

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

<http://www.wpsmedicare.com/provider/abn.shtml>

To review the LCD - Chiropractic Services, CHIRO-001 policy for coverage and billing guidelines please go to:

<http://www.wpsmedicare.com/policies/wisconsin/chiro001.pdf>

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-001 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-001 Chiropractic

Services Policy, Page 10, Documentation Requirements, 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 the most common reason for denial of chiropractic services?

Most often we find that documentation doesn't support the services provided. It is important that your documentation contains the appropriate PART format. Your documentation must show a direct relationship between the symptoms and the level of subluxation.

It is also important that your documentation is legible and that you fully document services you performed. We cannot assume anything, so if the service is not documented, we consider it not done. Per Local Coverage Determination (LCD) CHIRO-001, Section D, Documentation Requirements:

"These symptoms must **bear a direct relationship to the level of subluxation**. The symptoms should refer to the spine (spondyle or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal) and joint (arthro) and be reported as pain (algia), inflammation (itis), or as signs such as swelling, spasticity, etc. Vertebral pinching of spinal nerves may cause headaches, arm, shoulder, and hand problems as well as leg and foot pains and numbness. Rib and rib/chest pains are also recognized symptoms, but in general other symptoms must relate to the spine as such. 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.**"

Documentation Examples:

- "Low back pain with L3 subluxation due to abnormal gait from knee pain/problem" shows a direct relationship between the symptom and the level of subluxation.
- "L3 subluxation; knee pain." Since L3 subluxation is not the only diagnosis that causes knee pain, this *does not* document a direct relationship to the level of subluxation.

4. What is subluxation?

Local Coverage Determination (LCD) CHIRO-001 defines subluxation 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.

5. 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.

6. What is Chiropractic Maintenance Therapy?

Local Coverage Determination (LCD) CHIRO-001 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.

7. 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.

8. How is Chiropractic Manipulation Treatment (CMT) billed when manipulation is performed on more than one vertebrae of the same spinal region?

There are five spinal regions defined by the AMA 2006 Current Procedural Terminology (CPT) book for coding purposes: cervical, thoracic, lumbar, sacral, and pelvic. Regardless of the number of vertebra treated within a region, each region is counted once.

Example: Manipulation is performed on the second cervical vertebrae, the third cervical vertebrae, the second thoracic vertebrae, the third thoracic vertebrae, and the fifth thoracic vertebrae. This would be billed as 98940 for CMT of two spinal regions (cervical and thoracic).

Resources:

1. AMA 2006 Current Procedural Terminology (CPT); Professional Edition; page 406
2. Wisconsin Physicians Service, LCD Chiro-001, Chiropractic Services