipulative treatment code and an E&M service. When a high-level E&M service is submitted (99214, 99215, 99204, 99205), we may request to review documentation supporting the level of service billed.

For the above circumstances, 25 modifier must be submitted with the E&M service to signify that a separately identifiable service was performed.

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 atlanto-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.

Note: The level of manipulative treatment must be supported by 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

Durable medical equipment (DME)

Foot orthotics may be ordered/fitted and billed by chiropractors when determined to be medically necessary.

Diagnostic radiology services

Chiropractors can perform and bill for most traditional X-rays. Services billed for consultation on X-ray exams performed elsewhere, however, are not reimbursable. Per Current Procedural Terminology (CPT®), CMT procedures include the review of prior radiologic imaging, and the consultation is, therefore, considered an inclusive component of the CMT codes.

Chiropractors may order other necessary radiology services, such as computed tomography (CT), magnetic resonance imaging (MRI) and ultrasound, as permitted by the provider's scope of practice; however, our health plan will not reimburse these services when billed by a chiropractor.

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 both 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
- Wellness visits
- Record keeping
- Report writing costs
- Treatment preparation
- Member transportation
- Patient care conferences
- DME excluding foot orthotics
- Associated post-service work
- Application of hot and cold packs
- Pre-manipulation member assessments
- Advanced radiology services (CT, MRI, EKG etc.) excluding traditional X-rays
- Routine supplies and materials provided by the chiropractor and used during the encounter 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 therapists (LMTs)

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 LMT 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 an LMT is subject to applicable member contract limitations. When the treating LMT submits a claim, it is not necessary to include the patient's prescription. If state law or the member's benefits require a prescription for massage, the provider must keep the prescription on file in case we request it.

Most products cover services performed by an LMT 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:

- **CPT 97110** Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
- **CPT 97112** Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
- **CPT 97124** Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
- **CPT 97140** Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes

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 and DOs.
- 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. LMTs may not submit claims for services performed by another licensed provider.

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

Supplies

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

Services not covered

Services not covered are not separately reimbursed. The following is a list of common items not covered and is not all inclusive.

- 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 LMT 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 and DOs.
- 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.