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Overview of Medicare Policy Regarding Chiropractic Services

Note: This article was updated on July 31, 2012, to reflect current Web addresses. Previously, it was revised on September 9, 2011, to clarify some of the language. No changes in policy are conveyed by these clarifications.

Provider Types Affected

Chiropractors and other practitioners billing Medicare for chiropractic services are affected by this Special Edition article. No new policies are contained in this article.

Provider Action Needed



STOP – Impact to You

This Special Edition article highlights Medicare policy regarding coverage of chiropractic services for Medicare beneficiaries.

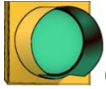


CAUTION – What You Need to Know

Please review this article and go to the links listed in the information section below for further details.

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GO – What You Need to Do

Please review your clinical documentation and billing practices. Ensure that your office staffs are aware of the correct use of codes and modifiers and Medicare coverage policy regarding chiropractic services.

Background

Numerous audits of chiropractic service claims have found a significant portion of the claims to have been paid inappropriately. Correct claim payment depends largely on providers complying with Medicare requirements for coverage, coding, and documentation of services. The goal of this article is to translate published Medicare coverage and payment requirements for chiropractic services into a few practical tips for better Medicare compliance to effectively lower the frequency of improper payments (and corresponding error rates).

The most common errors noted by Medicare auditors of chiropractic service claims are briefly described below.

- Technical errors such as missing signatures, date of service on the claim not found in the record, etc. In other words, specific documentation that is required as a condition of payment is often missing from the beneficiary's medical record.
- Documentation that does not substantiate that all procedure(s) reported were performed. For example,
 - No documentation or insufficient documentation that **all** spinal levels of manipulation reported had been performed;
 - No documentation that each manipulation reported related to a relevant symptomatic spinal level.
- Insufficient or absent documentation that all procedures or services were medically reasonable and necessary. In other words, the submitted documentation was not sufficient for Medicare auditors to determine whether the services furnished were medically necessary. Examples of insufficient or absent documentation for purposes of determining medical necessity are as follows:
 - Required elements of the history and examination were absent.
 - Treatment plan absent or insufficient.
- Treatment furnished was “maintenance therapy. As discussed later in this article, Medicare pays only for medically necessary chiropractic services, which are limited to active/corrective manual manipulations of the spine to correct subluxations. **When further improvement cannot reasonably be expected from continuing care, the services are considered maintenance therapy, which is not medically necessary and therefore not a covered service under the Medicare program.**

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- Non-Covered devices or techniques applied in performing manipulation. (See the key points section of this article.)

Previous Study by the Office of Inspector General (OIG) on Chiropractic Care

A recent study by the Office of Inspector General (OIG) entitled “*Inappropriate Medicare Payments for Chiropractic Services*” found inappropriate Medicare payments for chiropractic services.

The OIG study found that:

- Claims lack initial visit dates for treatment episodes, hindering the identification of maintenance therapy; and
- There is lack of compliance with the manual documentation requirements. For example, treatment plans, an important element in determining whether the chiropractic treatment was active/corrective in achieving specified goals, were either missing or lacked treatment goals, objective measures, or the recommended level of care.

The Key Points section below reviews Medicare policy for coverage of chiropractic services, with an emphasis on the billing and documentation requirements.

Key Points

Medicare Coverage of Chiropractic Services

Coverage of chiropractic services is specifically limited to treatment by means of manual manipulation (i.e., by use of the hands) of the spine to correct a subluxation. Subluxation is defined as a motion segment, in which alignment, movement integrity, and/or physiological function of the spine, are altered, although contact between joint surfaces remains intact.

Manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. No additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself.

No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor’s order is covered. If you order, take, or interpret an x-ray, or any other diagnostic test, the x-ray or other diagnostic test can be used for documentation, but Medicare coverage and payment are not available for those services. This does not affect the coverage of x-rays or other diagnostic tests furnished by other practitioners under the program.

