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Chiropractic Billing and Documentation

7/22/2025

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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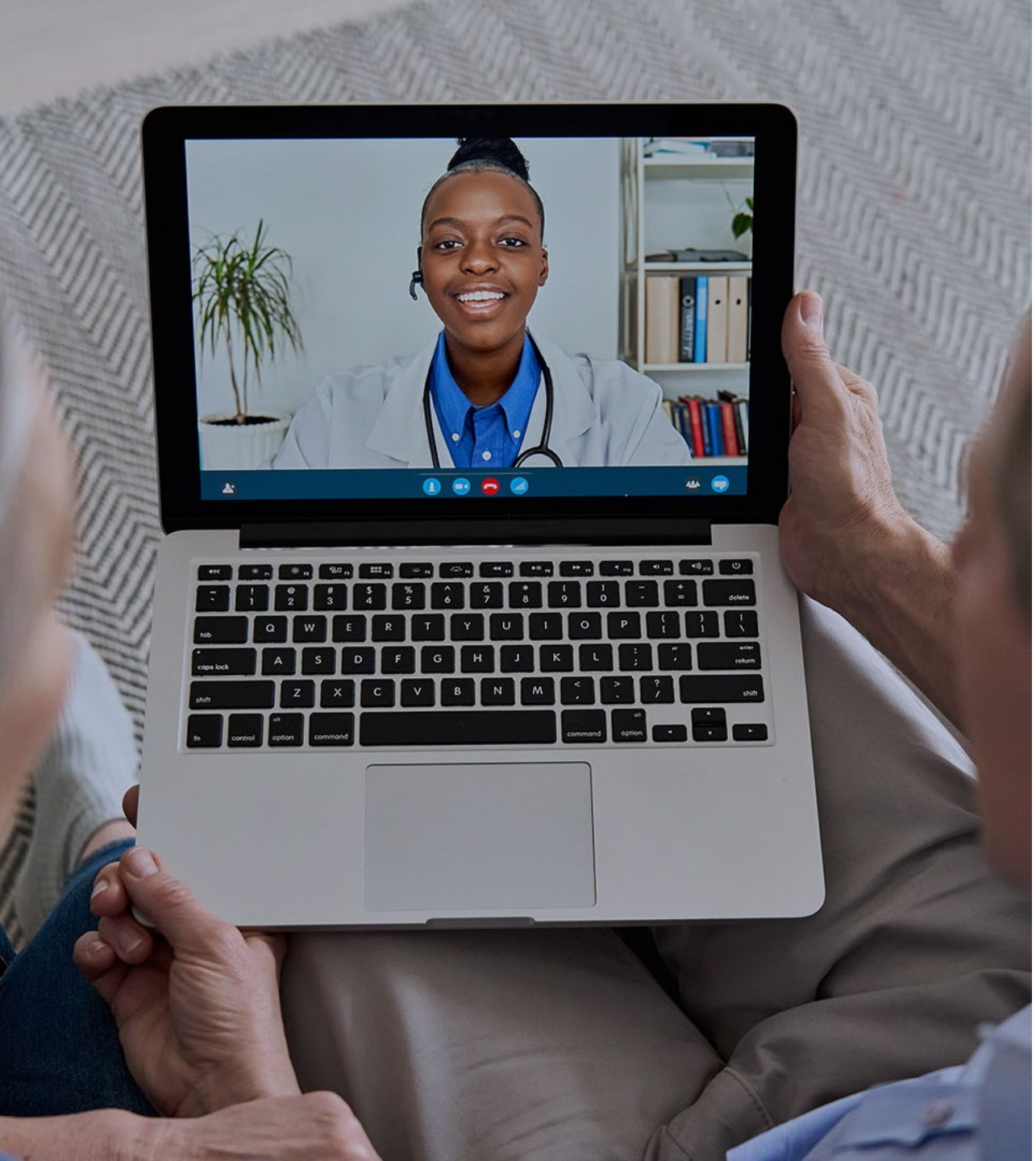

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Objective

Provide a sampling of chiropractic billing concepts and guidelines to give you a better understanding of the Medicare Program, while helping to decrease your National Government Services claim submission billing errors.

Agenda

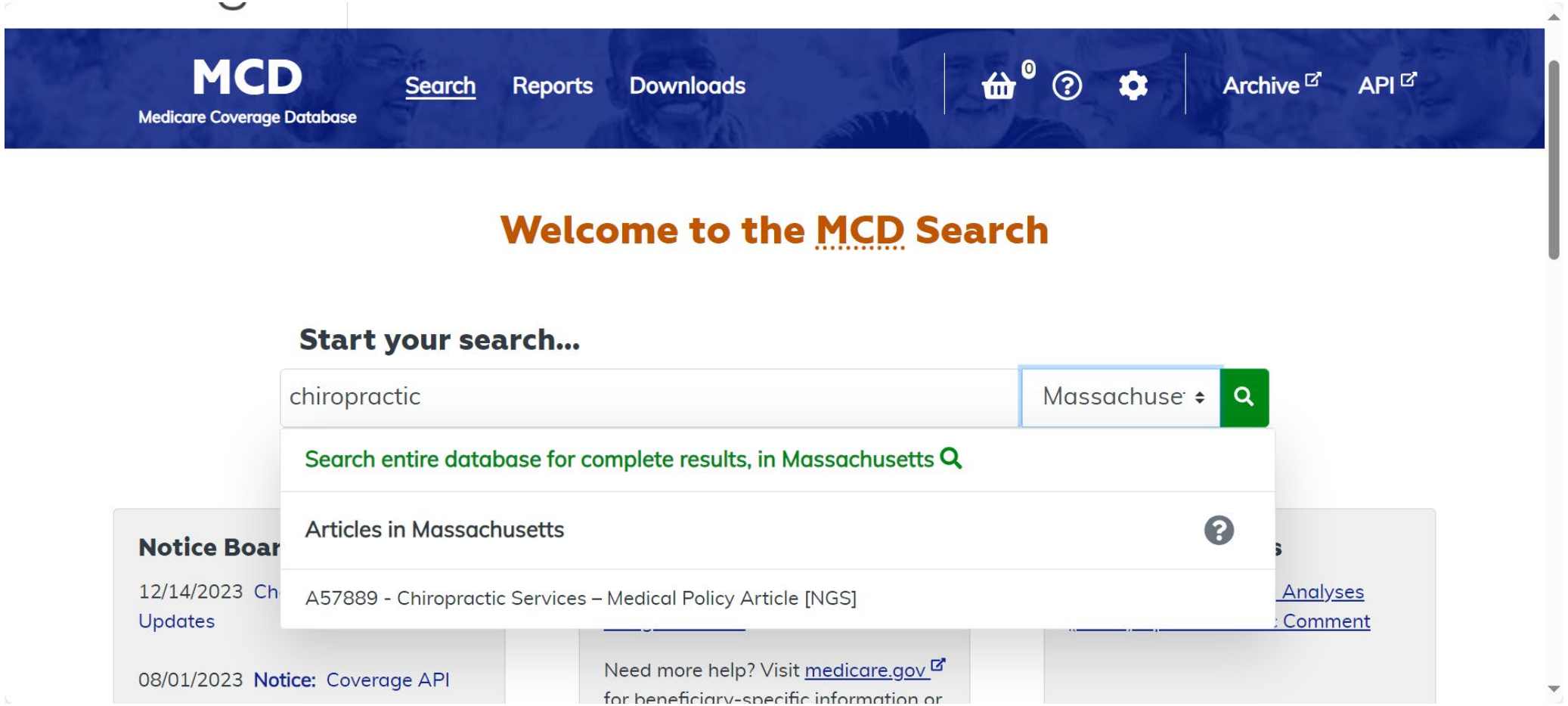
- Chiropractic Coverage Policy
- Medical Necessity
- Active Versus Maintenance Treatment
- Documentation Guidelines
- Coding Guidelines
- Administrative Simplification Compliance Act
- Significant Facts for Successful Chiropractic Billing
- NGSConnex
- Resources

