

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services



MLN Matters® Number: SE1601 **Revised**

Related Change Request (CR) #: N/A

Article Release Date: May 7, 2019

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Medicare Coverage for Chiropractic Services – Medical Record Documentation Requirements for Initial and Subsequent Visits

Note: CMS revised this article on May 7, 2019, to update sources of information regarding chiropractic services with additional references added to the Additional Information section of this article. We deleted resource references that are no longer available. All other information remains the same.

Provider Types Affected

This MLN Matters® Special Edition article is for doctors of chiropractic and other practitioners who submit claims to Medicare Administrative Contractors (MACs) for chiropractic services provided to Medicare beneficiaries.

This article is part of a series of Special Edition (SE) articles that the Centers for Medicare & Medicaid Services (CMS) prepared for doctors of chiropractic due to the request for educational materials at the September 24, 2015, Special Open Door Forum titled: “Improving Documentation of Chiropractic Services” and includes updated information. Other articles in the series are SE1602, which details the use of the AT modifier on chiropractic claims and SE1603, which identifies other useful resources to help doctors of chiropractic bill Medicare correctly for covered services.

Provider Action Needed

CMS is providing this SE article to help clarify CMS policy about Medicare coverage of chiropractic services for Medicare beneficiaries and documentation requirements for the beneficiary’s initial visit and subsequent visits to the doctor of chiropractic. Know these policies along with any Local Coverage Determinations (LCDs) for these services in your

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area that might limit circumstances under which Medicare pays for active/corrective chiropractic services.

Background

In 2018, the Comprehensive Error Testing Program (CERT) that measures improper payments in the Medicare Fee-For-Service (FFS) program reported a 41 percent error rate on claims for chiropractic services. Most of those errors were due to insufficient documentation or other documentation errors.

Medicare limits coverage of chiropractic services to treatment by means of manual manipulation (that is, by use of the hands) of the spine to correct a subluxation. The patient must require treatment by means of manual manipulation of the spine to correct a subluxation, and the manipulative services the doctor of chiropractic provides must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. The doctor of chiropractic may use manual devices (that is, those that are hand-held with the thrust of the force of the device being controlled manually) in performing manual manipulation of the spine. However, Medicare makes no additional payment for use of the device, nor does Medicare recognize an extra charge for the device itself.

Doctors of chiropractic are limited to billing three Current Procedural Terminology (CPT) codes under Medicare: 98940 (chiropractic manipulative treatment; spinal, one to two regions), 98941 (three to four regions), and 98942 (five regions). When submitting manipulation claims, doctors of chiropractic must use an Acute Treatment (AT) modifier to identify services that are active/corrective treatment of an acute or chronic subluxation. The AT modifier, when used appropriately, should indicate expectation of functional improvement, regardless of the chronic nature or redundancy of the problem.

Documentation Requirements

The Social Security Act states that “no payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.” See the Social Security Act ([section 1833\(e\)](#)).

In addition, the Medicare Benefit Policy Manual requires that the initial visit and all subsequent visits meet specific documentation requirements. See Chapter 15 ([section 240.1.2](#)).

Documentation Requirements for the Initial Visit

The following documentation requirements apply for initial visits whether the subluxation is demonstrated by x-ray or by physical examination:

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1. History: The history the provider records in the patient record should include the following:

- Chief complaint including the symptoms causing patient to seek treatment
- Family history if relevant
- Past medical history (general health, prior illness, injuries, hospitalizations, medications; surgical history)

2. Present Illness: Description of the present illness including:

- Mechanism of trauma
- Quality and character of symptoms/problem
- Onset, duration, intensity, frequency, location, and radiation of symptoms
- Aggravating or relieving factors
- Prior interventions, treatments, medications, secondary complaints
- Symptoms causing patient to seek treatment

Note: Symptoms must be related to the level of the subluxation that the doctor of chiropractic cites. A statement on a claim that there is “pain” is insufficient. Describe the location of the pain and whether the vertebra you listed can produce pain in that area.

