Health

2025

Comprehensive Guide to **Chiropractic Billing**

Table of Contents

Introduction

Running a successful chiropractic practice involves more than delivering exceptional patient care — it also requires mastering the financial side of the business.

Proper reimbursement for services rendered hinges on accurate chiropractic billing and coding, which can often feel like navigating a maze of regulations and requirements.

We have created this chiropractic billing cheat sheet to simplify the complexities of chiropractic billing and coding and offer practical insights into common challenges & effective solutions.

From understanding key CPT and ICD-10 updates to uncovering strategies for preventing claim denials, this resource equips you with the tools to streamline your billing process.

This guide also explores the benefits of chiropractic billing software and outsourcing billing to expert services, helping you optimize revenue and focus on what matters most: your patients

Chapter 1

Challenges in Chiropractic Medical Billing

Chiropractic medical billing is a specialized process that requires precision and in-depth knowledge of coding, compliance, and payer policies. Here are the key challenges faced by chiropractic practices in managing their billing:

Complex Insurance Policies

- Chiropractic care is often subject to restrictive insurance policies that vary by payer, making it difficult to navigate coverage limitations.
- Policies may only cover specific conditions, treatment frequencies, or a limited number of visits, requiring detailed verification before treatment begins.

Frequent Denials and Rejections

- Denials are common due to coding errors, lack of documentation, or exceeding the coverage limit for chiropractic visits.
- Common denial reasons include incorrect use of CPT or ICD-10 codes, missing modifiers, or failure to link diagnoses appropriately to treatments.

Proper Use of CPT and ICD-10 Codes

- Denials are common due to coding errors, lack of documentation, or exceeding the coverage limit for chiropractic visits.
- Common denial reasons include incorrect use of CPT or ICD-10 codes, missing modifiers, or failure to link diagnoses appropriately to treatments.

Medicare Compliance

- Medicare has stringent guidelines for chiropractic care, covering only spinal manipulation (CPT codes 98940-98942) when medically necessary.
- Chiropractors often face challenges ensuring their services meet Medicare requirements and documenting medical necessity to avoid audits or claims rejections.

Documentation and Medical Necessity

- Insufficient or incomplete documentation is one of the top reasons for claim denials.
- Chiropractors must thoroughly document patient encounters, treatment plans, and medical necessity to justify billed services.
- Medicare and private insurers often scrutinize notes for compliance, leading to additional administrative work.

Use of Modifiers

- Proper application of modifiers (e.g., GA, GY, 59) is critical to ensure claims are processed correctly.
- Misuse or omission of chiropractic modifiers can result in denied claims, delays, or reduced reimbursements.

Audits and Compliance Risks

- Chiropractic practices face audits by payers, particularly Medicare, to ensure claims meet billing and documentation requirements.
- Practices must regularly review their billing and documentation practices to reduce the risk of non-compliance and penalties.

Handling Denials and Appeals

- **Managing denied claims** is time-consuming and requires a systematic approach.
- Chiropractors must understand the payer's appeals process and provide additional documentation to overturn denials, which can delay payments.

Reimbursement Delays

- Billing errors, incomplete claim forms, or payer-specific requirements can lead to reimbursement delays.
- The complexity of following up on claims, reconciling payments, and resubmitting corrected claims adds to the administrative burden.

Reimbursement Delays

- Billing errors, incomplete claim forms, or payer-specific requirements can lead to reimbursement delays.
- The complexity of following up on claims, reconciling payments, and resubmitting corrected claims adds to the administrative burden.

Lack of Expertise in Chiropractic-Specific Billing

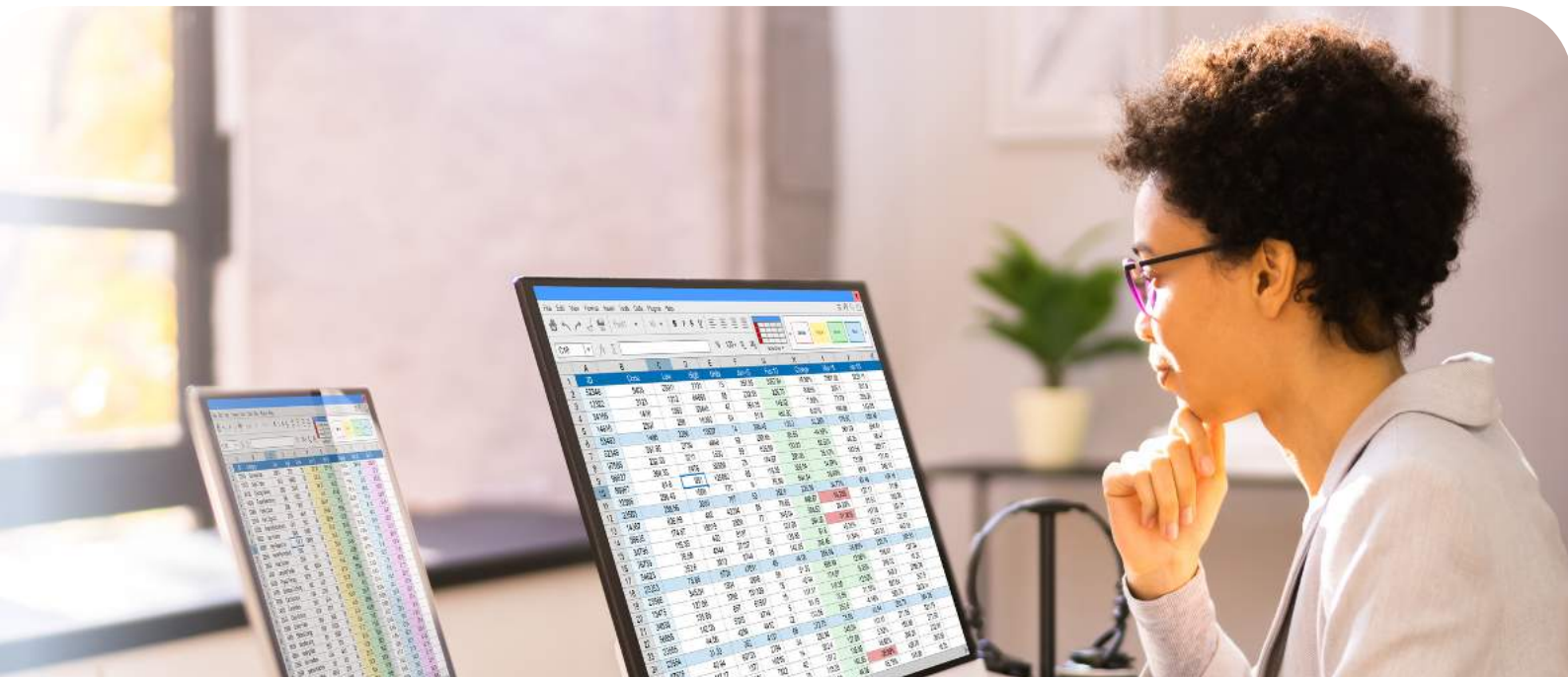
- General billing knowledge often doesn't translate well to chiropractic billing, which has unique rules, codes, and compliance requirements.
- Many practices lack in-house expertise, leading to errors and revenue loss.