Chiropractic Coverage Policy

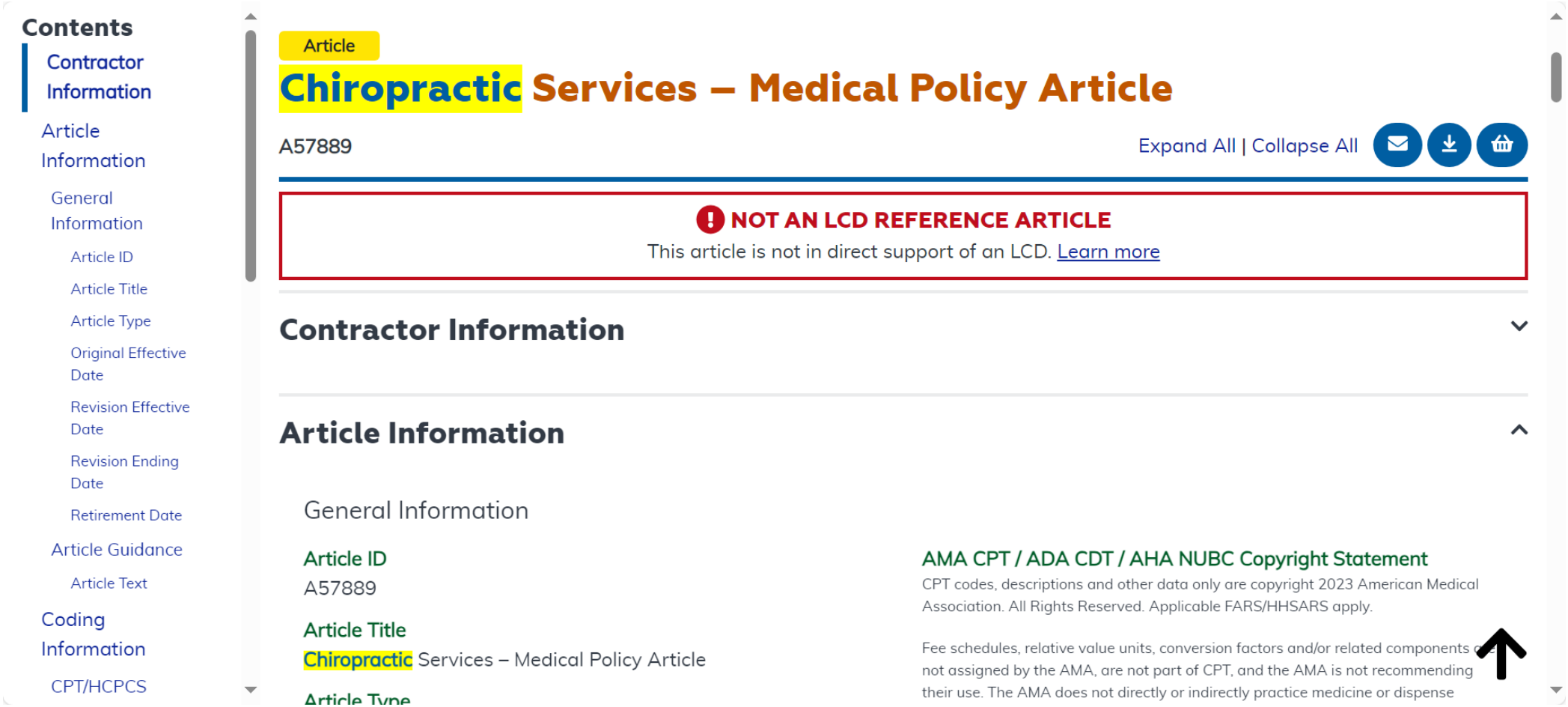
LCD L33613 – Coverage Document (RETIRED)
SIA A52853 – Supplemental Instructions (RETIRED)

- Medical Policy Article (A57889) for Chiropractic Services
  - Local Coverage Article for Chiropractic Services – Medical Policy Article
  - Coverage and Coding information
  - CPT codes
- Medicare Coverage Database – Overview

