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

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Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR3063

Note: Note: This article was updated on April 6, 2013, to reflect current Web addresses. This article was previously revised on August 8, 2011, to include a reference to MLN Matters® article SE1101 (http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE1101.pdf) for a description of policies and procedures that currently apply to billing for chiropractic services. All other information remains the same.

Provider Types Affected

Chiropractors

Provider Action Needed

STOP – Impact to You

Chiropractors have been submitting a very high rate of incorrect claims to Medicare. Medicare only pays for chiropractic services for active/corrective treatment (those using HCPCS codes 98940, 98941, or 98942). Claims for medically necessary services rendered on or after October 1, 2004 must contain the Acute Treatment (AT) modifier to reflect such services provided, or the claim will be denied.

CAUTION – What You Need to Know

This article completely replaces MM3063 on the same subject. On or after October 1, 2004, when you provide acute or chronic active/corrective treatment to Medicare patients, you must add the AT modifier to every claim that uses HCPCS codes 98940, 98941, or 98942. If you don't add this modifier, your care will be considered maintenance therapy and will be denied because maintenance

chiropractic therapy is not considered medically reasonable or necessary under Medicare.

GO – What You Need to Do

Ensure that your billing staff is aware that they must apply the AT modifier to HCPCS codes 98940, 98941, or 98942 when your clinical documentation reflects that the care you provided to a Medicare patient consists of active/corrective treatment. Additionally, your billing staff should be aware of any local coverage determinations (LCDs) for these services in your area that might limit circumstances under which active/corrective chiropractic can be paid.

Background

The 2003 Improper Medicare FFS Payment report indicates that chiropractors have the highest provider Compliance Error Rate in Medicare, filing claims incorrectly almost one-third of the time. Chapter 15, Section 30.5 of the Medicare Benefits Policy Manual states that the Medicare program does not consider chiropractic maintenance therapy as medically reasonable or necessary, and is not payable under the Medicare program. So, for you to bill Medicare correctly, you need to indicate which of your claims are for active/corrective therapy and which are for maintenance therapy. A modifier (AT) already exists that can be used for this purpose.

Therefore, you must place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. For services rendered on or after October 1, 2004, all of your claims for active/corrective therapy (HCPCS codes 98940, 98941, 98942) that do not contain the AT modifier will be denied. This is because (as mentioned above) services without this modifier will be considered maintenance therapy (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) and are not considered medically reasonable or necessary under Medicare.

As always, your Medicare contractor may deny your claim, if appropriate, after medical review.

For services that are maintenance therapy, you may wish to obtain an Advance Beneficiary Notice (ABN) from the beneficiary and also apply the GA modifier (to be used when you want to indicate that you expect that Medicare will deny a service as not reasonable and necessary and that you do have on file an ABN signed by the beneficiary) or the GZ modifier (to be used when you want 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.

Related Instructions

The revisions to Chapter 15 of the Medicare Benefits Policy Manual are attached to the official instruction released to your carrier. That instruction may be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R23BP.pdf on the CMS website. Also, you may check any local medical review policies (LMRPs)/LCDs that may apply to you at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx on the CMS website.

For more information about the use of the ABN, consult the Internet-Only Manual (IOM), Pub. 100-04, Chapter 23, Section 20.9.1.1. You can access this manual at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Additional Information

If you have any questions, please contact your carrier 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.