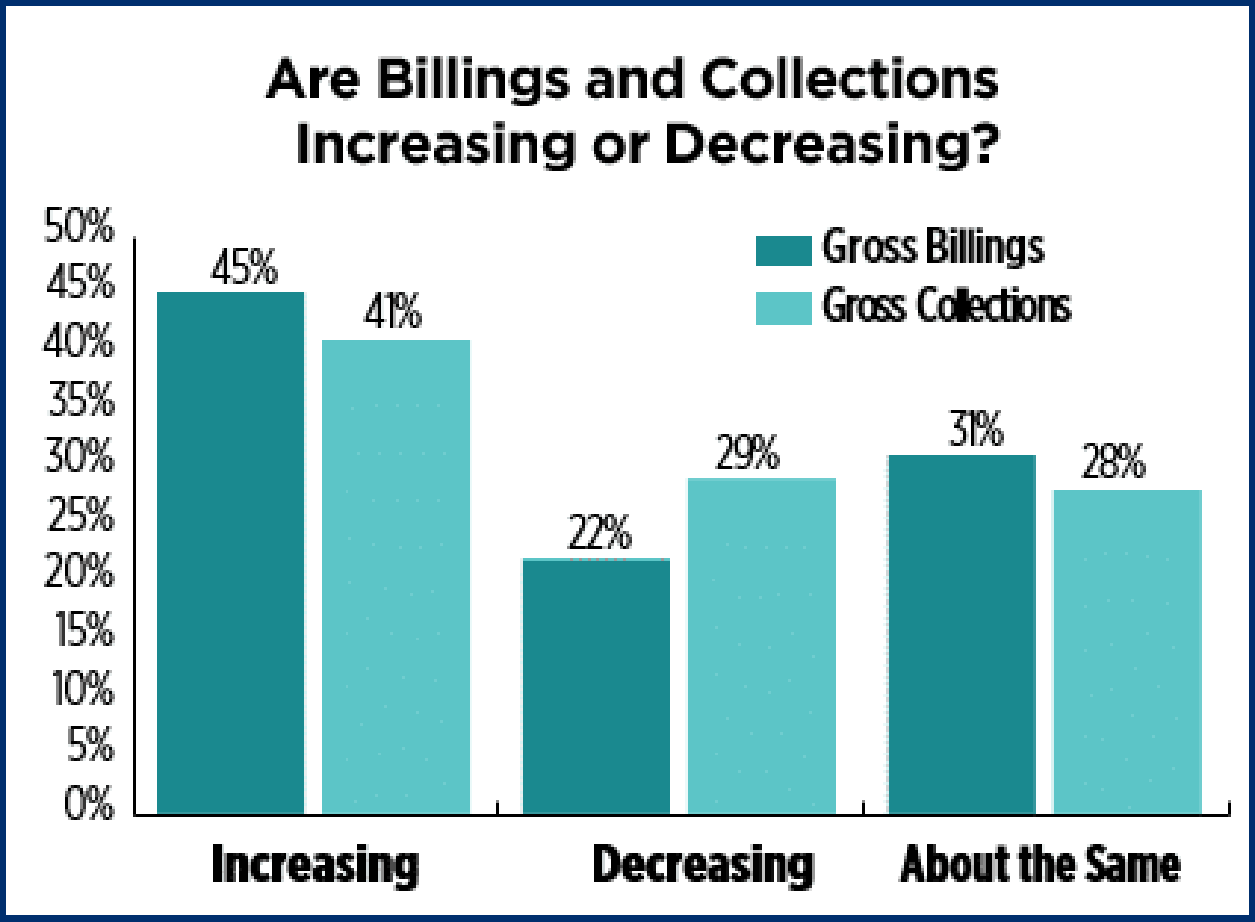
Balancing Patient Care and Billing

- Chiropractors often juggle patient care and administrative tasks, leading to missed billing opportunities or errors in claim submissions.
- **Outsourcing billing** to chiropractic billing companies or using specialized chiropractic billing software can help alleviate this challenge but comes with its own costs and considerations.

Lack of Expertise in Chiropractic-Specific Billing

- General billing knowledge often doesn't translate well to chiropractic billing, which has unique rules, codes, and compliance requirements.
- Many practices lack in-house expertise, leading to errors and revenue loss.





Source: ChiroEco

A study revealed that average gross billings were reported at $716,322 in 2024.

Collections were reported at $506,543.

This means that with good billing tools, knowledge, and accurate coding, clinics can significantly reduce revenue leakage, improve collections, and close the gap between gross billings and actual collections.

Chapter 2

ICD-10 Codes for Chiropractors

ICD-10 codes are essential in chiropractic care, serving as the universal language for diagnosing and documenting patient conditions. These codes ensure accuracy in describing musculoskeletal disorders, justifying the necessity of treatments, and securing appropriate reimbursements from insurance providers.

For chiropractors, the ICD-10 system is invaluable in identifying conditions like back pain, spinal misalignments, joint dysfunctions, and soft tissue injuries. Each code provides precise details about the patient's health status, enabling tailored care plans and ensuring compliance with payer requirements. By using an **ICD-10 codes chiropractic cheat sheet**, chiropractors can enhance their documentation accuracy, streamline their billing process, and ultimately improve patient care.

To ensure maximum reimbursement for chiropractic services, partnering with a reliable chiropractor billing company can make all the difference. These companies provide expertise in selecting the right ICD-10 codes, maintaining proper documentation, and minimizing claim denials, allowing practices to streamline their billing process and focus on delivering exceptional care.

Whether you're addressing common conditions like sciatica or more complex issues like systemic connective tissue disorders, leveraging professional chiropractor billing services is essential for optimizing patient outcomes and simplifying billing processes. Mastering ICD-10 codes not only supports compliance but also strengthens the financial stability of chiropractic practices

Understanding ICD-10 Code Structure

The ICD-10 (International Classification of Diseases, 10th Edition) system uses an alphanumeric structure to categorize and describe diagnoses with precision. This structure ensures detailed documentation, facilitates accurate billing, and allows healthcare providers, including chiropractors, to communicate effectively with payers and other practitioners.

