Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash - ***Effective March 1, 2008,*** Medicare fee-for-service 837P and CMS-1500 claims must include an NPI in the primary fields on the claim (i.e., the billing, pay-to, and rendering fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim. You may not submit claims containing only a legacy identifier in the primary fields. Failure to submit an NPI in the primary fields will result in your claim being rejected or returned as unprocessable beginning March 1, 2008. Until further notice, you may continue to include legacy identifiers only for the secondary fields.

MLN Matters Number: SE0749
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Note: This article was updated on August 28, 2012, to reflect current Web addresses. All other information is the same.

Addressing Misinformation Regarding Chiropractic Services and Medicare

Provider Types Affected

Providers submitting claims to Medicare contractors (carriers, and/or Part A/Part B Medicare Administrative Contractors (A/B MACs)) for Chiropractic services provided to Medicare beneficiaries

Provider Action Needed

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to correct misinformation in the chiropractic community relating to Medicare and its regulations as they relate to chiropractic services. This article is informational only and represents no changes to existing Medicare policy.

Background

In order to correct misinformation about Medicare and its regulations which exist in the chiropractic community, the American Chiropractic Association (ACA) works to check the validity of all claims and provide accurate information based on the

Medicare manual system maintained by CMS, as well as information in regulatory and statutory language. CMS is providing this special edition article which it hopes will clarify certain issues, around which there may be some confusion. The specific issues being addressed are:

MISINFORMATION #1: There is a 12 visit cap or limit for chiropractic services.

Correction: There are no caps/limits in Medicare for covered chiropractic care rendered by chiropractors who meet Medicare's licensure and other requirements as specified in the Medicare Benefit Policy Manual, Chapter 15, Section 30.5. (This manual is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html on the CMS website.)

There may be review screens (numbers of visits at which the Medicare carrier or A/B MAC may require a review of documentation), but caps/limits are not allowed.

The Social Security Act (Section 1862 (a)(1); see http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the Internet) provides that Medicare will only pay for items or services it determines to be "reasonable and necessary," and if those items or services can be shown to be "reasonable and necessary," then those items or services are covered and will be paid by Medicare.

MISINFORMATION #2: If you are a non-participating (non-par) provider, you do not have to worry about billing Medicare.

Correction: Being non-par does not mean you don't have to bill Medicare. All Medicare covered services must be billed to Medicare, or the provider could face penalties.

A non-par provider is actually a provider involved in the Medicare program who has enrolled to be a Medicare provider but chooses to receive payment in a different method and amount than Medicare providers classified as participating. The non-par provider may receive reimbursement for rendered services directly from their Medicare patients. They submit a bill to Medicare so the beneficiary may be reimbursed for the portion of the charges for which Medicare is responsible.

It is important to note that non-par providers may choose to accept assignment, therefore, the amount paid by the beneficiary must be reported in Item 29 of the CMS 1500 claim form. This ensures that the beneficiary is reimbursed (if applicable) prior to Medicare sending payment to the provider.

Whether or not a non-par provider chooses to accept assignment on all claims or on a claim-by-claim basis, their Medicare reimbursement is five percent less than a participating provider, as reflected in the annual Medicare Physician Fee Schedule.

You can find a copy of the Medicare Participating Provider Agreement at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms460.pdf on the CMS website. The form contains important information regarding the participation process and the annual opportunity you have to make or change your participation decision.

Additional information is available in the Medicare Benefit Policy Manual (Chapter 15; Covered Medical and Other Health Services) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf on the CMS website and the Medicare Claims Processing Manual (Chapter 12; Physician/Nonphysician Practitioners) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf on the CMS website.

MISINFORMATION #3: If you are a non-participating (non-par) provider, you will never be audited nor have claims reviewed, etc.

Correction: Any Medicare claim submitted can be audited/reviewed; the non-participating (non-par) or participating (par) status of the physician does not affect the possibility of this occurring. CMS audits/reviews are intended to protect Medicare trust funds and also to identify billing errors so providers and their billing staff can be alerted of errors and educated on how to avoid future errors. Correct coverage, reimbursement, and billing requirements are readily available to assist you in understanding Medicare requirements. This information is in Medicare manuals that are at *http://www.cms.gov/Manuals/* on the CMS website. In addition, an excellent way to stay informed about changes to Medicare billing and coverage requirements is to monitor MLN Matters articles, such as this one, which are available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html on the same site.

MISINFORMATION #4: You can opt out of Medicare.

Correction: Opting out of Medicare is not an option for Doctors of Chiropractic. Note that opting out and being non-participating are not the same things. Chiropractors may decide to be participating or non-participating with regard to Medicare, but they may not opt out.

For further discussions of the Medicare "opt out" provision, see the Medicare Benefits Policy Manual (Chapter 15, Section 40; Definition of Physician/Practitioner) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf on the CMS website.

MISINFORMATION #5: You should get an Advance Beneficiary Notification (ABN) signed once for each patient, and it will apply to all services, all visits.

Correction: The decision to deliver an ABN must be based on a genuine reason to expect that Medicare will not pay for a particular service on a specific occasion for that beneficiary due to lack of medical necessity for that service. The ABN then allows the beneficiary to make an informed decision about receiving and paying for the service. Should the beneficiary decide to receive the service, you must then submit a claim to Medicare even though you expect the beneficiary to pay and you expect that Medicare will deny the claim.

For further information, see the Medicare Claims Processing Manual (Chapter 30) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf and the Medicare Benefits Policy Manual (Chapter 15) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf on the CMS website.

MISINFORMATION #6: Maintenance care is not a covered service under Medicare.

Correction: Spinal manipulation is a covered service under Medicare, no matter which phase of care you may be in; however, maintenance care is not medically reasonable and necessary and therefore not reimburseable by Medicare. Acute, chronic, and maintenance adjustments are all "covered" services, but only acute and chronic services are considered active care and may, therefore, be reimbursable. Maintenance therapy is defined (per Chapter 15, Section 30.5.B. of the Medicare Benefits Policy Manual)) as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to 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, the treatment is then considered maintenance therapy.

See MM3449 (Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy) at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3449.pdf on the CMS website. This

article contains important information on completing claims and how to identify acute and chronic adjustments as opposed to maintenance adjustments. The article also recommends you consider issuing an ABN to the Medicare beneficiary when you provide maintenance services. Additional details are available in the Medicare Benefits Policy Manual, Chapter 15, Section 30.5 (Chiropractor's Services) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf on the CMS website.

MISINFORMATION #7: Non-par providers do not have the same documentation requirements as par providers.

Correction: Chiropractic care has documentation requirements to show medical necessity. The participating status of the provider is irrelevant to the documentation requirements.

Specific details regarding documentation are in the Medicare Benefit Policy Manual (Chapter 15, Sections 30.5 and 240) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf on the CMS website. Also, see the Medicare Claims Processing Manual (Chapter 12, Section 220) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf on the CMS website.

Additional Information

If you have any questions regarding chiropractic issues and Medicare, please contact your Medicare carrier or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

News Flash - **It's seasonal flu time again! If you have Medicare patients who haven't yet received their flu shot, you can help them reduce their risk of contracting the seasonal flu and potential complications by recommending an annual influenza and a one-time pneumococcal vaccination. Medicare provides coverage for flu and pneumococcal vaccines and their administration. – And don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot – Not the Flu! Remember - Influenza vaccination is a covered Part B benefit but the influenza vaccine is NOT a Part D covered drug. Health care professionals and their staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing Special Edition *MLN Matters* article SE0748 at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0748.pdf on the CMS website.**