BCBS Fee Schedule

Effective date 09/01/15

(Revised 12/11/20 to remove CPT 99201 which is deleted as of 01/01/21.)

It is important to note that just because a code is listed on this fee schedule does not necessarily mean it is covered or will be paid. Payment for each code is reviewed at the time of adjudication and is based on medical policy, medical necessity and individual plan benefits.

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CMT Services

Procedure Code	Code Description	BCBS Allowable
98940	Chiropractic Manipulation; Spinal, one to two regions	$29.25
98941	Chiropractic Manipulation; Spinal, three to four regions	$35.50
98942	Chiropractic Manipulation; Spinal, five regions	$40.00
98943	Chiropractic Manipulation; Extraspinal, 1 or more regions	$22.75
(Modifier Information)	If reporting a CMT service on the same date of service as Manual Therapy (97140), always add modifier -59 to the 97140 CPT code to indicate a distinct procedural service.	
(Modifier Information)	If reporting a spinal manipulation on the same date of service as an extraspinal, always add modifier -59 to the extraspinal to indicate a distinct procedural service.	

E/M Services

Procedure Code	Code Description	BCBS Allowable
99202	E/M New Patient – Limited	$41.00
99203	E/M New Patient – Intermediate	$48.75
99204	E/M New Patient – Extensive	$48.75
99205	E/M New Patient – Comprehensive	$48.75
99211	E/M Established Patient – Brief	$19.54
99212	E/M Established Patient – Limited	$31.00
99213	E/M Established Patient – Intermediate	$39.25
99214	E/M Established Patient – Extensive	$39.25
99215	E/M Established Patient – Comprehensive	$39.25

E/M Services (*cont.*)

Procedure Code	Code Description	BCBS Allowable
99241	Consultation; New or Established	$34.04
99242	Consultation; New or Established	$34.04
99243	Consultation; New or Established	$34.04
99244	Consultation; New or Established	$34.04
99245	Consultation; New or Established	$34.04
99354	Prolonged Physician Service	$34.04
(Modifier Information)	If the patient's condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and post service associated with another service or procedure being performed on the same date of service, add modifier -25 to the E/M code that is being reported.	
(Modifier Information)	If reporting CMT service on the same date of service as an E/M service, ALWAYS add modifier -25 to the E/M service.	

Radiology Services

Procedure Code	Code Description	BCBS Allowable
70328	Temporomandibular Joint; Unilateral	$22.05
70330	Temporomandibular Joint; Bilateral, open & closed mouth	$34.55
71045	Chest; single view	$18.95
71046	Chest; two views	$24.47
71100	Ribs; Unilateral, two views	$24.47
72020	Spine; single view, specify level	$17.76
72040	Spine; Cervical, Anteroposterior and Lateral	$35.44
72050	Spine; Cervical, minimum of four views	$38.54
72052	Spine; Cervical, compl, incl Obl. & Flex and/or Extension	$48.42
72070	Spine; Thoracic, Anteroposterior and Lateral	$33.96
72072	Spine; Thoracic, AP and Lateral, inc swimmer's view	$28.88
72074	Spine; Thoracic, compl, including Obliques, min four views	$34.14
72080	Spine; Thoracolumbar, Anteroposterior and Lateral	$26.72
72081	Spine; Thoracic and Lumbar, including skull, cervical and sacral, one view	$29.44
72082	Spine; Thoracic and Lumbar, including skull, cervical and sacral, two or three views	$47.13
72100	Spine; Lumbrosacral, Anteroposterior and Lateral	$37.29
72110	Spine; Lumbrosacral, complete with oblique views	$39.66
72114	Spine; Lumbrosacral, complete, including bending views	$51.50
72120	Spine; Lumbrosacral, bending views only, min four views	$35.54
72170	Pelvis; Anteroposterior only	$20.34
72190	Pelvis; complete, minimum three views	$28.66
72202	Sacroiliac Joints; three or more views	$26.11
72220	Saccrum and Coccyx; minimum of two views	$22.69
73020	Shoulder; one view	$18.04

Radiology Services (*cont.*)

