

Chiropractic Services Coding Guide

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Purpose

CareOregon strives to follow current coding guidelines in conjunction with Centers for Medicare and Medicaid Services (CMS) and Oregon Health Authority (OHA) policies. As such, we would like to provide guidance to chiropractors serving our community to better the adjudication process and transparency of claims submitted.

Medicare and Medicare Advantage coverage for chiropractic visits is limited and specific to diagnosis codes billed. CareOregon covers chiropractor services subject to the patient's plan and limitations.

Scope

This guide applies to all providers, non-physician providers and subcontractors who submit chiropractor claims, including but not limited to evaluation and management services, manipulation, traction, etc. The purpose of this guide is to provide guidance to chiropractors serving the CareOregon community.

Policy

Coding for Medicare

Medicare and Medicare Advantage plans limit chiropractic services to chiropractic manipulation codes with the appropriate modifier. Coverage is limited to treatment by means of manual manipulation. Additionally, chiropractors can use handheld devices. Medicare does not recognize an extra charge for these handheld devices.

| 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 |

No other diagnostic or therapeutic services provided by or ordered by a chiropractor are covered by Medicare.

Coding for Medicaid

Medicaid generally covers chiropractic care when it is medically necessary, within the provider's scope of practice, and consistent with the Prioritized List and Coordinated Care Organization (CCO) policies, including pre-authorization.

| 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 |
| 98943 | Chiropractic manipulative treatment (CMT); to 1 or more extra spinal regions |

Medically Unlikely Edits (Medicare)

The CMS National Correct Coding Initiative (NCCI) established Medically Unlikely Edits (MUE) values, which are the maximum units of chiropractic services allowed per date of service. CareOregon follows CMS maximums to billing units.

| Code | MUE Value |
|-------|-----------|
| 98940 | 1 |
| 98941 | 1 |
| 98942 | 1 |
| 98943 | 0 |

Medically Unlikely Edits (Medicaid)

The CMS National Correct Coding Initiative (NCCI) established Medically Unlikely Edits (MUE) values, which are the maximum units of chiropractic services allowed per date of service. CareOregon applies the CMS maximums to billing units for Medicaid.

| Code | MUE Value |
|-------|-----------|
| 98940 | 1 |
| 98941 | 1 |
| 98942 | 1 |
| 98943 | 1 |

Other diagnostic or therapeutic services provided by or ordered by a chiropractor may be allowed if medically necessary and appropriate authorizations are in place.

Coding for initial care and follow up

After establishing care with the patient, evaluation and management services should be limited to once every 30 calendar days.

If a re-exam is done less than 30 days after the initial exam, there should be documented evidence supporting that the patient:

- has a flare-up or exacerbation
- has a new injury or significant added complaints
- has a positive response to care, which dictates a change in the care plan to a more active-based care or, at minimum, some significant change in the treatment plan; or is ready for release

Covered services and plan limitations

Evaluation and management (E/M) codes are not reimbursable if/when chiropractic services are not a covered benefit of the patient's plan.

Other applicable chiropractic services

CareOregon covers treatments which are ranked on the covered Prioritized List line for a patient's reported medical condition. Please reference the Prioritized List of Health Services

Limitations

- Claims that lack proper documentation or do not support the number of body regions billed are subject to denial or adjustment.
- Claims billed by a provider without proper credentialing on file.
- Services that do not meet medical necessity criteria are not eligible for reimbursement.
- Claims that include improper coding, insufficient documentation, or failure to meet supervision, credentialing, or scope-of-practice requirements may be denied or subject to post-payment review.
- Services billed outside of the scope of practice or licensure are not reimbursable.
- Duplicate or repetitive services without documented clinical benefit may be denied.
- Providers are responsible for remaining current with changes to CPT®, HCPCS, and applicable federal and state regulations, as codes and coverage guidelines are updated periodically.

Definitions

Chiropractic: A form of complementary medicine based on the diagnosis and manipulative treatment of misalignments of the joints, especially those of the spinal column which are believed to cause other disorders by affecting the nerves, muscles, and organs.

CMS: Centers for Medicare & Medicaid Services

E/M: Evaluation and Management

MUE: Medically Unlikely Edit

References

Centers for Medicare & Medicaid Services. Medicare Benefit Policy Manual, Chapter 15: Covered Medical and Other Health Services. Accessed January 15, 2026.

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>

Oregon Health Authority. Prioritized List of Health Services. Updated February 1, 2026.

<https://www.oregon.gov/oha/HPA/DSI-HERC/PrioritizedList/2-1-2026%20Prioritized%20List%20of%20Health%20Services.pdf>

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These guidelines have been developed to accompany and complement the official conventions and instructions provided within the American Medical Association's Current Procedural Terminology (CPT®) itself. Additions and deletions conform it to the most recent publications of CPT® and HCPCS Level II and to changes in CareOregon and its affiliates coverage policy and payment status, and as such these guidelines are current as of 01/01/2026. Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful. CareOregon and its affiliates make no claim, promise, or guarantee of any kind about the accuracy, completeness, or adequacy of the content for a specific claim, situation, or provider office application, and expressly disclaim liability for errors and omissions in such content. As CPT® codes change annually, you should reference the current version of published coding guidelines and/or recommendations from nationally recognized coding organizations for the most detailed and up-to-date information.

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