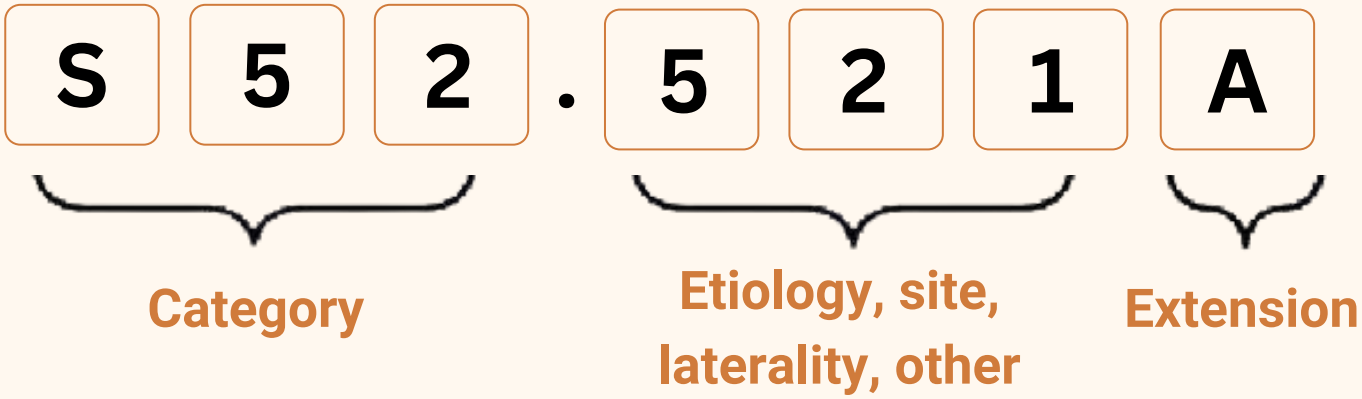
Chiropractor ICD-10 Codes Structure

Each ICD-10 code can be up to 7 characters long and is organized as follows:

1. **Category (First 3 Characters)**
   - Represents the general classification of the condition (e.g., M54 for dorsopathies or low back pain).
   - Example: M54.5 – Low back pain.

2. **Etiology, Anatomical Site, Severity (Characters 4–6)**
   - Adds specificity about the cause, location, and severity of the condition.
   - Example: M54.51 – Low back pain with right-sided sciatica.

3. **Extension (7th Character, Optional)**
   - Used in cases of injuries or complications to provide additional details, such as the encounter type:
     - A – Initial encounter.
     - D – Subsequent encounter.
     - S – Sequela (complications or conditions resulting from a previous injury).



Diseases of the Musculoskeletal System and Connective Tissue (M00–M99)

Category	Code Range	Description	Common Uses in Chiropractic
Arthropathies	M00–M25	Includes arthritis, inflammatory joint conditions, and other joint disorders.	Used to document cases like osteoarthritis (M15–M19) or rheumatoid arthritis (M05–M06).
Dentofacial Anomalies	M26–M27	Disorders related to jaw alignment, malocclusion, or temporomandibular joint (TMJ).	For diagnosing TMJ disorders or malocclusion impacting posture or neck pain.
Systemic Connective Tissue Disorders	M30–M36	Covers systemic conditions such as lupus or systemic sclerosis.	Rarely used in chiropractic but relevant for co-managing patients with systemic inflammation affecting mobility.
Dorsopathies	M40–M54	Disorders of the spine, including scoliosis, kyphosis, and low back pain.	Essential for billing spinal disorders like lumbago (M54.5) and sciatica (M54.3).
Soft Tissue Disorders	M60–M79	Includes myositis, fibromyalgia, and tendonitis.	Used for diagnosing soft tissue conditions like rotator cuff syndrome (M75.1) or fibromyalgia (M79.7).
Osteopathies and Chondropathies	M80–M94	Includes osteoporosis, osteonecrosis, and cartilage disorders.	Relevant for managing osteoporosis-related fractures (M80.0) or chondromalacia (M94.2).
Other Disorders of the Musculoskeletal System	M95–M95.9	Covers miscellaneous conditions not classified elsewhere.	Rarely used in chiropractic; may apply in unique cases like acquired deformities.
Intraoperative and Postprocedural Complications	M96–M96.89	Conditions resulting from surgical or procedural complications.	Rarely billed in chiropractic unless co-managing post-surgical patients with complications like instability.
Periprosthetic Fracture Around Prosthetic Joint	M97–M97.9XXS	Fractures occurring around internal prosthetic joints.	Used in co-management of post-surgical prosthetic joint complications.
Biomechanical Lesions	M99–M99.9	Covers spinal and joint dysfunctions not classified elsewhere.	Critical in chiropractic, used for diagnosing segmental dysfunction (M99.01–M99.05) and subluxations.

ICD-10 Codes Chiropractic Cheat Sheet

Dorsopathies (M40–M54)

Code	Description	Example Use
M40.0	Postural kyphosis	Diagnosing patients with poor posture affecting spinal curvature.
M41.0–M41.9	Scoliosis (idiopathic, congenital)	For treating scoliosis patients with manual adjustments or therapeutic exercises.
M43.6	Torticollis	Patients presenting with neck stiffness or head tilting due to muscular or vertebral issues.
M54.5	Low back pain (lumbago)	The most frequently billed code for chiropractic spinal adjustments.
M54.3	Sciatica	Diagnosing and treating nerve pain radiating from the lower back to the legs.

Soft Tissue Disorders (M60–M79)

Code	Description	Example Use
M75.1	Rotator cuff syndrome	Diagnosing shoulder pain or restricted range of motion.
M79.7	Fibromyalgia	Patients presenting with chronic widespread pain and fatigue.
M76.0	Achilles tendinitis	Treating patients with heel pain caused by soft tissue inflammation.

Biomechanical Lesions (M99.01–M99.05)

Code	Description	Example Use
M99.01	Segmental dysfunction of cervical region	Used for spinal adjustments targeting cervical vertebrae.
M99.02	Segmental dysfunction of thoracic region	Adjustments aimed at thoracic spinal regions.
M99.03	Segmental dysfunction of lumbar region	Common in low back adjustments and treatments.
M99.04	Segmental dysfunction of sacral region	For issues related to the sacral vertebrae or sacroiliac joints.
M99.05	Segmental dysfunction of pelvic region	Treating pelvic misalignments or dysfunction.

Note: Category 1 codes (those used for chiropractic services and procedures) are updated yearly and those changes go into effect January 1 each year

ICD-10 Codes Chiropractic Cheat Sheet and Tips

- Always Use the Most Specific Code
- Document Thoroughly
- Pair with Appropriate CPT Codes
- Keep Updated with Annual Changes
- Know Common Chiropractic Codes
- Avoid Coding Errors
- Check Insurance Payer Guidelines
- Use Chiropractic Billing Software
- Keep this guide handy
- Hire chiropractic billing services

ICD-10 Codes Chiropractic Cheat Sheet and Tips

Using the correct ICD-10 codes is critical for accurate billing and claim approvals. Mistakes in coding can lead to denied claims, delays in payment, or even compliance issues. By following these tips, you can avoid errors:

01. Always Use the Most Specific Code

Select codes with maximum detail to reflect the exact diagnosis. Avoid using unspecified codes unless absolutely necessary.