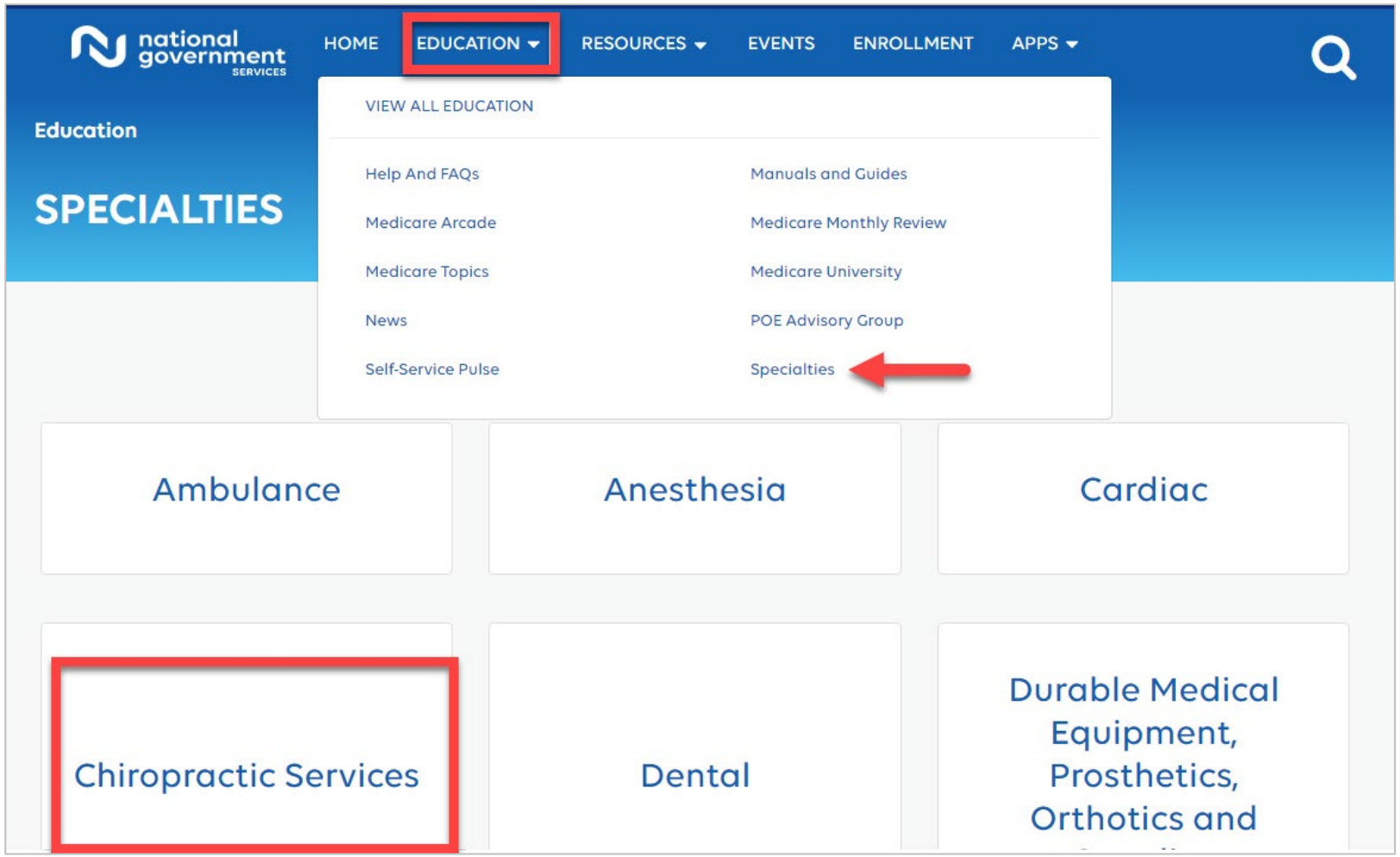
CMS Medicare Coverage Database



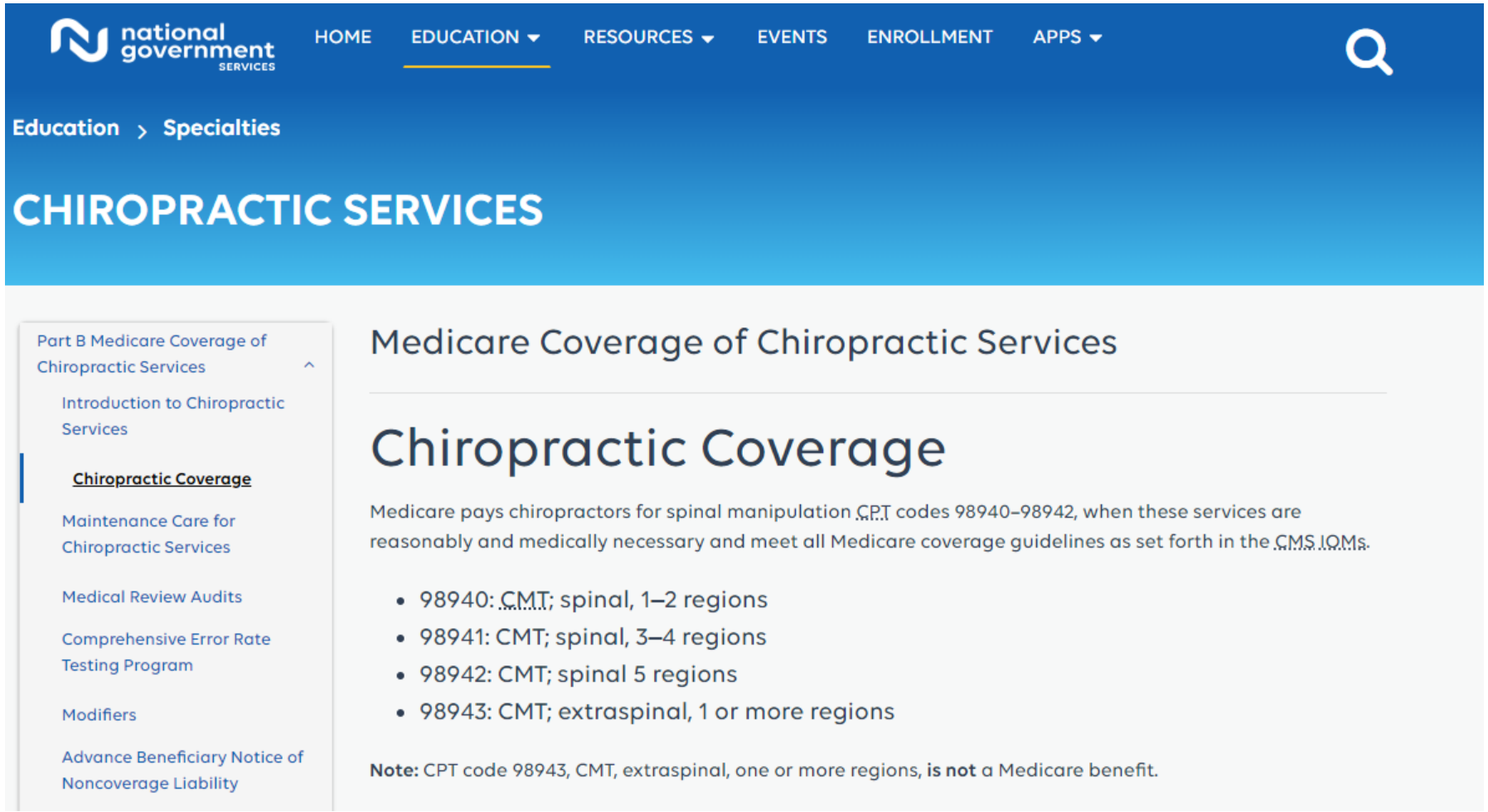
Chiropractic Services – Medical Policy Article (A57889)



Chiropractic Services – Education



Chiropractic Services Manual



CMS Internet-Only Manual

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 240
  - Guidelines given to us from CMS
  - LCD cannot contradict IOMs
  - NCD

Internet-Only Manuals

The Internet-only Manuals (IOMs) are a replica of the Agency's official record copy. They are CMS' program issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives. The CMS program components, providers, contractors, Medicare Advantage organizations and state survey agencies use the IOMs to administer CMS programs. They are also a good source of Medicare and Medicaid information for the general public.

