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Use of the AT modifier for Chiropractic Billing (New Information Along with Information in MM3449)

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 Special Edition (SE) MLN Matters® article is for chiropractors 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 prepared for chiropractors by the Centers for Medicare & Medicaid Services (CMS) in response 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.

Provider Action Needed

The Active Treatment (AT) modifier was developed to clearly define the difference between active treatment and maintenance treatment. Medicare pays only for active/corrective treatment to correct acute or chronic subluxation. Medicare does not pay for maintenance therapy. Claims should include a primary diagnosis of subluxation and a secondary diagnosis that reflects the patient's neuromusculoskeletal condition. The patient's medical record should support the services you are billing. Related MLN Matters Article **SE1601** discusses those medical record documentation requirements.

Be aware of these policies along with any Local Coverage Determinations (LCDs) for chiropractic services in your 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 program reported a 41 percent error rate for chiropractic services. Most of those errors were due to insufficient documentation or documentation errors. Year after year these error rates appear. CMS is providing an explanation of the AT modifier to help providers document claims correctly for chiropractic services they provide to Medicare beneficiaries.

The AT modifier defines the difference between active treatment and maintenance treatment. Effective October 1, 2004, Medicare requires the AT Modifier on Medicare claims to receive reimbursement for CPT codes 98940-98942. For Medicare purposes, chiropractors should use the AT modifier only when billing for active/corrective treatment (acute and chronic care). The policy requires the following:

1. Every chiropractic claim for 98940/98941/98942, with a date of service on or after October 1, 2004, should include the AT modifier if active/corrective treatment is being performed

2. Do not use the AT modifier for maintenance therapy. MACs deny chiropractic claims for 98940, 98941, or 98942, with a date of service on or after October 1, 2004, that do not have the AT modifier.

The following categories help determine coverage of treatment. (See the **Necessity for Treatment**, Chapter 15, Section 240.1.3, of the Medicare Benefit Policy Manual (pages 226-227)) at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf.

1. **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). (See **SE1601** for details of the x-ray and examination requirements.) The result of chiropractic manipulation is expected to be **an improvement in, or arrest of progression of**, the patient's condition.

2. **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.

Medicare covers both these scenarios while there is active treatment which you document correctly and you expect the patient to improve. As stated 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, 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.

Maintenance: Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, Medicare considers the treatment is maintenance therapy. Do not use the AT modifier when you provided maintenance therapy.

Doctors of chiropractic should consider obtaining an Advance Beneficiary Notice (ABN) from beneficiaries in the event of a denial of a claim. Information about the ABN, including downloadable forms is available at **https://www.cms.gov/MEDICARE/medicare-general-information/bni/abn.html**. Also, see the Medicare Claims Processing Manual, **Chapter 23 section 20.9.1.1** pages 49 and 50, for important information about the use of an appropriate modifier on your claims with regard to the ABN.

Be aware that once the provider cannot determine there is any improvement, treatment becomes maintenance and Medicare no longer covers the treatment.

Key Points

For Medicare purposes, a doctor of chiropractic must place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However, the presence of the AT modifier may not in all instances indicate that the service is reasonable and necessary. As always, MACs may deny the claim if a medical review determines that the medical record does not support active/corrective treatment.

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.

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/2018MedicareFFSSuplementalImproperPaymentData.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 SE1601, which is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1601.pdf. SE1601 discusses medical record documentation requirements for chiropractic services. Also, SE1603 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.
- March 16, 2016 – Initial article released.