02. Document Thoroughly

Ensure patient records (e.g., SOAP notes) provide sufficient evidence to support the selected chiropractor ICD-10 codes. This is critical for justifying medical necessity.

03. Pair with Appropriate CPT Codes

Link ICD-10 codes to the right procedural (CPT) codes to align diagnoses with treatments. For example:

- ICD-10 Code: M99.03 (Segmental dysfunction of lumbar region).
- CPT Code: 98941 (Chiropractic manipulation of 3–4 regions)

04. Keep Updated with Annual Changes

ICD-10 codes are updated annually, often adding new codes or modifying existing ones. Chiropractors should stay informed about changes to avoid errors

05. Be Aware of Insurance Payer Guidelines

Different insurers may have specific rules about which ICD-10 codes they accept. Verify codes for Medicare, Medicaid, or private insurance requirements.

06. Know Common Chiropractic Codes

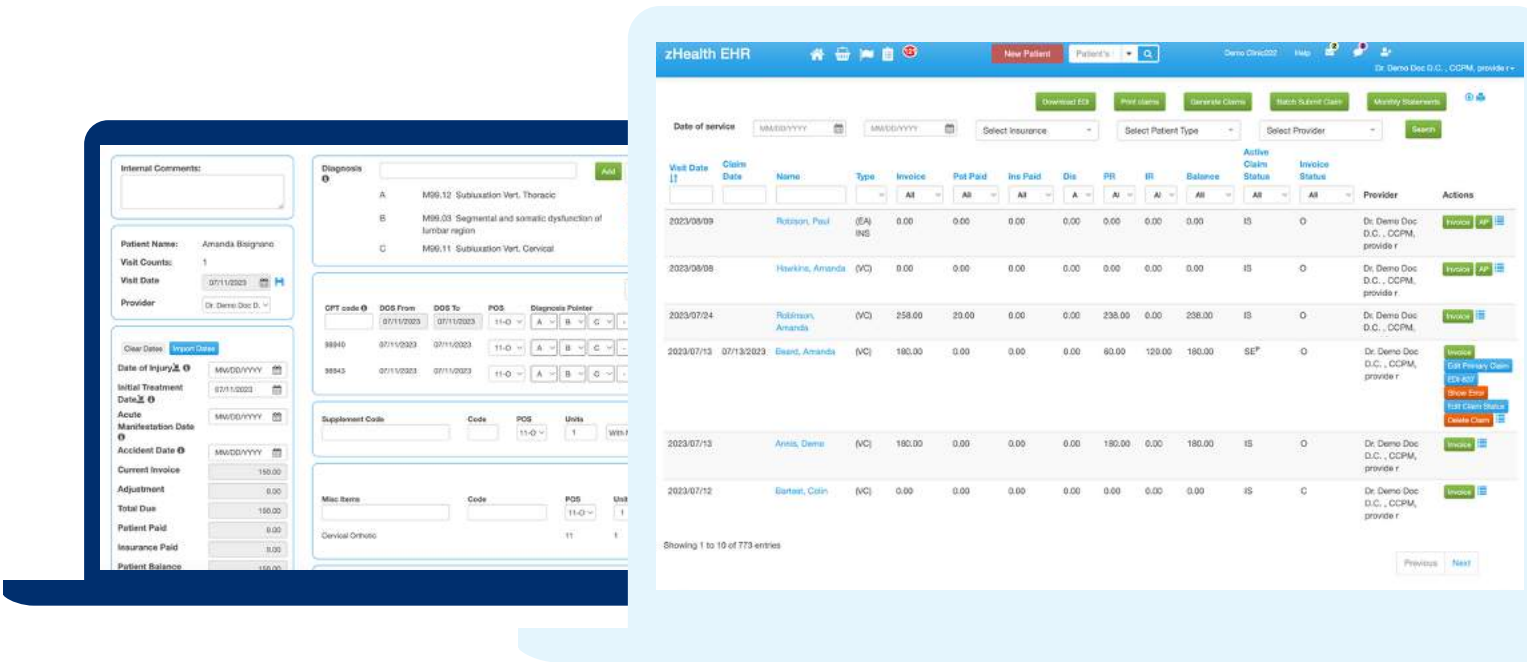
Chiropractors frequently use codes from categories like M54 (dorsopathies), M99 (biomechanical lesions), and M75 (soft tissue disorders).

07. Avoid Coding Error

Common mistakes include incomplete codes, incorrect extensions, or mismatching diagnoses with treatments. Double-check codes for accuracy

08. Use Chiropractic Billing Software

Reference updated ICD-10 code manuals or chiropractic practice management software with coding tools to streamline the process.



Chapter 3

Chiropractic CPT Codes

CPT (Current Procedural Terminology) codes are essential for documenting and billing chiropractic services.

These chiropractic billing codes standardize communication between healthcare providers and insurance payers, ensuring clarity in service descriptions and facilitating accurate reimbursement.

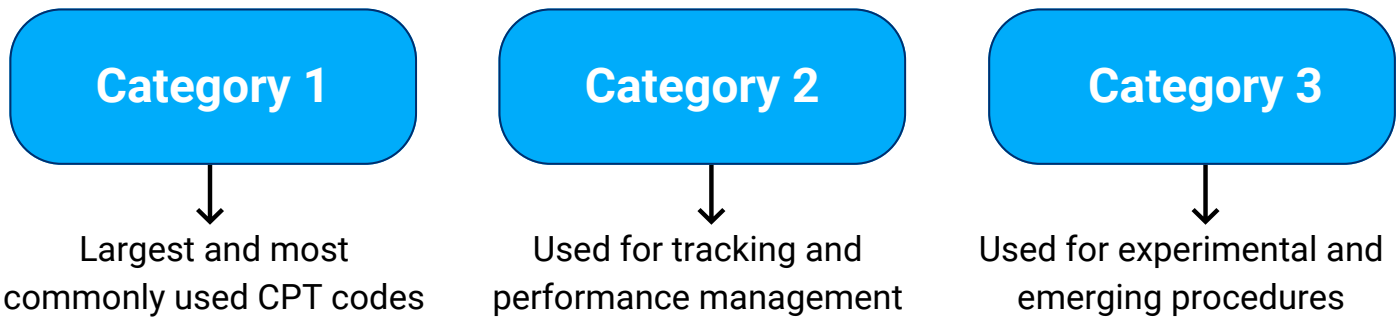
Commonly used CPT codes for chiropractors fall under categories such as chiropractic manipulative treatment (CMT), physical medicine and rehabilitation, therapeutic procedures, and modalities. These precise chiropractic billing codes ensure accurate documentation and support seamless reimbursement processes.