3. Physical Exam: Evaluation of musculoskeletal/nervous system through physical examination. If you demonstrate a subluxation you based on physical examination, two of the following four criteria (one of which must be asymmetry/misalignment or range of motion abnormality) are required and you need to document the criteria:

- **P - Pain/tenderness:** The perception of pain and tenderness is evaluated in terms of location, quality, and intensity. Most primary neuromusculoskeletal disorders manifest with a painful response. Pain and tenderness findings may be identified through one or more of the following: observation, percussion, palpation, provocation, and so forth. Furthermore, pain intensity may be assessed using one or more of the following; visual analog scales, algometers, pain questionnaires, and so forth.
- **A - Asymmetry/misalignment:** Asymmetry/misalignment may be identified on a sectional or segmental level through one or more of the following: observation (such as posture and heat analysis), static palpation for misalignment of vertebral segments, and/or diagnostic imaging.
- **R - Range of motion abnormality:** Changes in active, passive, and accessory joint movements may result in an increase or a decrease of sectional or segmental mobility. Range of motion abnormalities may be identified through one or more of the following: motion palpation, observation, stress diagnostic imaging, range of motion, and/or other measurement(s).
- **T -Tissue tone, texture, and temperature abnormality:** Changes in the characteristics of contiguous and associated soft tissue including skin, fascia, muscle, and ligament may be identified through one or more of the following procedures: observation, palpation, use of instrumentation, and/or test of length and/or strength.

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Note: The P.A.R.T. (**P**ain/tenderness; **A**symmetry/misalignment; **R**ange of motion abnormality; and **T**issue tone, texture, and temperature abnormality) evaluation process is recommended as the examination alternative to the previously mandated demonstration of subluxation by x-ray/MRI/CT for services beginning January 1, 2000. The acronym P.A.R.T. identifies diagnostic criteria for spinal dysfunction (subluxation).

4. Diagnosis: The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the bone named. The precise level of the subluxation must be specified by the doctor of chiropractic to substantiate a claim for manipulation of the spine. This designation is made in relation to the part of the spine in which the subluxation is identified as shown in the following table:

Area of Spine	Names of Vertebrae	Number of Vertebrae	Short Form or Other Name	Subluxation ICD-10 code
Neck	Occiput Cervical Atlas Axis	7	Occ, CO C1-C7 C1 C2	M99.00 M99.01
Back	Dorsal or Thoracic Costovertebral Costotransverse	12	D1-D12 T1-T12 R1-R12 R1-R12	M99.02
Low Back	Lumbar	5	L1-L5	M99.03
Pelvis	Ilii, R and L (I, Si)		I, Si	M99.05
Sacral	Sacrum, Coccyx		S, SC	M99.04

In addition to the vertebrae and pelvic bones listed, the Ilii (R and L) are included with the sacrum as an area where a condition may occur which would be appropriate for chiropractic manipulative treatment.

There are two ways you may specify the level of the subluxation in the patient's record.

- List the exact bones, for example: C5, C6, etc.
- The area may suffice if it implies only certain bones such as: occipito-atlantal (occiput and C1 (atlas)), lumbo-sacral (L5 and Sacrum) sacro-iliac (sacrum and ilium)

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Following are some common examples of acceptable descriptive terms for the nature of the abnormalities:

- Off-centered
- Misalignment
- Malpositioning
- Spacing - abnormal, altered, decreased, increased
- Incomplete dislocation
- Rotation
- Listhesis - antero, postero, retro, lateral, spondylo
- Motion - limited, lost, restricted, flexion, extension, hypermobility, hypomotility, aberrant

You may use other terms. If they are understood clearly to refer to bone or joint space or position (or motion) changes of vertebral elements, they are acceptable.

X-rays

As of January 1, 2000, Medicare does not require an x-ray to demonstrate the subluxation. However, you may use an x-ray for this purpose if you so choose.

The date of the x-ray must be reasonably close to (within 12 months prior or 3 months following) the beginning of treatment. In certain cases of chronic subluxation (for example, scoliosis), an older x-ray may be accepted if the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent.

A previous CT scan and/or MRI are acceptable evidence if a subluxation of the spine is demonstrated.

5. Treatment Plan: The treatment plan should include the following:

- Recommended level of care (duration and frequency of visits)
- Specific treatment goals
- Objective measures to evaluate treatment effectiveness

Date of the initial treatment.

