

**Guidance on coding of clinical encounters in VHA on-station chiropractic care**  
**Chiropractic Program Office**  
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The VHA Health Information Management (HIM) Program Office is charged with developing and maintaining coding guidelines with the highest standards for accurate coding of health information throughout the Department of Veterans Affairs. Per the VHA Coding Guidelines, coding will follow current published ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting, as well as other established industry standard coding guidance such as CPT Assistant and the American Hospital Association's (AHA) Coding Clinic. In rare cases, VHA will deviate from industry practice due to the unique nature of the VHA and the Veteran patient. These variations are included in the VHA Coding Guidelines found on the HIM Share Point site. [VHA Coding Guidelines - All Documents \(sharepoint.com\)](#)

VHA chiropractic care follows standard medically appropriate approaches to diagnosis and management, based on current published evidence and available best practices. Use of appropriate ICD and CPT coding is important in clinical documentation, and contributes to high-quality clinical data capture. Thus VHA processes for coding of chiropractic visits should be consistent with standard medical coding procedures to allow the most precise description of patient conditions seen and services provided.

Medicare and/or some private payers may place certain limitations on chiropractic ICD and/or CPT coding outside of VHA. These limitations do not appear to contribute to improved patient care, and furthermore they result in less accurate data attributed to chiropractic visits, thus are not applicable in VHA.

For high-quality clinical coding in VHA on-station chiropractic care, the following are recommended:

**1. Diagnostic Coding (ICD)**

- The diagnosis/es should be specific to the given problem/complaint, and supported by appropriate clinical documentation
- The most accurate ICD code(s) should be selected
- Segmental/somatic dysfunction and/or subluxation ICD codes are not required to be used, but may be appropriate in given cases
- When multiple ICD codes are applicable in a given visit, they should be entered in descending order of complexity or severity

**2. Procedural Coding (CPT®)**

- Codes for all services that were delivered and documented should be indicated on the encounter. Use of CPT codes is not limited by external payer policies.
- Evaluation & Management Services
  - Any given E&M code should be used as clinically appropriate and consistent with widely accepted parameters on documentation justifying the level of care
- Therapeutic Services
  - Chiropractic Manipulative Therapy (CMT)
    - Spinal CMT codes (98940, 98941 and 98942)

- 98940 - one to two spinal regions
  - History, examination and diagnosis(es) involving at least one spinal region
- 98941 - three to four spinal regions
  - History, examination and diagnosis(es) involving at least three spinal regions
- 98942 - five spinal regions
  - History, examination and diagnosis(es) involving five spinal regions
- Definitions of spinal CMT Regions
  - Cervical: C1 through C7, including the atlanto-occipital joint
  - Thoracic: T1 through T12, including costovertebral and costotransverse junctions
  - Lumbar: L1 through L5
  - Sacral: sacrum including sacrococcygeal junction
  - Pelvic: the sacroiliac joint and other pelvis articulations
- Extraplinal CMT code
  - 98943 – extrapinal, one or more regions
    - History, examination and diagnosis(es) involving extrapinal region(s)
  - Definition of extrapinal CMT Regions
    - Head, including temporomandibular joint, excluding atlanto-occipital joint
    - Upper extremities, rib cage, lower extremities and abdomen
- Other therapeutic procedural codes (not CMT)
  - Any other services provided consistent with the chiropractor's privileges, clinical indications, and clinical documentation should be attributed using standard CPT codes
  - Appropriate use of active care codes is recommended
  - Specific codes should not be changed to global codes
    - E.g. 97014 (electrical stimulation) should not be changed to the Medicare code G0283

## Notes

### *Medicare Modifiers*

Medicare currently requires specific modifiers for chiropractic care, which are not required elsewhere. Conventional modifiers should be used appropriately, but there should not be additional chiropractic-specific modifiers.

### *Advance Beneficiary Notice (ABN)*

ABNs or waivers of liability are not required.