Procedure Code	Code Description	BCBS Allowable
73030	Shoulder; complete, minimum of two views	$22.71
73070	Elbow; Anteroposterior and Lateral	$20.29
73080	Elbow; complete, minimum of three views	$24.94
73090	Forearm; Anteroposterior and Lateral	$20.59
73100	Wrist; Anteroposterior and Lateral	$20.87
73110	Wrist; complete, minimum of three views	$24.27
73120	Hand; two views	$20.31
73130	Hand; minimum of three views	$22.86
73140	Fingers; minimum of two views	$19.96
73501	Hip; Unilateral, including pelvis, one view	$22.66
73502	Hip; Unilateral, including pelvis, two or three views	$31.27
73521	Hips; Bilateral, including pelvis, two views	$30.20
73560	Knee; one or two views	$21.46
73562	Knee; three views	$24.96
73564	Knee; complete; four or more views	$28.41
73590	Tibia and Fibula; Anteroposterior and Lateral	$20.90
73600	Ankle; Anteroposterior and Lateral	$20.31
73610	Ankle; complete, minimum of three views	$22.86
73620	Foot; Anteroposterior and Lateral	$20.03
73630	Foot; complete, minimum of three views	$22.86
73660	Toes; minimum of two views	$19.40
77073	Bone Length Studies	$30.41

Lab Services

Procedure Code	Code Description	BCBS Allowable
81000	Urinalysis; with microscopy	$4.43
81002	Urinalysis; without microscopy	$3.57

Tests

Procedure Code	Code Description	BCBS Allowable
95851	Range of Motion Measurement & Report; each extremity	$15.65
95852	Range of Motion Measurement & Report; hand	$12.20
95860	Needle Electromyography; one extremity	$92.25
95861	Needle Electromyography; two extremities	$128.19
95863	Needle Electromyography; three extremities	$155.90
95864	Needle Electromyography; four extremities	$179.31
95869	Needle Electromyography; Thoracic Paraspinal Muscles	$56.82
95870	Needle Electromyography; limited study, one extremity	$66.14
95872	Needle Electromyography; single Fiber Electrode	$157.74
95885	Needle Electromyography; each extremity	$44.26

Tests (*cont.*)

Procedure Code	Code Description	BCBS Allowable
95886	Needle Electromyography; compl, 5 or more muscle studies	$69.94
95887	Needle Electromyography; non-extremity	$65.70
95905	Motor / Nerve Conduction; each limb with F waves	$50.84
95907	Nerve Conduction; one to two studies	$72.51
95908	Nerve Conduction; three to four studies	$89.47
95909	Nerve Conduction; five to six studies	$107.70
95910	Nerve Conduction; seven to eight studies	$141.57
95911	Nerve Conduction; nine to ten studies	$172.23
95912	Nerve Conduction; eleven to twelve studies	$202.63
95913	Nerve Conduction; thirteen or more studies	$234.75

*codes in blue may only be billed by active Diplomates of the American Chiropractic Neurology Board (DACNB)

Modalities & Procedures

Supervised Modalities (not time based) – these services do NOT require direct one-on-one patient contact by provider

Procedure Code	Code Description	BCBS Allowable
97010	Hot and Cold Packs	$2.76
97012	Traction/Modality; one or more areas	$16.25
97014	Electrical Stimulation; unattended, one or more areas	$16.10
97016	Vasopneumatic devices	$8.92
97024	Diathermy; one or more areas	$3.00
97026	Infrared; one or more areas	$2.76

Constant Attendance (time based services) – requires DIRECT one-on-one patient contact by provider or therapist

Procedure Code	Code Description	BCBS Allowable
97032	Electrical Stimulation; manual, one or more areas, ea. 15 min	$9.72
97034	Contrast Baths; one or more areas, ea. 15 min	$8.50
97035	Ultrasound; one or more areas, ea. 15 min	$6.90
97530	Therapeutic Activities; ea. 15 min	$20.55

Modalities & Procedures (*cont.*)

Therapeutic Procedures / Tests (time based services) – requires DIRECT one-on-one patient contact by provider or therapist

Procedure Code	Code Description	BCBS Allowable
97110	Therapeutic Exercises; ea. 15 min	$16.00
97112	Neuromuscular Reeducation of Movement; ea. 15 min	$10.00
(Modifier Information)	If reporting a CMT service together with 97112, always add modifier -59 to the 97112 CPT code.	
97124	Therapeutic Massage; ea. 15 min	$10.00
(Modifier Information)	If reporting a CMT service together with 97124, always add modifier -59 to the 97124 CPT code.	
97140	Manual Therapy; ea. 15 min (myofascial release)	$15.74
(Modifier Information)	If reporting a CMT service together with 97140, always add modifier -59 to the 97140 CPT code.	
97750	Physical Performance Test & Written Report; ea. 15 min	$20.23
(Modifier Information)	Use modifier -52 to report reduced services.	

