

TITLE:	Chiropractic Manipulative Treatment
DEPARTMENT:	PAYMENT POLICY
ORIGINAL EFF. DATE:	10/20/2026
REVISION DATE:	N/A

1. PURPOSE

This Payment Policy outlines clear and consistent reimbursement guidelines to ensure compliant, transparent, and timely payment for medically necessary, cost-effective care.

2. SCOPE

This policy applies to the reimbursement of covered services for all members and providers. Curative will allow reimbursement for services according to the criteria outlined in this policy, unless modified or superseded by contractual language.

3. DEFINITIONS

The following terms are defined as follows regarding this policy.

- 3.1. **Chiropractic Manipulative Treatment** A form of manual treatment to influence joint and neurophysiological function. The treatment may be accomplished using a variety of techniques. The chiropractic manipulative treatment codes include a pre-manipulation patient assessment.

4. POLICY

Disclaimer: These Payment Policies serve as a comprehensive guide for all providers, assisting in submitting accurate claims and outlining the essential framework for reimbursement. The determination that a service, procedure, or item is covered under a Curative member's benefit plan does not constitute a guarantee of payment. Services must meet medical necessity and authorization guidelines appropriate to the procedure and diagnosis and, where mandated, the members state of residence. Services rendered must be within the legal scope of practice for the specific type of provider and align with the professional credentials and training in the state where the care is furnished.

To ensure proper processing, providers are required to adhere to industry-standard, compliant codes and follow proper coding, billing, and submission guidelines. To ensure accurate reimbursement and proper claims adjudication, all services provided to the same member, by the same provider, and on the same date of service must be reported on a single claim. Current Procedure Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or relevant revenue codes must be used for billing. Codes submitted must be fully supported by corresponding documentation in the medical record. Unless noted otherwise within a policy, these payment policies apply to both participating and non-participating providers and facilities.

Curative reserves the right to take corrective action, which may include the rejection or denial of the claim, or the recovery and/or recoupment of any previous claim payment if proper coding, billing guidelines, or these established payment policies are not followed. Providers may refer to the Provider Manual for guidance on addressing such actions, including the formal claim reconsideration, appeals, and dispute resolution processes.

These policies may be superseded by mandates within provider contracts, state or federal laws, or requirements issued by the Centers for Medicare & Medicaid Services (CMS). Curative retains the right to revise these policies as deemed necessary and will publish the most current version on the Curative website.

Curative reserves the right to request and review comprehensive medical records to support claims submitted under this policy. Discrepancies, incomplete documentation, or coding misalignments may result in claim adjustments, denials, or post-payment recoveries.

Reimbursement is contingent upon provider, state, and federal contracts, and is subject to review on an individual claim basis.

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Reimbursement Guidelines

Chiropractic Manipulative Treatment and E&M Services:

Chiropractic Manipulative Treatment codes (98940-98943) automatically include routine pre-, intra-, and post-service work.

A separate Evaluation and Management (E&M) service is only reimbursable if it is **significant and separately identifiable**. Providers must append modifier -25 to the E&M code; without it, the E&M service will not be separately paid. An E&M service is appropriate only under the following conditions:

- Initial evaluation of a new patient or condition, or re-evaluation of an established patient's progress once every 30 days;
 - Acute exacerbation of symptoms or a significant change in condition; or
 - A distinct indication unrelated to the manipulation.
- New patient E&M visits are reimbursable once every three years. Established patient E&M visits are reimbursable once every 30 days per episode of care without requiring medical records; more frequent billing requires medical record submission.
- Codes 99202–99205 apply to new patients, and 99212–99215 apply to established patients.
- Definitions & Clarifications:
 - **New Patient:** Has not received professional services from the provider or group practice (same specialty/subspecialty) within the past 3 years.
 - **Established Patient:** Has received professional services from the provider or group practice within the past 3 years.
 - **Coding & Medical Necessity:** E&M levels must be supported by documented Medical Decision Making (MDM) or total time spent per AMA/CMS guidelines.
 - **High-Level E&M (Level 4–5):** Per CMS guidelines, most routine visits do not justify Level 4 or 5 E&M codes.

Documentation/Coding Requirements

All regions treated must include a corresponding diagnosis code on the billing or claim form.

98940 CMT; spinal, one to two regions

- Valid diagnosis for one or two spinal regions, and

- Documentation to support manipulative treatment in one to two regions of the spine (region as defined by CPT).

98941 CMT; spinal, three to four regions

- Valid diagnosis for three to four spinal regions, or
- Valid diagnoses for two spinal regions, plus one or two adjacent spinal regions with documented soft tissue and segmental findings, and
- Documentation to support manipulative treatment in three to four regions of the spine (region as defined by CPT).

98942 CMT; spinal, five regions

- Valid diagnoses for five spinal regions, or
- Valid diagnoses for three spinal regions, plus two adjacent spinal regions with documented soft tissue and segmental findings, or
- Valid diagnoses for four spinal regions, plus one adjacent spinal region with documented soft tissue and segmental findings, and
- Documentation to support manipulative treatment in five regions of the spine (region as defined by CPT).

98943 CMT; extraspinal, one to five regions

- Validated diagnosis for one or more extraspinal regions for which manipulation has been shown to be both safe and effective, and
- Documentation to support manipulative treatment in one or more extraspinal regions (region as defined by CPT).

By definition, CPT 98943 applies to CMT of 1 or more extraspinal regions; therefore only one unit of service is eligible for reimbursement per date of service.

Documentation in the member's medical record must include sufficient information to substantiate the need for administering CMT to any given region.

Medical record documentation must support the level of E/M service billed and must be supplied upon request, including for Level 4 or Level 5 E/M codes and for repeat E/M services within an episode of care for an established patient.

97140 Manual therapy techniques (e.g., mobilization, manipulation, manual lymphatic drainage, manual traction) one or more regions, each 15 minutes.

When reporting the CPT code 97140 in conjunction with CMT codes, there are six criteria that must be documented to validate the service:

- Manipulation was not performed to the same anatomic region or a contiguous anatomic region e.g., cervical, and thoracic regions are contiguous; cervical and pelvic regions are noncontiguous

- The clinical rationale for a separate and identifiable service must be documented e.g., contraindication to CMT is present
- Description of the manual therapy technique(s) Location
- Location e.g., spinal region(s), shoulder, thigh
- Time i.e., number of minutes spent in performing the services associated with this procedure meets the timed-therapy services requirement
- CPT code 97140 should be reported with modifier 59 or the appropriate **X{EPSU} modifier** when required, in addition to any other applicable modifiers, such as the required “always therapy” modifier.

5. REFERENCE DOCUMENTS AND MATERIALS

- 5.1. American Medical Association. Current Procedural Terminology (CPT) Professional Edition.
- 5.2. Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners
- 5.3. Centers for Medicare & Medicaid Services. National Correct Coding Initiative Policy Manual for Medicare Services

6. COLLABORATING DEPARTMENTS

- 6.1. Claims
- 6.2. Compliance
- 6.3. Medical Management
- 6.4. Network
- 6.5. System Configuration

7. POLICY & PROCEDURE CONTROL

This Policy will be reviewed at least annually and as necessary.

REVISION HISTORY			
Date	Author	Version	Comments
10/20/2026	CJW	001	Initial Version