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## Is Your Office Submitting Accurate Claims Information for Chiropractic Services?

Providers are encouraged to review the following information, and also reference the Local Carrier Decision (LCD) CHIRO-501, available at [http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd\\_id=26621&lcd\\_version=2&show=all](http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=26621&lcd_version=2&show=all) on the Centers for Medicare and Medicaid Services (CMS) Website. After complete review providers can then, if necessary, adjust their billing practices accordingly.

### **Date of the Initial Treatment:**

It is required to indicate the date of the initial treatment, or the date that the provider first saw the patient, made a diagnosis, and initiated the treatment plan for chiropractic care, in Item 14 on the CMS-1500 form, or loop 2300/DTP03 (454) of the electronic ANSI 4010A1. The date of initial treatment may also be the date of exacerbation of an existing condition for a patient already under chiropractic care. This is not necessarily the date of injury or onset of a new condition.

Frequently documentation is requested for medical review with a cover letter that asks for the treatment records and additional information related to the chiropractic services billed. Specifically, the letter asks for the "date of onset" and the "date patient first seen for this course of treatment." These can be the same date; however, they usually are not. For example, a patient may have fallen down the steps on January 1, 2004, and may not have been examined by the chiropractor until February 1, 2004. In this situation, you should indicate February 1, 2004 as the date of initial treatment in Item 14 on the CMS-1500 form. For electronic submitters, this is loop 2300/DTP03 (454) of the electronic ANSI 4010A1. The date of injury, January 1, 2004, should be kept in the patient record and available to the carrier upon request.

### **Medical Necessity of Chiropractic Services:**

Subjective complaints, or symptoms, documented in the patient medical record must be related to, or caused by, the level of subluxation(s) cited. The exact level of subluxation(s) must be documented, with the most accurate ICD-9 or diagnosis code(s) for these subluxations reported in Item 21 on the CMS-1500 form, or, in loop 2300/HI for electronic ANSI 4010A1 submitters.

The manipulative services provided must have a direct therapeutic relationship to the patient's diagnosed condition, and must be documented in the patient record. For example, if a patient presents with a chief complaint of neck pain, the chiropractor identifies a subluxation at C5, and in turn, performs manual manipulation to the cervical spine, one region (CPT code 98940) should be billed. Even if the technique used to treat the above example involves manipulation of the entire spine, only one region can be billed. The subjective complaints must match the objective findings/diagnosis in order to bill for that region. Subjective complaints, objective findings, reported diagnoses, and treatment provided must also be directly related, and documented accurately, to support the medical necessity of the chiropractic services provided.