Structure of CPT Codes

A CPT code is a 5-digit numeric or alphanumeric code representing a specific service or procedure. Here's the breakdown:

Numeric Format: Standard codes used for procedures (e.g., 98940 – Chiropractic manipulative treatment for 1–2 spinal regions).

Modifiers: Two-character numeric or alphanumeric suffixes added to chiropractic CPT codes for additional specificity (e.g., 98940-25, indicating a separately identifiable evaluation and management service)



Common CPT Codes for Chiropractic

Chiropractic Manipulative Treatment (CMT)

- 98940: Spinal manipulation, 1–2 regions.
- 98941: Spinal manipulation, 3–4 regions.
- 98942: Spinal manipulation, 5 regions.
- 98943: Extraspinal manipulation, 1 or more regions (e.g., extremities)

Modalties

Supervised (No direct patient contact required)

- 97010: Hot or cold packs.
- 97012: Traction, mechanical.
- 97014: Electrical stimulation, unattended.
- G0283: Electrical stimulation, unattended (VA, MC, UHC).
- 97016: Vasopneumatic devices.
- 97018: Paraffin bath.
- 97022: Whirlpool.
- 97024: Diathermy (includes microwave).
- 97026: Infrared.
- 97028: Ultraviolet.

Laser Modalities

- S8948: Low-level laser therapy, each 15 minutes.
- 0552T: Low-level laser therapy with dynamic photonic and dynamic thermokinetic energy by a physician or qualified healthcare professional.

Common CPT Codes for Chiropractic Contd.

Constant Attendance (Direct patient contact required)

- 97032: Electrical stimulation (manual), each 15 minutes.
- 97033: Iontophoresis, each 15 minutes.
- 97034: Contrast baths, each 15 minutes.
- 97035: Ultrasound, each 15 minutes.
- 97036: Hubbard tank, each 15 minutes.
- 97039: Unlisted modality (specify type and time).
- S8930: Electrical stimulation of auricular acupuncture points (15 minutes of personal one-on-one contact).

Therapeutic Procedures

- 97110: Therapeutic exercises, 15 minutes.
- 97112: Neuromuscular reeducation.
- 97113: Aquatic therapy with therapeutic exercises.
- 97116: Gait training (includes stair climbing).
- 97124: Massage therapy.
- 97139: Unlisted therapeutic procedure (specify).
- 97140: Manual therapy techniques (e.g., mobilization/manipulation).

Additional Procedures

- 97530: Therapeutic activities, direct (one-on-one).
- 97535: Self-care/home management training.
- 97537: Community/work reintegration training.
- 97542: Wheelchair management training.
- 97545: Work hardening/conditioning (initial 2 hours).
- 97546: Work hardening/conditioning (each additional hour).
- 97799: Unlisted physical medicine/rehabilitation service.

Common CPT Codes for Chiropractic Contd.

Orthotic Fitting and Training

- 97760: Orthotics management and training.
- 97763: Orthotic(s)/Prosthetic(s) management and training.

Tests and Measurements

- 97750: Physical performance test/measurement (e.g., musculoskeletal functional capacity).

Maintenance Care

- S8990: Physical or manipulative therapy for maintenance rather than restoration

Modifiers for CPT Codes for Chiropractic Services

Chiropractic Modifier Codes provide additional information about the service performed. Chiropractors often use these:

- **-25:** Significant, separately identifiable evaluation and management (E/M) service on the same day as another procedure.
- **-59**: Distinct procedural service (used to indicate that two procedures were performed independently).
- -**GP**: Services delivered under a physical therapy plan of care.
- **-GA**: Advance beneficiary notice (ABN) on file, indicating a service might not be covered by Medicare.
- **-GZ**: Service expected to be denied due to lack of medical necessity

Key Pointers for Using Chiropractic CPT Codes

Mastering **CPT codes for chiropractors** doesn't have to be complicated—it's your ticket to faster payments and fewer billing headaches!

CPT codes are the key to ensuring you get reimbursed accurately for the care you provide. However, understanding and accurately using chiropractic diagnosis codes can further minimize errors and help you avoid claim rejections. Here, we have listed some simple yet powerful tips to help you code with confidence, avoid denials, and maximize your practice's earnings.

Pair CPT Codes with Relevant Chiropractor ICD-10 Codes

Always link CPT codes to diagnosis codes that justify the necessity of the treatment. For example, M99.01 (segmental dysfunction of the cervical region) can pair with 98940

Time-Based Codes

Many codes, like 97110 and 97032, are billed in 15-minute increments. Ensure documentation reflects the time spent

Medicare Compliance

Use Medicare-accepted codes like G0283 for unattended electrical stimulation. Medicare does not reimburse for CPT code 97014.

Document Medical Necessity

Ensure detailed notes justify the need for the services billed. Lack of documentation is a common reason for denials.

Avoid Upcoding or Downcoding

Select the most accurate CPT code that reflects the service rendered. Improper coding can lead to audits or claim rejections.

Chapter 4

Coding Guidelines for Chiropractic Services

To ensure proper reimbursement and avoid claim denials or delays, chiropractic claims must adhere to the following guidelines:

- **Primary and Secondary Diagnoses:**
  - Specify the precise level of subluxation on the claim as the primary diagnosis.
  - Include the neuromusculoskeletal condition necessitating treatment as the secondary diagnosis.

- **All chiropractic service claims must include:**
  a. Date of treatment initiation
  b. Symptom/condition/secondary diagnosis code(s)
  c. Subluxation(s)/primary diagnosis code(s)
  d. Date of Service
  e. Place of Service
  f. Procedure Code

- Failing to report any of these details can result in claim denials or delays.
- **X-Ray Date:**
  - The date of last x-ray is no longer required.
  - Avoid entering any date in Item 19 of the CMS-1500 claim form, as it may be misinterpreted as the x-ray date.

- **Limitation of Liability Rules:**
  - These rules protect beneficiaries from liability in denial cases when services are deemed medically unnecessary.
  - If the AT Modifier is used and the provider anticipates Medicare may deny the service as not medically necessary, the patient must sign an Advance Beneficiary Notification (ABN), and the GA Modifier must be added.

- **Physician Signature Requirements:**
  - Progress notes and reports must include the physician’s signature.
  - Acceptable formats include handwritten or electronic signatures, initials over a typed or printed name, or accompanied by a signature log or attestation statement.

Coding Guidelines for Chiropractic Services Contd.

Non-Covered Services

Medicare excludes all services other than manual manipulation of the spine for subluxation treatment. Chiropractors are not required to bill these services to Medicare but may choose to do so to obtain a denial for submission to a secondary insurer. Examples of excluded services include:

- Laboratory tests
- X-rays
- Office visits (history and physical)
- Physiotherapy and traction
- Supplies
- Injections and drugs
- Diagnostic studies (e.g., EKGs)
- Orthopedic devices
- Nutritional supplements and counseling

Medicare does not cover chiropractic treatments for extraspinal regions (CPT 98943), including the head, extremities, rib cage, and abdomen.