Subluxation May Be Demonstrated by X-Ray or Physician’s Examination

X-rays

As of January 1, 2000, an x-ray is not required by Medicare to demonstrate the subluxation. However, an x-ray may be used for this purpose if you so choose. The x-ray must have been taken reasonably close to (within 12 months prior or 3 months following) the beginning of treatment. In certain cases of chronic subluxation (e.g., 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

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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.

Physical examination

To demonstrate a subluxation based on physical examination, two of the following four criteria (one of which must be asymmetry/misalignment or range of motion abnormality) are required:

1. Pain/tenderness evaluated in terms of location, quality, and intensity;
2. Asymmetry/misalignment identified on a sectional or segmental level;
3. Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or decrease of sectional or segmental mobility); and
4. Tissue, tone changes in the characteristics of contiguous or associated soft tissues, including skin, fascia, muscle, and ligament.

Documentation Requirements Must Be Placed in the Patient's File

Initial Visit

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

1. The history includes the following:

- a. Symptoms causing patient to seek treatment;
- b. Family history if relevant;
- c. Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history);
- d. Mechanism of trauma;
- e. Quality and character of symptoms/problem;
- f. Onset, duration, intensity, frequency, location, and radiation of symptoms;
- g. Aggravating or relieving factors; and
- h. Prior interventions, treatments, medications, secondary complaints.

2. Description of the present illness, including:

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

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These symptoms must bear a direct relationship to the level of subluxation. The subluxation must be causal, i.e., the symptoms must be related to the level of the subluxation that has been cited. A statement on a claim that there is “pain” is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.

3. Evaluation of musculoskeletal/nervous system through physical examination

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 particular bone named. The precise level of the subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine.

5. Treatment Plan should include the following:

- a. Recommended level of care (duration and frequency of visits);
- b. Specific treatment goals; and
- c. Objective measures to evaluate treatment effectiveness.

6. Date of the initial treatment.

7. The patient’s medical record.

- Validate all of 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.

Subsequent Visits

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

1. History

- a. Review of chief complaint;
- b. Changes since last visit; and
- 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.

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3. Documentation of treatment given on day of visit.

Necessity for Treatment

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), but where 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 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.

Maintenance Therapy

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, the treatment is then considered maintenance therapy.

The AT modifier **must not** be placed on the claim when maintenance therapy has been provided. **Claims without the AT modifier will be considered as maintenance therapy and denied.**

You should consider providing the **Advance Beneficiary Notice of Noncoverage (ABN)** to the beneficiary. Chiropractors who give beneficiaries an ABN will place the **modifier GA** (or in rare instances **modifier GZ**) on the claim. 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 beneficiary can then make a reasonable and informed decision about receiving and paying for the service. If the beneficiary decides to receive the service, you must submit a claim to Medicare even though you expect that Medicare will deny the claim and that the beneficiary will pay.

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"Since March 3, 2008 CMS has issued one form with the official title "Advance Beneficiary Notice of NonCoverage (ABN)" (form CMS-R-131). A properly executed ABN must use this form for each date an ABN is issued and all the required fields on the form must be completed including a mandatory field for cost estimates of the items/services at issue and a valid specific reason why the chiropractor believes Medicare payment for CMT will be denied on this date for this beneficiary. ABNs should not be issued routinely citing the same reason for each occurrence. One ABN cannot be used with added lines for future dates of services. For additional instructions on the proper completion of the ABN, see <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html> on the CMS website.

Key Billing Requirements

In addition to other billing requirements explained in Medicare's Manuals, it is important that you include the following information on the claim:

- The primary diagnosis of subluxation;
- The initial visit or the date of exacerbation of the existing condition;
- The appropriate Current Procedural Terminology (CPT) code that best describes the service:
 - **98940:** Chiropractic Manipulative Treatment (CMT); spinal, one or two regions;
 - **98941:** Spinal, three to four regions;
 - **98942:** Spinal, five regions.

NOTE: 98943: CMT, extraspinal, one or more regions, is not covered by Medicare.