Group Therapeutic Procedures (not time based) – group therapy requires constant attendance by provider or therapist but by definition does not require one-on-one patient contact by provider or therapist (group is 2 or more individuals)

Procedure Code	Code Description	BCBS Allowable
97150	Therapeutic Procedures; group	$12.31
	(report 97150 for each member of the group)	

Emergency Care

Procedure Code	Code Description	BCBS Allowable
99050	After Hours Care	$18.18
99056	Service Provided Outside of Office	$17.09
99058	Emergency Basis Services	$21.40

Foot Orthotic Services

Procedure Code	Code Description	BCBS Allowable
97760	Orthotic Management and Training; includes assess / fitting	$20.52
97763	Orthotic Management and Training; subsequent encounter	$20.48
L3020	Orthotic; foot insert, per foot	$129.02
L3030	Orthotic; foot insert, per foot	$56.24
(Modifier and Billing Information)	When billing for orthotics, bill each orthotic ***on a separate service line*** and add the appropriate modifier using RT (right) and LT (left).	

Example:	Code	Modifier	Units
	L3020	RT	1
	L3020	LT	1

Other DME Services

Procedure Code	Code Description	BCBS Allowable
A4565	Slings	$4.18
A4570	Splint	$10.46
E0720	TENS Device; two leads	$150.00
E0720	TENS **Rental**; two leads	$22.11
E0730	TENS Device; four or more leads	$150.00
E0730	TENS **Rental**; four or more leads	$22.41
L0120	Cervical, Flexible, non-adj Foam Collar	$20.62
L0220	Thoracic, Rib Belt; custom fabricated	$36.75
L0621	Sacroiliac Orthosis; flexible	$35.00
L0625	Lumbar Orthosis; flexible	$30.00
L0626	Lumbar Orthosis; rigid posterior panel	$57.45
L1810	KO; elastic with joints	$89.22
L1820	KO; elastic with condylar pads	$88.87
L3650	Shoulder Orthosis	$40.15
L3710	Elbow Orthoses; elastic, metal joints, prefab incl fitting & adj	$97.24
L3908	WHO Wrist Extension Control; prefabricated, non-molded	$40.19
L3923	Hand Finger Orthosis	$58.34

Acupuncture

Procedure Code	Code Description	BCBS Allowable
97810	Acupuncture; 1 or more needles, w/o stim, initial 15 min	$22.51
97811	Acupuncture; 1 or more needles, w/o stim, ea addtl 15 min	$17.16
97813	Acupuncture; 1 or more needles, w/ stim, initial 15 min	$23.82
97814	Acupuncture; 1 or more needles, w/ stim, ea addtl 15 min	$19.21

It is important to note that just because a code is listed on this fee schedule does not necessarily mean it will be paid for by BCBSNC or a Blue Cross and Blue Shield plan outside of North Carolina. Payment for each code is reviewed by BCBSNC at the time of adjudication and payment is based on medical policy, medical necessity and individual plan benefits. As such, you may find that a specific code is reimbursed for one member but not another. Please remember to verify benefits for each member prior to providing services.

Modifier Information

The information regarding modifier usage included on this fee schedule is meant as guidance only and HNS cannot assure that the use of these modifiers as described above will guarantee payment. Providers should review the ACA Coding Solutions Manual as well as the AMA CPT book to determine when modifiers should be used and which modifiers are appropriate for a particular service. Please contact your HNS Service Rep for assistance with correct modifier usage.

Frequently Used Modifiers for Chiropractic Services

Modifier	Description
-25	Significant, separately identifiable E/M service performed by the same provider on the same date of service as another procedure or service **(Note: this modifier is ONLY to be used with E/M codes)**
-50	Bilateral procedure
-52	Indicates reduced service
-59	Distinct, procedural service