Keystone First
Family of Health Plans

Chiropractic Services

Reimbursement Policy ID: RPC.0052.PA01

Recent review date: 01/2026

Next review date: 12/2026

Keystone First VIP Choice 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. Keystone First VIP Choice 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 Medicare 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

The primary diagnosis must be reported once. Additional diagnoses for resulting neuromusculoskeletal disorders are listed as secondary diagnoses.

M99.01 - Segmental and somatic dysfunction of cervical region
M99.02 - Segmental and somatic dysfunction of thoracic region
M99.03 - Segmental and somatic dysfunction of lumbar region
M99.04 - Segmental and somatic dysfunction of sacral region
M99.05 - Segmental and somatic dysfunction of pelvic region

Diagnostic x-rays provided by a chiropractor to determine the existence of a vertebral subluxation are not eligible for reimbursement.

Per CPT guidelines, Chiropractic manipulative treatment codes (98940- 98942) include a pre-manipulation patient assessment.

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

These codes for active/active or chronic treatment must include modifier AT (active/acute treatment). Maintenance therapy is not covered by Medicare.

Medicare does not cover:

- Laboratory tests
- X-rays
- Office visits (history and physicals)
- 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.

Modifier AT – Active Treatment
Modifier AT is submitted with chiropractic treatment codes when the chiropractor furnishes active/acute treatment.

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. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=56273
V. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
VI. https://www.medicare.gov/coverage/chiropractic-services

Attachments

N/A

Associated Policies

N/A

Policy History

01/2026	Reimbursement Policy Committee Approval
12/2025	Annual review • No major changes
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
02/2025	Reimbursement Policy Committee Approval
01/2025	Annual review • No major changes
04/2024	Revised preamble
03/2024	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by Keystone First VIP Choice from Policy History section
01/2023	Template revised • Preamble revised • Applicable Claim Types table removed • Coding section renamed to Reimbursement Guidelines • Associated Policies section added