Request for Review

If a claim is denied, submit documentation supporting the medical necessity of the denied service for review.

By following these guidelines, chiropractic practices can reduce errors, minimize delays, and streamline the reimbursement process.

Chapter 4

Medicare Billing for Chiropractic Services

Medicare plays a significant role in reimbursing chiropractic services, but the billing process can be complex due to strict guidelines and documentation requirements. This in-depth guide explains everything chiropractors need to know about know about billing for chiropractic services, covering eligibility, covered services, billing guidelines, and tips for compliance. For more efficient billing, leveraging a trusted chiropractic insurance billing service can help ensure compliance and optimize reimbursements.

Understanding Medicare's Chiropractic Coverage

Medicare Part B is the primary payer for chiropractic services. It covers only spinal manipulative treatment (SMT) when it is deemed medically necessary. Here's what chiropractors need to know:

- **Covered Services:** Medicare reimburses for manual spinal manipulations to correct a subluxation (as demonstrated by x-ray or physical exam).
- **Excluded Services:** Examinations, diagnostic imaging, physiotherapy, massage, acupuncture, and nutritional advice are not covered.
- **Frequency of Visits:** Medicare does not impose a strict cap on the number of visits but expects documentation for the medical necessity of ongoing care.

Key CPT Codes for Medicare Chiropractic Billing

- 98940: Chiropractic manipulative treatment (CMT), spinal, one or two regions.
- 98941: CMT, spinal, three or four regions.
- 98942: CMT, spinal, five regions.

Note: These are the only chiropractic CPT codes reimbursed by Medicare

Medicare Billing for Chiropractic Services Contd.

Documentation Requirements for Medicare

Medicare requires detailed and specific documentation to demonstrate medical necessity. Key components include:

- **Initial Visit Documentation:**
  - Patient history, including chief complaint and relevant medical history.
  - Description of the present illness and past treatments.
  - Objective findings such as subluxation confirmed by x-ray or physical exam.

- **Subsequent Visit Documentation:**
  - Daily notes with subjective patient feedback.
  - Objective findings such as functional improvement.
  - Assessment and treatment plans.

- **Treatment Plans Must Include:**
  - Specific goals for patient improvement.
  - Duration and frequency of care.
  - Planned re-evaluations.

The Role of Subluxation in Medicare Billing

To bill Medicare, a subluxation diagnosis is mandatory. Chiropractors must use one of the following ICD-10 codes for subluxation:

- M99.01: Subluxation of cervical region.
- M99.02: Subluxation of thoracic region.
- M99.03: Subluxation of lumbar region.
- M99.04: Subluxation of sacral region.
- M99.05: Subluxation of pelvic region.

Chiropractors must support the subluxation diagnosis through x-rays or the PART (Pain, Asymmetry, Range of motion, and Tissue tone) evaluation method.

Medicare Billing for Chiropractic Services Contd.

Modifiers for Medicare Billing

Using the correct modifiers is critical to prevent claim denials. Common chiro billing modifiers include:

- AT Modifier: Indicates active treatment. Use this modifier only when the treatment is medically necessary.
- GA Modifier: Indicates that the patient has signed an Advance Beneficiary Notice (ABN) for services likely to be denied by Medicare.
- GY Modifier: Used for services excluded from Medicare coverage (e.g., maintenance therapy).

Maintenance Care and Medicare

Medicare does not cover maintenance therapy, which includes ongoing care for patients whose conditions are stable. To ensure compliance:

- Clearly document when a patient transitions from active to maintenance care.
- Provide the patient with an ABN to inform them that Medicare will not pay for maintenance visits.

Completing the CMS-1500 Form for Medicare

The CMS-1500 form is used for submitting Medicare claims. Here's how to ensure accurate completion:

- **Box 24D**: Enter the CPT codes for chiropractors services (e.g., 98940, 98941, or 98942).
- **Box 21**: Enter the ICD-10 code(s) for the subluxation diagnosis.
- **Box 19:** Include additional information, such as x-ray dates or PART evaluation findings.
- **Modifiers**: Use the AT modifier with the chiropractic CPT codes when billing for active treatment.

Best Practices for Completing the CMS-1500 Form

The CMS-1500 form is the standard claim form used by healthcare providers, including chiropractors, to bill Medicare and other insurance payers. Proper completion of this form is essential to avoid delays, denials, or rejections of claims. Below are best practices to ensure accuracy and compliance when filling out the CMS-1500 form for chiropractic services.

Boxes 1-13	Verify Patient Information

- **Patient's Details:** Ensure the patient's name, address, date of birth, and gender (Boxes 2-5) are accurate and match the insurance records.
- **Insurance Coverage:** Check the payer's name and ensure the correct insurance policy or group number is entered (Boxes 1a and 9a-d).
- **Signature and Date:** Confirm that the patient or their authorized representative has signed Box 12, authorizing the release of medical information.

Box 21	Accurately Report Diagnoses

- **ICD-10 Codes for Chiropractic:** Enter the correct diagnosis codes for the patient's condition. For chiropractic services, subluxation codes such as M99.01 (cervical region) or M99.03 (lumbar region) are commonly used.
- **Order of Diagnosis:** List the primary diagnosis first, followed by any secondary or related diagnoses, in order of relevance to the service provided.

Box 24D	Properly Enter Procedure Codes

Chiro CPT Codes: Use the appropriate chiropractic codes, such as:

- 98940: Chiropractic manipulative treatment, one or two regions.
- 98941: Chiropractic manipulative treatment, three or four regions.
- 98942: Chiropractic manipulative treatment, five regions.

Modifiers: Apply modifiers as needed, such as:

- **AT Modifier:** Indicates active treatment.
- **GA Modifier:** Indicates that the patient has signed an Advance Beneficiary Notice (ABN).

Box 24A	Include Dates of Service

Accurately record the start and end dates of services provided. For chiropractic services, this is typically the date of treatment.

Box 24G	Ensure Units and Time are Correct

Enter the number of units for time-based codes (e.g., 97032, electrical stimulation, 15 minutes). For one-time services like manual manipulations, the unit is “1.”

Box 24B	Use the Correct Place of Service

Enter the Place of Service (POS) code to indicate where the service was performed:

- 11: Office.
- 12: Home.
- 31: Skilled nursing facility.

Box 24F	Accurately List Charges

Ensure that the billed charges for each service align with the practice’s fee schedule. Double-check for accuracy to prevent undercharging or overcharging.

Box 24J and 33A	NPI and Provider Information

- Individual NPI: Include the National Provider Identifier (NPI) of the chiropractor who performed the service in Box 24J.
- Practice NPI: Enter the NPI of the practice or facility in Box 33A.

