



Chiropractic Questions and Answers

1) Am I required to have an Advanced Beneficiary Notice (ABN) signed for each service rendered?

No. An ABN should be signed when the provider expects the service to be denied. In the case of an extended course of treatment, one ABN is acceptable if the notice identifies all the dates of services and procedures the physician believes Medicare will not pay. If, as the course of treatment progresses, additional services are furnished which the physician believes Medicare will not pay, the beneficiary must be separately notified of the likelihood of Medicare nonpayment and the beneficiary must agree to pay.

The provider must add the GZ modifier when the service provided is expected to be denied as not reasonable & necessary and there is not a signed ABN on file.

The provider must add the GA modifier when the service provided is expected to be denied as not reasonable & necessary and there is a signed ABN on file.

The provider must make the beneficiary aware of the possibility of denial before having the ABN signed.

For more information on ABNs please review the following:

http://www.cms.hhs.gov/MLNProducts/downloads/ABN_READERS.PDF

To review the LCD - Chiropractic Services, CHIRO-501 policy for coverage and billing guidelines please go to:

http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=26621&lcd_version=2&show=all

2) Why do I have to place the AT modifier on all of my CMT codes (98940, 98941, and 98942)?

You do not have to place the AT modifier on all of your CMT codes. The AT modifier should only be used according to Medicare Guidelines. According to LCD CHIRO-501 Chiropractic Services Policy, use of the AT modifier by the Chiropractic provider signifies to Medicare that **ACTIVE/CORRECTIVE** chiropractic manipulative treatment (CMT) is being performed. The AT modifier should not be placed on CMT codes when providing **MAINTENANCE** therapy.

Active/corrective manipulative treatment is delivered *when the result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.* Chiropractic active/corrective manipulative treatment is considered medically reasonable and necessary under the Medicare program, and is therefore payable. The AT modifier is appropriate to use when providing CMT that is active/corrective.

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 chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. Per LCD CHIRO-501 Chiropractic Services Policy ongoing maintenance therapy is not considered to be medically reasonable or necessary, and is therefore not payable. For maintenance therapy, it is not appropriate to use an AT modifier.

3) What is subluxation?

Local Coverage Determination (LCD) CHIRO-501 defines 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.

A subluxation of the spine is when one or more vertebral bones move out of position or alignment and create pressure on or irritate spinal nerves that can result in alteration of sensation and/or somatic dysfunction.

4) What is the difference between the "Date of the Initial Treatment" and the "Date of Injury/Onset"?

The *date of the initial treatment* is the date that the provider first saw the patient, made a diagnosis, and initiated the treatment plan for chiropractic care. The *date of injury or onset* is the actual date that the injury occurred. For example, a patient may have fallen down the steps on January 1, 2005 and may not have been examined by the chiropractor until February 1, 2005. In this situation, February 1, 2005 is the date of the initial treatment. The date of injury, January 1, 2005, should be kept in the patient record and available to the carrier upon request.

5) What is Chiropractic Maintenance Therapy?

Local Coverage Determination (LCD) CHIRO-501 defines Chiropractic Maintenance Therapy 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. Medicare does not consider ongoing maintenance therapy as medically necessary and it is not payable under the Medicare Program.

6) If a patient comes in for a non-covered service do I have to take assignment?

No. A provider is not required to submit a non-covered service to Medicare unless the beneficiary specifically requests the provider to submit the non-covered service to Medicare. A participating provider must accept assignment on all claims submitted to Medicare. A nonparticipating provider may take assignment on a case by case basis.