Showing 1-10 of 25 entries

Show entries: 10 per page

Filter On

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Publication #	Title
100	Introduction
100-01	Medicare General Information, Eligibility and Entitlement Manual
100-02	Medicare Benefit Policy Manual

MLN Matters® Articles

- CRs put into simple language
  - MLN Matters® Articles – CMS website

Medicare Learning Network

MLN Matters®

CMS

Official Information Health Care Professionals Can Trust

MLN Matters® Number: SE1603 | **Related Change Request (CR) #: N/A**

Related CR Release Date: N/A | **Effective Date: N/A**

Related CR Transmittal #: N/A | **Implementation Date: N/A**

Educational Resources to Assist Chiropractors with Medicare Billing

Provider Types Affected

This Special Edition (SE) MLN Matters® article is intended for Chiropractors submitting claims to Medicare Administrative Contractors (MACs) for chiropractic services provided

Medical Necessity

Medicare Coverage

- Medical Necessity
  - Title XVIII of the Social Security Act, Section 1862 (a)(1)(A). This section allows coverage and payment for only those services considered medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Medical Necessity

- Medical necessity
  - Assures services to Medicare patients are reasonable and necessary for diagnosis or treatment of illness or injury
- Remittance remark code
    - CO-50 Medical Necessity Denial

Medical Necessity Denials

- Some services are only covered in some instances
- Example: chiropractic manipulation
  - Only covered for a diagnosis listed in LCD
  - Any other diagnosis will be denied as not medically necessary

Medicare Coverage

- Medical Necessity
  - Patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment
  - The manipulative services rendered must have a direct therapeutic relationship to 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/physical exam

Active Versus Maintenance Treatment

Active/Corrective Treatment

- Goal driven
- Treatment plan
- Individualized
- Usually short term
- Measurable progress towards goals

Active Treatment

- Reasonable expectation of improvement
- Not always recovery
- Not always complete return to prior level of function

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 exam 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 improve/resolve with further treatment, 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, further manipulative treatment is considered maintenance therapy and is not covered

Acute Exacerbation

- Temporary but marked deterioration of patient's condition that is causing significant interference with activities of daily living due to an acute flare-up of the previously treated condition
- Patient's clinical record must specify the date of occurrence, nature of the onset, or other pertinent factors that would support the medical necessity of treatment
- As with an acute injury, treatment should result in improvement or arrest of the deterioration within a reasonable period of time

Maintenance

- Preventive
- Promote health
- Prolong or enhance the quality of life
- Maintain/prevent deterioration
- Supportive

- Noncorrective
- No reasonable expectation of further clinical improvement
- May be beneficial
- May be necessary treatment
- Not covered by Medicare

Contraindications

- Dynamic thrust is therapeutic force/maneuver delivered by the physician during manipulation in the anatomic region of involvement
- Contraindication adds significant risk of injury to the patient from dynamic thrust, but does not rule out the use of dynamic thrust
- The doctor must discuss this risk with the patient and record this in the chart
  - See LCD for contraindication listing

Documentation Guidelines

Medical Necessity Documentation

- Patient's medical record must contain documentation that fully supports medical necessity for services
- Documentation includes, but is not limited to, relevant medical history, physical examination and results of pertinent diagnostic tests or procedures

Medical Necessity Documentation- Plan of Care

- Chiropractic care is focused on treatment goals outlined in the plan of care and should be individualized for each patient and include the following
  - Recommended level of care (duration/frequency of visits)
  - Specific treatment goals (with documentation of progress or lack thereof within the clinical records)
  - Objective measures to evaluate treatment effectiveness (with qualitative and/or quantitative measures)

Medical Necessity Documentation

- Use of objective measures at beginning of treatment, during and/or after treatment is recommended to quantify progress and support justifications for continued treatment
- Treatment effectiveness must be assessed at appropriate intervals during subsequent visits (objective measurable goals)
- For patients who have not achieved the goals documented in the plan of care, the practitioner should conclude the episode of chiropractic care in the last visit by documenting the clinical factors that contributed to the inability to meet the stated goals in the treatment plan

Documentation of Subluxation

- The precise level of subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine
- The level of spinal subluxation must bear a direct causal relationship to patient's symptoms, and symptoms must be directly related to level of subluxation that has been diagnosed

Documentation of Subluxation

- X-ray
  - 12 months before/three months after
  - CT/MRI
- Physical exam
  - Pain/tenderness
  - Asymmetry/misalignment
  - ROM abnormality
  - Tissue, tone, texture and temperature changes
    - Must have two of the four mentioned above, one of these must be asymmetry or ROM abnormality

Medical Necessity Documentation – Prolonged Treatment

- The need for an extensive, prolonged course of treatment must be clearly documented in the medical record
- Treatment should result in improvement or arrest of deterioration of subluxation within a reasonable and generally predictable period of time

Documentation of History

- Patient's history should include the following
  - Symptoms causing patient to seek treatment
  - Family history, if relevant
  - Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history)
  - Mechanism of trauma
  - Quality and character of symptoms/problem
  - Onset, duration, intensity, frequency, location and radiation of symptoms
  - Aggravating or relieving factors, and
  - Prior interventions, treatments, medications, secondary complaints

Documentation of Initial Visit

- All components of history
- Description of present illness
- Evaluation
- Diagnosis
- Treatment plan
- Date of initial treatment
- Signature

Documentation of Subsequent Visits

- History (review chief complaint, changes)
- Physical exam (progress, presence/absence of subluxation)
- Documentation of treatment (given on day of treatment)
- Progress or lack of related to goals/plan of care
- D/C when no further progress (or give an ABN)

Medicare Coverage

- Breakdown of key points
  - Significant health problem in the form of a neuro-musculoskeletal condition
  - Services have a direct therapeutic effect
  - Reasonable expectation of recovery or improvement of function
  - Subluxation

Covered Services

- CPT/HCPCS codes
  - Chiropractic manipulative treatment
    - 98940 CMT; spinal, one to two regions
    - 98941 CMT; spinal, three to four regions
    - 98942 CMT; spinal, five regions
- Regions: cervical region (atlanto-occipital joint), thoracic region (costovertebral/ costotransverse joints), lumbar region, pelvic region (sacro-iliac joint) and sacral region

Diagnosis Codes

ICD-10-CM Codes	Description
M99.01	Segmental/somatic dysfunction cervical region
M99.02	Segmental/somatic dysfunction thoracic region
M99.03	Segmental/somatic dysfunction lumbar region
M99.04	Segmental/somatic dysfunction sacral region
M99.05	Segmental/somatic dysfunction pelvic region

Medicare Coverage

- Coverage is specifically limited to treatment by means of manual manipulation i.e., by use of hands
- Manual devices may be used but no additional payment is available for use of the device

Utilization Guidelines

- A chiropractic manipulation service for a beneficiary can only be reimbursed once per day
- The frequency and duration of chiropractic treatment must be medically necessary and based on the individual patient's condition and response to treatment
- Medical necessity determines visits/no set number of visits

Noncovered Services

- The following services are considered noncovered services when ordered, performed, or interpreted by a chiropractor
  - Labs
  - Physical therapy (CPT 97140)
  - X-rays
  - Massage
    - Use the GY modifier when billing these services