- The appropriate modifier that describes the services:
 - **AT modifier*** used on a claim when providing active/corrective treatment to treat acute or chronic subluxation;
 - **GA modifier** used to indicate that you expect Medicare to deny a service (e.g., maintenance services) as not reasonable and necessary and that you have on file an Advance Beneficiary Notice (ABN) signed by the beneficiary; or
 - **GZ modifier** used to indicate that you expect that Medicare will deny an item or service as not reasonable and necessary and that you have **not** had an ABN signed by the beneficiary, as appropriate.

NOTE: You must use the Acute Treatment modifier "AT" to identify services that are active/corrective treatment of acute or chronic subluxation and must document services in accordance with the Centers for Medicare & Medicaid Services' (CMS) "Medicare Benefit Policy Manual", Chapter 15, Section 240, when submitting claims.

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Beneficiary Responsibility

For Medicare covered services, the beneficiary pays the Part B deductible and then 20 percent of the Medicare-approved amount. The beneficiary also pays all costs for any services or tests you order. If you provide an ABN, you must submit a claim to Medicare, even though you expect the beneficiary to pay and you expect Medicare to deny the claim.

Additional Information

Providers improving their compliance with Medicare documentation requirements should lower the likelihood of continued audit identified shortcomings. In this regard, consider the following suggestions:

- Signatures

CMS published national provider “signature” requirements in April 2010. For details, please refer to the "Medicare Program Integrity Manual," Chapter 3; Section 3.3.2.4 .

[\(<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf>\)](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf).

- Documenting Procedures

Document procedures as soon as possible after performing them and include the code on which the service is based on that documentation. A helpful technique for assuring good documentation is to periodically self-audit claims against records to determine if the codes chosen are supported by the records. Auditing and correcting non-conforming office practices help minimize claim errors occurring with the clerical task of preparing and submitting the claim. It is helpful for practitioners who use devices to assist manipulations to clearly document the device’s name, and, if necessary, send with records to auditors a device description or other information describing how the device meets CMS requirements for assistive devices.

- Medical Necessity

Thorough documentation of clinically relevant and CMS required documentation elements serve to create a clear portrait of the patient’s baseline condition, treatments provided, and a treatment timeline in terms of the patient’s symptomatic functional response. The patient’s condition (symptoms, physical signs, and function) must be described with objective, measurable terms along with pertinent subjective information. Documentation must provide a clear description of the mechanism of injury and how it negatively impacts baseline function. A clear plan of treatment that includes treatment goals (expected duration and frequency) and the clinical milestones to be used as measures of progress is also necessary. Demonstrate progress in objective, rather than conclusory, terms. You should document modifications in the treatment plan, when needed, because of failure to satisfactorily progress in the clinically reasonable and predicted timeframe. Adequately demonstrate that treatments provide more than short term symptom control unaccompanied by durable functional improvement.

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Documentation of the initial evaluation and periodic reevaluations at reasonable intervals is essential. Evaluation/reevaluation elements above need not be documented at each treatment. However, they must be documented often enough to show measurable progress or failure to progress. And, above all, they must be included with the documentation of any procedures sent to Medicare auditors.

If you have any questions, please contact your carrier or A/B Medicare Administrative Contractor 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.

CMS Manual References

The “Medicare Benefit Policy Manual,” Chapter 15, Section 30.5 – Chiropractor’s Services and Section 240 – Chiropractic Services, can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf> on the CMS website.

The “Medicare Claims Processing Manual,” Chapter 12, Section 220 – Chiropractic Services, can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf> on the CMS website.

Other References

Office of Inspector General, May 2009, “Inappropriate Medicare Payments for Chiropractic Services,” can be found at <http://oig.hhs.gov/oei/reports/oei-07-07-00390.pdf> on the Internet.

The Medicare Learning Network® (MLN) educational product titled, “Advance Beneficiary Notice of Noncoverage (ABN),” can be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf on the CMS website.

The MLN educational product titled, “Addressing Misinformation Regarding Chiropractic Services and Medicare,” can be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Chiropractors_fact_sheet.pdf on the CMS website.

MLN Matters® Article #MM3449, “Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR3063,” can be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM3449.pdf> on the CMS website.

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