Box 31	Signature and Certification

Ensure the form is signed and dated by the provider or an authorized representative. This certifies the accuracy of the information and compliance with chiro billing regulations.

Tip 1	Avoid Common Errors

- **Mismatched Codes**: Ensure chiro CPT codes correspond to the diagnosis codes provided.
- **Incomplete ABN Documentation:** If billing for non-covered services, ensure the GA Modifier and signed ABN are included.
- **Incorrect Modifiers:** Misapplication of **chiropractic modifiers** can lead to claim rejections.
- **Illegible Forms**: If submitting paper forms, ensure all information is clear and legible.

Tip 2	Use Software to Streamline Claims

Invest in chiro billing software that integrates with chiropractic EHR systems to automate CMS-1500 form completion, reducing errors and ensuring compliance.

Tip 3	Submit Claims Electronically

Whenever possible, submit claims electronically to Medicare and other payers. Electronic claims are processed faster and reduce the risk of errors compared to paper submissions.

Chapter 5

Chiropractor Billing Tips

Documentation Accuracy

- Ensure comprehensive patient histories and treatment plans are recorded to support the medical necessity of treatments. A detailed, well-organized SOAP note (Subjective, Objective, Assessment, Plan) helps align treatments with insurance expectations.
- Include specific notes on modalities, chiropractic techniques, and therapeutic exercises used, as these can directly impact reimbursement.

Maximizing Reimbursement

- Explore fee schedules and contract terms with insurance providers to ensure you're billing at the appropriate rates for services rendered.
- Implement regular audits of payment postings to identify underpayments or discrepancies that can be addressed with the payer, ensuring you aren’t leaving money on the table.

Preventing Denials

- Double-check patient eligibility before services are rendered, especially for chiropractor billing services that are sometimes more complex to verify. This ensures you don’t end up with claims that are rejected for incorrect patient data or coverage issues.
- Utilize payer-specific chiro billing guides to ensure claims are submitted with all the necessary supporting documentation and modifiers to avoid denials for incomplete or incorrect information. Regular audits are an essential component of insurance billing for chiropractors, as they help maintain financial accuracy and optimize revenue recovery.

Appeals Process

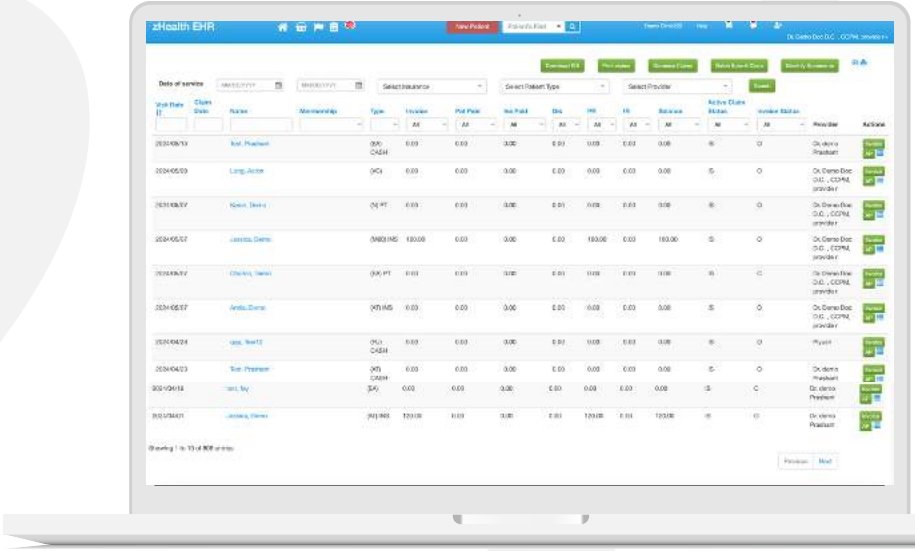
- Familiarize yourself with the specific procedures for appealing insurance denials. Each payer may have different processes, so it's crucial to track timelines and documentation requirements to avoid missed deadlines.
- When submitting an appeal, include any new information or clarifications that support the medical necessity of the treatment. This may include additional notes or testimonials from referring physicians.

Updated Coding Tips

- Stay up-to-date with current chiro CPT codes and ICD-10 coding changes that may impact chiropractic care. For instance, modifiers like 59 (Distinct Procedural Service) or 25 (Significant, Separately Identifiable E/M Service) can be crucial in specific circumstances to avoid claim rejections.
- Leverage the new chiropractic-specific codes that might be introduced in the future to ensure billing accuracy, keeping an eye on payer-specific coding updates and payer compliance.

Technology and Automation in Billing

- Leverage software tools that can automate coding suggestions based on your notes and clinical data, reducing human error and speeding up the claim process.
- Implement practice management systems that sync with EHRs and billing, creating seamless integration that reduces the chance of data entry errors, such as incorrect diagnosis codes or incomplete treatment details.
- Utilizing chiropractic billing software ensures that your practice runs smoothly, allowing you to focus on patient care while optimizing your billing and reimbursement processes.



Chapter 6

Outsourcing Chiropractic Billing

Managing an in-house billing team for a chiropractic practice requires significant resources, including skilled personnel, advanced software, and staying updated with the latest chiropractic CPT codes for 2025.

On top of that, billing errors and delays can lead to denied claims and disrupted cash flow, impacting the financial health of your practice. Partnering with a chiropractic medical billing company offers an effective solution to these challenges.

Accurate Billing

Billing for chiropractic services can be complex, especially when handling the latest chiropractic CPT or ICD-10 codes for 2025.

Outsourcing to experienced chiropractic billing companies ensures precise billing and coding, reducing errors that lead to claim denials. This accuracy results in smoother revenue cycles and faster reimbursements.

Save Time and Money

Building an in-house billing team involves costs for hiring, training, and investing in chiropractic EHR and billing software.

Outsourcing eliminates these expenses, making it a cost-effective alternative. With the best chiropractic billing services, your practice can streamline operations while focusing on patient care.

Improve Cash Flow

Late payments and denied claims can severely impact your cash flow.

By outsourcing to a reliable chiropractic medical billing company, claims are submitted accurately and processed quickly. This ensures consistent cash flow, helping your practice maintain financial stability and meet operational needs.

Boost Revenue and Profitability

Working with the best chiropractic billing services reduces claim denials and accelerates payment cycles.

With lower operating costs and more efficient billing, chiropractic practices often experience significant revenue growth and improved profitability.

Support Strategic Growth

As your practice grows, outsourcing to a scalable chiropractic billing company ensures your billing operations can handle increased demands without needing to expand your in-house team. This flexibility allows you to focus on strategic growth opportunities.