Coding Guidelines

Coding Guidelines

- One diagnosis required on all claims
  - Precise level of the subluxation (region of spine) must be listed as the primary diagnosis
  - Resulting disorders (condition) are to be listed as secondary diagnosis in medical record
- Date of initial treatment/exacerbation of existing condition
  - Must be entered in Item 14 of the CMS-1500 claim form or the electronic equivalent

Coding Guidelines

- If using an X-ray as documentation of the subluxation
  - The date of the X-ray (or existing MRI or CT scan) must be entered in Item 19 of the CMS-1500 claim form or the electronic equivalent
- Modifier AT (acute treatment) used for medically necessary manipulation

Administrative Simplification Compliance Act

ASCA Requirements for Paper Claim Submissions

- All Medicare claims are required to be submitted electronically, with limited exceptions
- Requirements
  - You must meet one of the ASCA exception criteria
    - Small practice – fewer than ten full-time employees (Part B)
    - No method for submitting claims electronically
    - Unusual circumstances
  - Complete the ASCA Waiver Request Form
    - Email: NGS.ASCA@anthem.com or mail to the appropriate PO Box
  - Provide supporting documentation
  - ASCA Requirements for Paper Claim Submissions

Significant Facts for Successful Chiropractic Billing

Medical Record Documentation Requirements for Initial and Subsequent Visits (SE1601)

- Majority of denials due to insufficient documentation or other documentation errors
  - Indication of “pain” is insufficient
- Two ways the level of subluxation may be specified in the patient’s record
  - May refer either to the condition of the spinal joint involved or
  - Direction of position assumed by the particular bone named

Medical Record Documentation Requirements for Initial and Subsequent Visits (SE1601)

- Examples of acceptable descriptive terms for the nature of the abnormalities
  - Off-centered
  - Misalignment
  - Malpositioning
  - Spacing – abnormal, altered, decreased, increased
  - Incomplete dislocation
  - Rotation
  - Listhesis – antero, postero, retro, lateral, spondylo
  - Motion – limited, lost, restricted, flexion, extension, hypermobility, hypomotility, aberrant

Medical Record Documentation Requirements for Initial and Subsequent Visits (SE1601)

- Treatment Plan
  - Recommended level of care (duration and frequency of visits)
  - Specific treatment goals
  - Objective measures to evaluate treatment effectiveness
- Date of the initial treatment
- Patient's medical record
  - Validate all the information on the face of the claim, including the patient's reported diagnosis, physician work (CPT code), and modifiers
  - Verify that all Medicare benefits and medical necessity requirements were met
- MLN Matters® *SE1601 Revised: Medicare Coverage for Chiropractic Services - Medical Record Documentation Requirements for Initial and Subsequent Visits*

Use of the AT Modifier for Chiropractic Billing (SE1602)

- Active treatment (AT) modifier
  - Not used if maintenance therapy is being performed
- Acute and chronic subluxation may be covered as long as there is active treatment which is well documented and improvement is expected
- MLN Matters® *SE1602 Revised: Use of the AT modifier for Chiropractic Billing*

Educational Resources to Assist Chiropractors with Medicare Billing (SE1603)

- Article provides the correct resources providers should be accessing to properly bill Medicare
  - Enrollment Information
  - Coverage, Documentation, and Billing
- MLN Matters® *SE1603 Revised: Educational Resources to Assist Chiropractors with Medicare Billing*

Limited Coverage for Services Ordered or Furnished by a Chiropractor

- X-rays or other diagnostic/therapeutic services furnished or ordered by a chiropractor are considered statutorily excluded services
  - Beneficiary would be responsible for any charges incurred
  - Use modifier GY

Billing Medicare for Therapy Services

- Noncovered “always therapy” services must be submitted according to the therapy guidelines along with one of the therapy modifiers
  - GN - Service delivered under an outpatient speech-language pathology plan of care
  - GO - Service delivered under an outpatient occupational therapy plan of care
  - GP - Service delivered under an outpatient physical therapy plan of care
- Claims submitted without an appropriate modifier will be returned to provider
- Claims will be appropriately denied as noncovered only with a valid modifier
- Annual Therapy Update
- Chiropractors Billing Medicare for Therapy Services

Timely Claims Filing Requirement

- Claims not submitted timely are provider-liable
  - Beneficiary cannot be charged
- For claims submitted with spanned dates of service, the line item “From” date will be used to determine the date of service and filing timeliness
- If a line item “From” date is not timely, but the “To” date is timely, the line item will be split and deny the untimely services

Submitting Duplicate Claims

- May delay payment
  - Resubmitting your claim prior to receiving a determination is considered an inappropriate billing practice
  - Increases administrative costs to the Medicare Program and the provider
- Could cause you to be identified as an abusive biller; or may result in an investigation for fraud if a pattern of duplicate billing is identified

Unprocessable

- Information is
  - Invalid
  - Missing
  - Insufficient
  - Incomplete
- Claims will be rejected
- Must submit a new claim
- No appeal rights granted

Unprocessable

- Methods for rejection
  - Remittance advice shows an MA130
  - Additional remark codes used to identify the error
- Paper claims are screened
  - Form letter sent back indicating the error
- Electronic claims
  - Fail initial edits