The patient's medical record.

- Validate all the information on the face of the claim, including the patient's reported diagnosis(s), physician work (CPT code), and modifiers.
- Verify that all Medicare benefit and medical necessity requirements were met.

Documentation Requirements for Subsequent Visits

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

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1. History

- a. Review of chief complaint
- b. Changes since last visit
- c. Systems review if relevant

2. Physical examination

- a. Examination of area of spine involved in diagnosis
- b. Assessment of change in patient condition since last visit
- c. Evaluation of treatment effectiveness

3. Documentation of treatment given on day of visit.**Necessity for Treatment of Acute and Chronic Subluxation**

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function.

The patient must have a subluxation of the spine as demonstrated by x-ray or physical examination, as described above.

Most spinal joint problems fall into the following categories:

- **Acute subluxation**-A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical examination as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.
- **Chronic subluxation**-A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition); however, the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

You must place the HCPCS modifier AT on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However, the presence of the HCPCS modifier AT may not in all instances indicate that the service is reasonable and necessary.

As shown in the Medicare Benefit Policy Manual, Chapter 15, Section 240, the doctor of chiropractic should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time. Acute subluxation (for example, strains or sprains) problems may require as many as three months of treatment but some require very little treatment. In the first several days,

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treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained.

Chronic spinal joint condition implies, of course, the condition has existed for a longer period of time and that, in all probability, the involved joints have already “set” and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

ICD-10 Codes that Support Medical Necessity for Chiropractic Services

The chiropractic LCDs for MACs include ICD-10 Coding Information for ICD-10 Codes that support the medical necessity for chiropractic services. There may be additional documentation information in your LCD. There are links to the chiropractic LCDs in MLN Matters SE article [SE1603](#).

The **Group 1 (primary) codes** are the only covered ICD-10-CM codes that support medical necessity for chiropractic services.

- Primary: ICD-10-CM Codes (Names of Vertebrae)
- List the precise level of subluxation as the primary diagnosis.

The Groups 2, 3, and 4 ICD-10-CM codes support the medical necessity for diagnoses and involve short, moderate, and long-term treatment:

- **Group 2 Codes:** Category I - ICD-10-CM Diagnosis (diagnoses that generally require **short term treatment**)
- **Group 3 Codes:** Category II - ICD-10-CM Diagnosis (diagnoses that generally require **moderate term treatment**)
- **Group 4 Codes:** Category III - ICD-10-CM Diagnosis (diagnoses that may require **long term treatment**)

ICD-10 Codes that DO NOT Support Medical Necessity are **all** ICD-10-CM codes **not** listed in LCDs under *ICD-10-CM Codes That Support Medical Necessity*.

Additional Information

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

A new Medicare Learning Network Educational Tool, Medicare Documentation Job Aid For Doctors of Chiropractic, is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/MLN1232664.html>.

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The Medicare Benefit Policy Manual, Chapter 15, Section 240 is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>.

The CERT 2018 Medicare Fee-For-Service Supplemental Improper Payment Data report is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2018MedicareFFSSupplementalImproperPaymentData.pdf>.

Article SE1101, **Overview of Medicare Policy Regarding Chiropractic Services**, is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1101.pdf>.

Article MM3449, **Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR3063** is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm3449.pdf>.

Article SE0749, **Addressing Misinformation Regarding Chiropractic Services and Medicare**, is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0749.pdf>.

Other articles in this series on chiropractic services include [SE1602](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1602.pdf), which is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1602.pdf>. [SE1603](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1603.pdf) at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1603.pdf> lists a wide array of other materials to assist doctors of chiropractic in delivering covered services to Medicare beneficiaries and correctly billing for those services.

Document History

- **May 7, 2019 - CMS revised this article to update sources of information regarding chiropractic services with additional references added to the Additional Information section of this article. We deleted resource references that are no longer available. All other information remains the same.**
- **June 18, 2018 – We revised the article to delete the word “always” from the line for item 5 (Treatment Plan) on page 5. All other information remains the same.**
- **March 16, 2016 – Initial article released.**

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