Turn Billing into a Revenue Generator

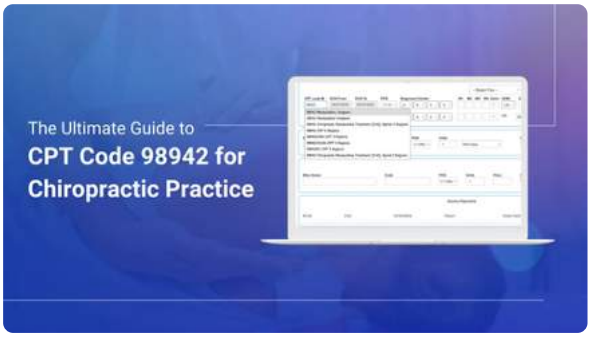
Outsourcing your billing operations simplifies the management of your billing processes and ensures your practice operates more efficiently.

With expert support from chiropractic medical billing companies, you can focus on delivering quality patient care while improving cash flow, reducing costs, and driving profitability for your practice.

Chiropractor Billing CPT Code Series

The Complete Guide to CPT Code 98940 for Maximum Reimbursements

A Comprehensive Guide to CPT Code 98941 for Chiropractors



The Ultimate Guide to CPT Code 98942 for Chiropractic Practice

How CPT Code 98943 Can Improve Your Chiropractic Billing Efficiency

Resources for Chiropractic Coding and Billing

Here are some valuable resources chiropractors can use to look up chiro CPT codes and ensure accurate billing practices:

American Chiropractic Association (ACA)

The ACA offers a wealth of resources, including coding updates, educational materials, and webinars. Their website helps chiropractors stay informed on the latest billing practices and coding standards.

Centers for Medicare and Medicaid Services (CMS)

The CMS website provides critical information on coding, billing, and reimbursement policies for chiropractic services. Chiropractors billing government payers like Medicare and Medicaid must adhere to CMS regulatory requirements. The Medicare Claims Processing Manual and other resources are available to ensure compliance with these guidelines.

Current Procedural Terminology (CPT) Codebook

The CPT codebook is a comprehensive guide that lists codes for medical procedures and services. Chiropractors can refer to this book to find the correct codes for their billing purposes, ensuring they stay aligned with industry standards.

zHealth's All-in-One Chiropractic Software

zHealth's all-in-one software offers a complete solution for chiropractic practice management, including billing and coding. With integrated EHR and practice management features, zHealth provides integrated billing solutions that helps chiropractors stay on top of Chiro CPT codes, optimize billing workflows, and streamline reimbursement processes. This chiro billing software provides coding suggestions based on patient data, reducing the chance of errors and ensuring compliance with payer requirements, all from a single platform.

Chapter 7

Conclusion

Proper chiropractic billing and coding are essential to ensuring timely and accurate reimbursements, minimizing denials, and maintaining compliance with payer requirements.

With this chiropractic billing cheat sheet and by utilizing the right resources, chiropractors can optimize their billing processes and focus on providing the best care for their patients.

For those looking for more streamlined billing solutions, zHealth offers an all-in-one chiropractic software platform that not only simplifies billing and coding but also provides integrated EHR and practice management tools. Our billing software for chiropractors is designed to make chiropractor billing more efficient and accurate

With **zHealth's chiropractor billing services**, you can outsource your billing tasks to a team of experts, ensuring accuracy and maximizing your revenue cycle efficiency. Our chiropractic billing software seamlessly integrates with these services, providing a comprehensive solution tailored to your practice's needs.

To learn how zHealth's Managed Billing Services can improve a practice's financial performance, check out our **Case Study** to see how our solutions have helped chiropractors reduce denials and increase reimbursements.

Whether you choose to manage billing in-house with zHealth Billing Software or leverage our managed services, our solutions are designed to save you time, reduce errors, and help your practice thrive.

The All-in-One Practice Management Software

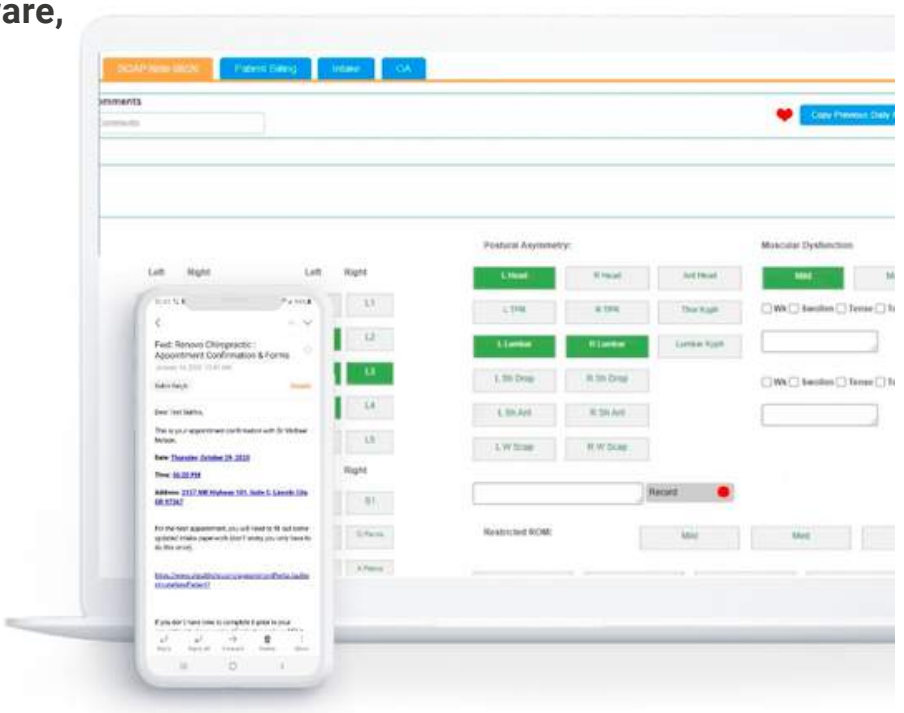
zHealth software comes with online appointment scheduling and unlimited reminders. The speech recognition functionality assists chiropractors with SOAP note dictation and real-time speech-to-text conversion. As one of the top practice management software solutions, zHealth also offers a patient portal, allowing patients to complete intake forms and check in on a front desk kiosk, ensuring a smooth start to their visit. The software includes a built-in tool that sends outcome assessment forms to patients and automatically scores the assessments, allowing you to monitor their progress.

zHealth's billing module allows billers to create invoices, submit insurance claims and generate reports. The integrated payment processing solution - zHealth Pay - allows you to collect payments online, in the office, save cards on file, and automatically collect patient balances via an automated text message. The solution is available on a monthly subscription and support is provided via email and phone.

Call **+1 800-939-0319**

Visit **https://myzhealth.io/**

Award-winning chiropractic software, trusted by providers like you!



The all-in-one practice management software for wellness practices

Call 1-800-939-0319 | Email sales@zhealthehr.com
Visit www.myzhealth.io