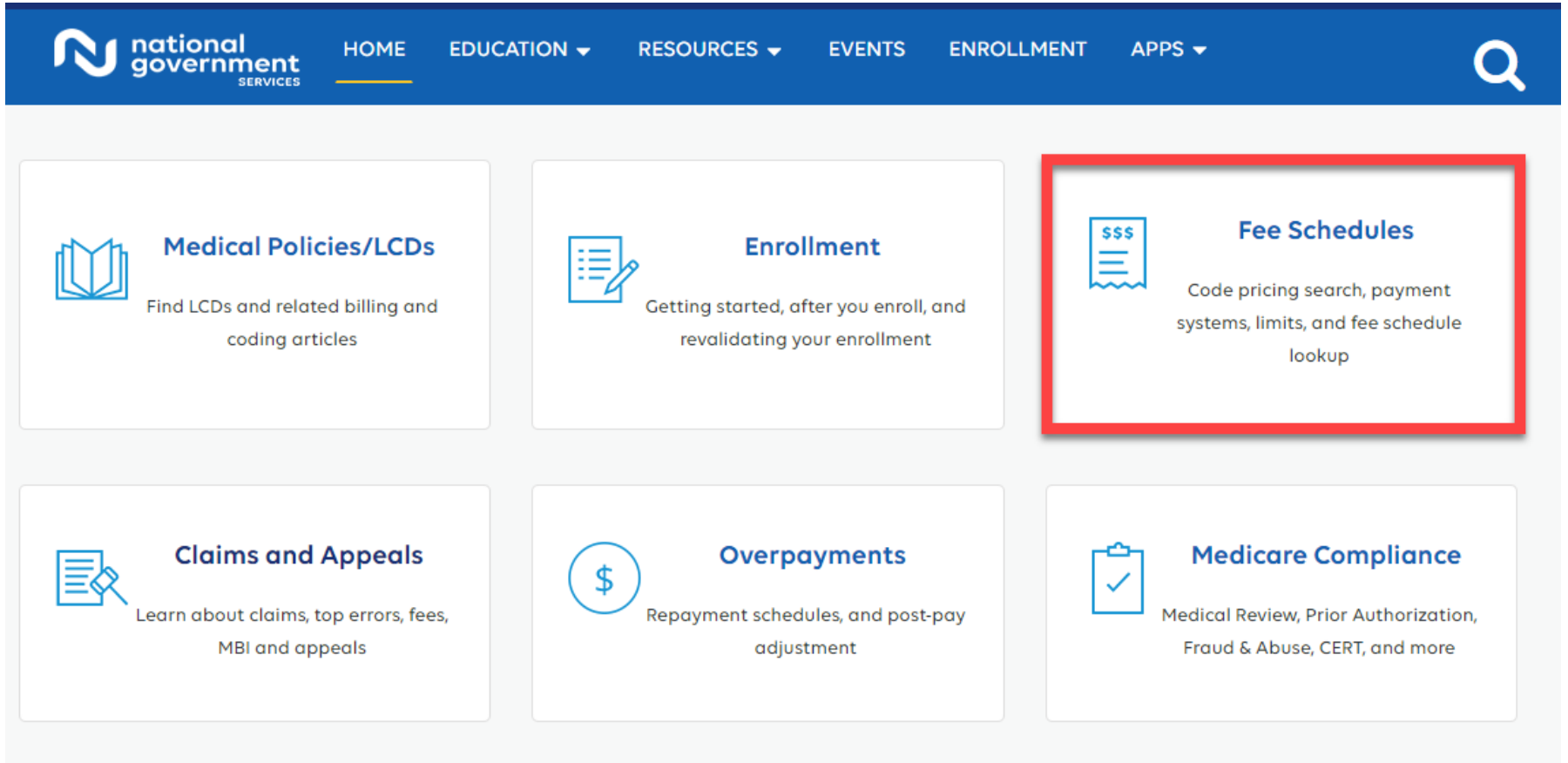
JK Contact Information

- IVR: 877-869-6504
- Provider Contact Center: 866-837-0241
- EDI Helpdesk: 888-379-9132
- Provider Enrollment: 888-379-3807
- Correspondence
  - General Inquiries
  - NGSConnex User Guide

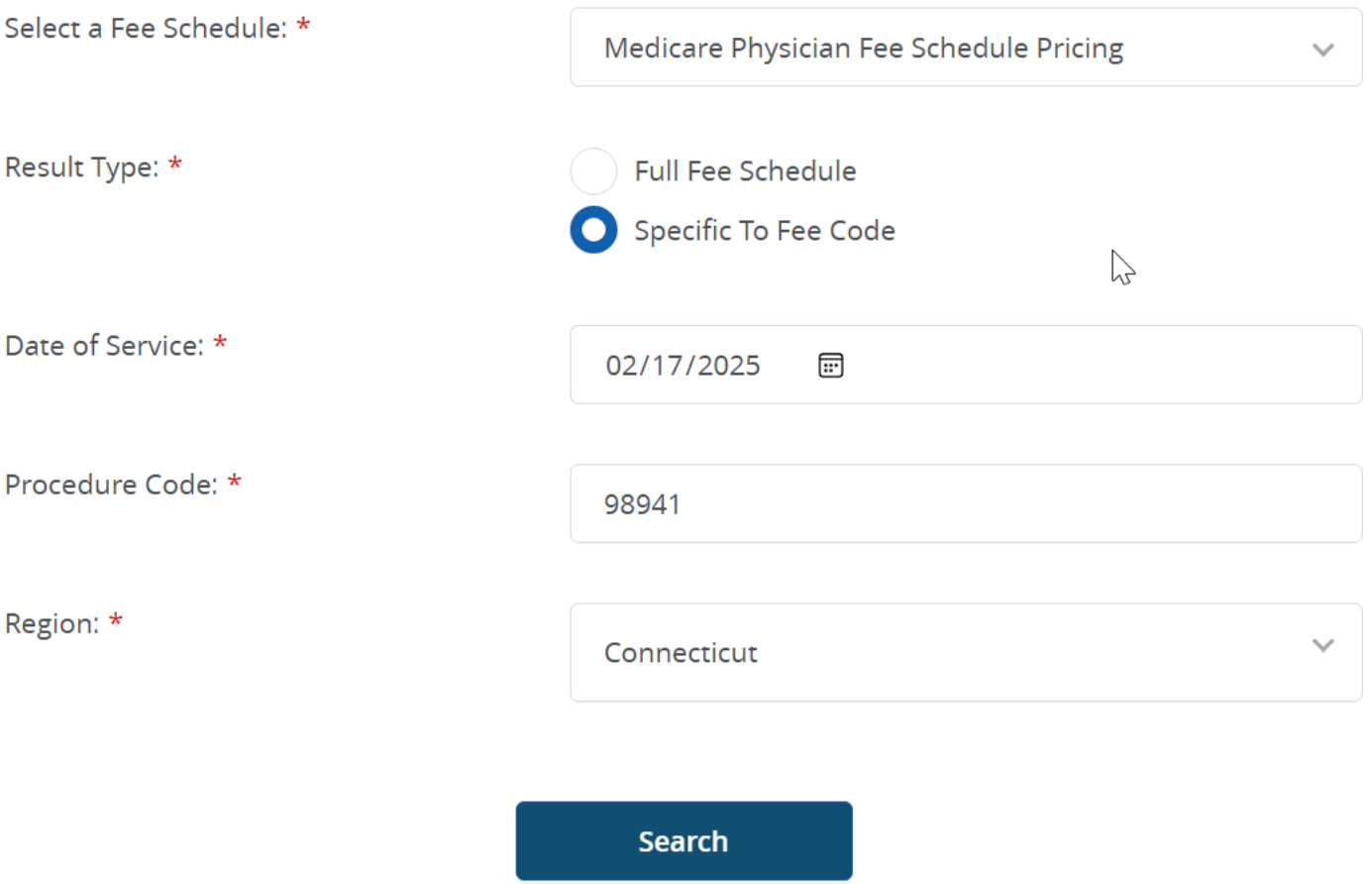
J6 Contact Information

- IVR: 877-908-9499
- Provider Contact Center: 866-234-7340
- EDI Helpdesk: 888-379-9132
- Provider Enrollment: 877-908-8476
- Correspondence
  - General Inquiries
  - NGSConnex User Guide

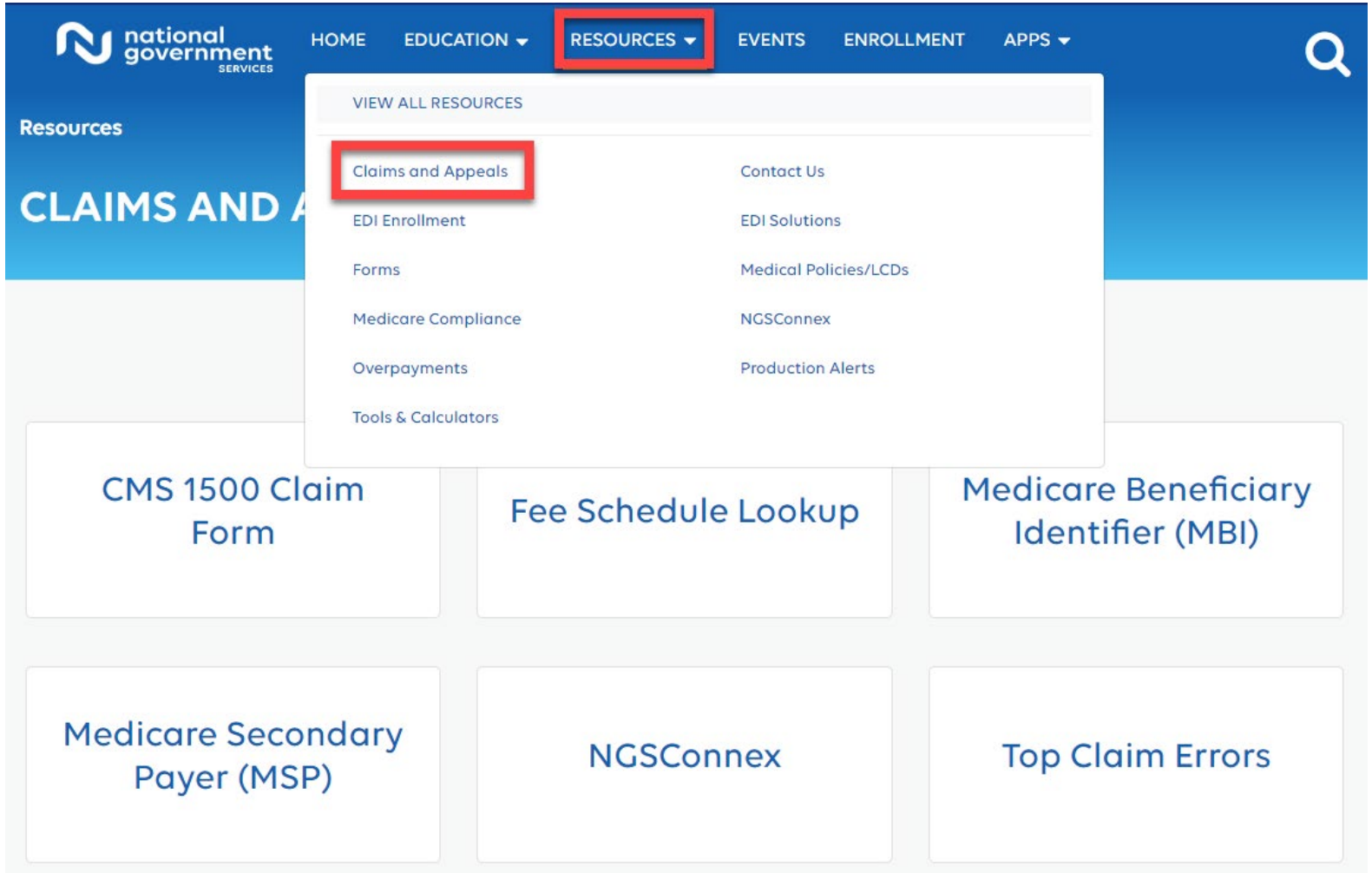
Fee Schedules



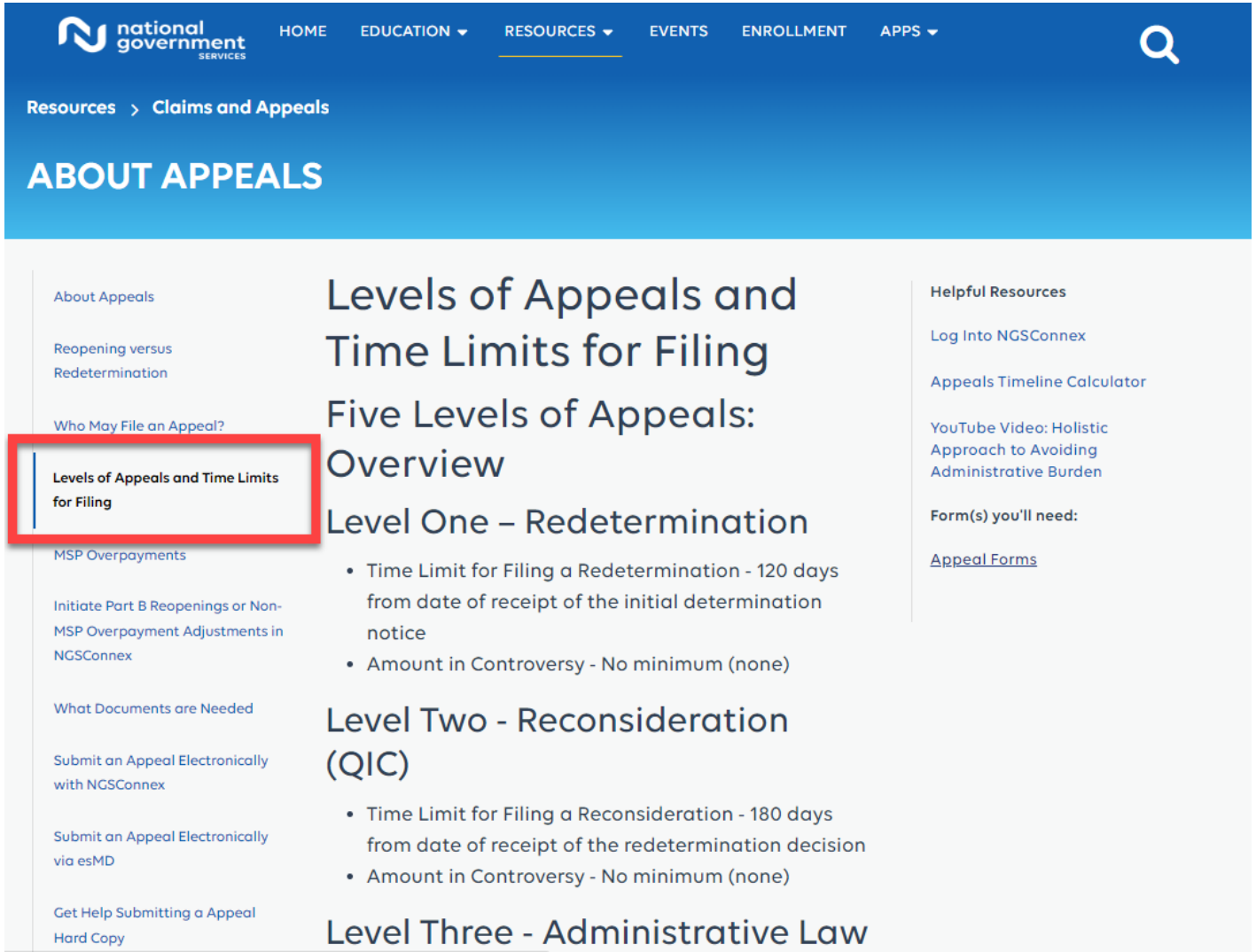
Fee Schedule Lookup Page



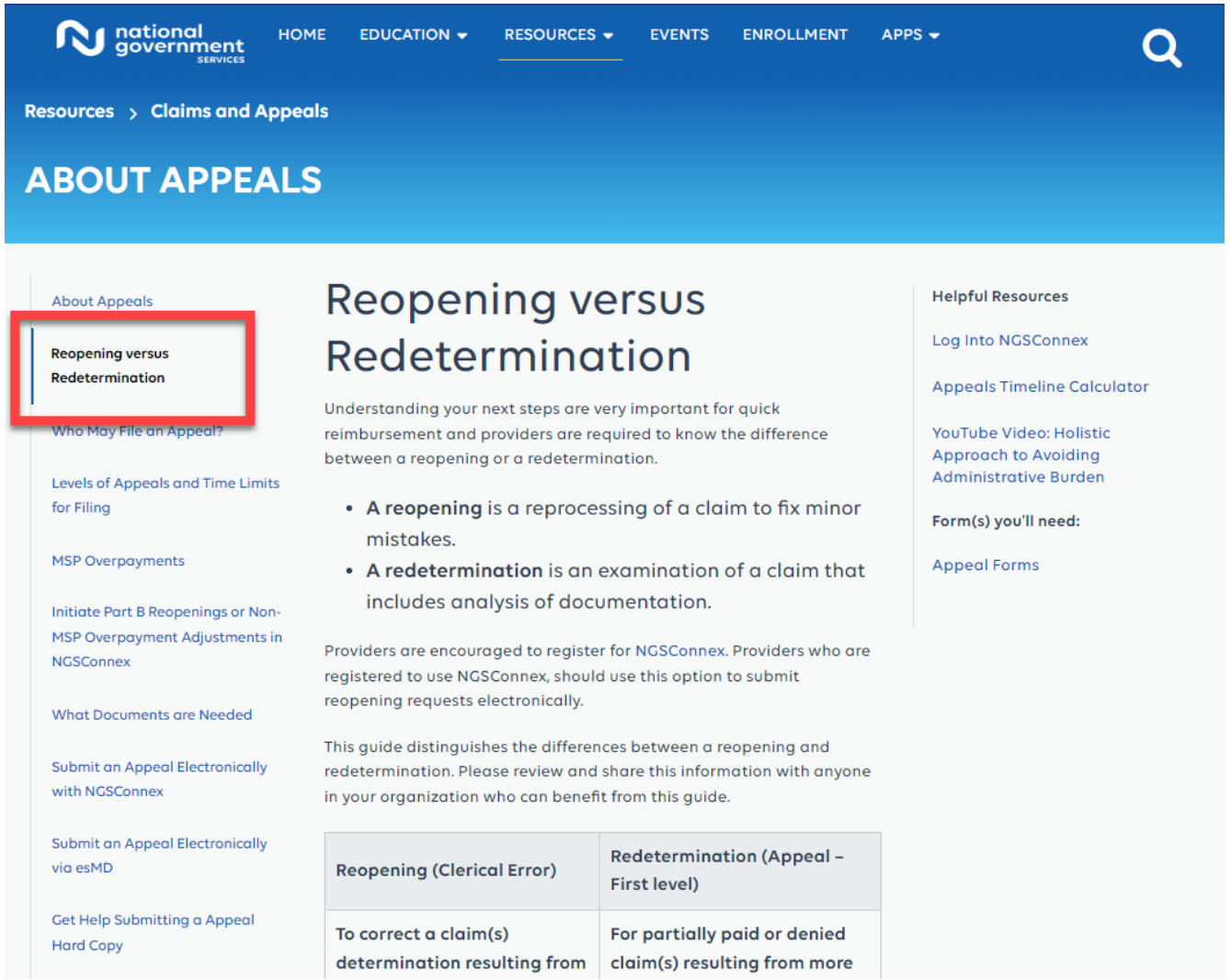
Claims and Appeals



About Appeals



Reopening versus Redetermination



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Resources > Claims and Appeals

ABOUT APPEALS

About Appeals

Reopening versus Redetermination

Who May File an Appeal?

Levels of Appeals and Time Limits for Filing

MSP Overpayments

Initiate Part B Reopenings or Non-MSP Overpayment Adjustments in NGSConnex

What Documents are Needed

Submit an Appeal Electronically with NGSConnex

Submit an Appeal Electronically via esMD

Get Help Submitting a Appeal Hard Copy

Reopening versus Redetermination

Understanding your next steps are very important for quick reimbursement and providers are required to know the difference between a reopening or a redetermination.

- **A reopening** is a reprocessing of a claim to fix minor mistakes.
- **A redetermination** is an examination of a claim that includes analysis of documentation.

Providers are encouraged to register for NGSConnex. Providers who are registered to use NGSConnex, should use this option to submit reopening requests electronically.

This guide distinguishes the differences between a reopening and redetermination. Please review and share this information with anyone in your organization who can benefit from this guide.

Reopening (Clerical Error)	Redetermination (Appeal – First level)
To correct a claim(s) determination resulting from	For partially paid or denied claim(s) resulting from more

Helpful Resources

Log Into NGSConnex

Appeals Timeline Calculator

YouTube Video: Holistic Approach to Avoiding Administrative Burden

Form(s) you'll need:

Appeal Forms

Contacting the Telephone Reopening Unit

- Part B TRU Line
  - J6: 877-867-3418
  - JK: 888-812-8905
    - Each state will have a different option
- When calling TRU, provide the following information
  - Beneficiary's name
  - Medicare Health Insurance Claim Number/MBI
  - Your full name (first and last name)
  - Your phone number
  - Provider's name (Name listed on the Medicare Remittance Advice)
  - PTAN
  - Date(s) of service in question
  - Item or service in question
  - Reason for request

Telephone Reopening Unit/Part B Reopening Request Form

- Requests that can be completed via the Telephone Reopening Unit (TRU) or Part B Reopening Request Form
  - Assignment of claims (carrier errors only)
  - CLIA certification denials
  - Duplicate claim denials
  - Fee schedule corrections
  - Medicare Advantage plan denials (clinical trial or hospice only)
  - MSP (Medicare now primary)
  - Patient paid amount (contractor error only)
- These scenarios cannot be handled though NGSConnex

Additional Development Request (ADR)

- Claims selected for review
  - An ADR letter will be generated
    - Mailed to the “Pay To” or “Practice Location” address
  - Forward to the appropriate person in your organization as soon as possible
  - Submit the requested medical documentation
  - Respond in a timely manner
    - Recommended response within 35–40 days
    - Additional Development/Documentation Request Timeline Calculator
    - Ways to Respond to ADRs

Record Requests Documentation Tips

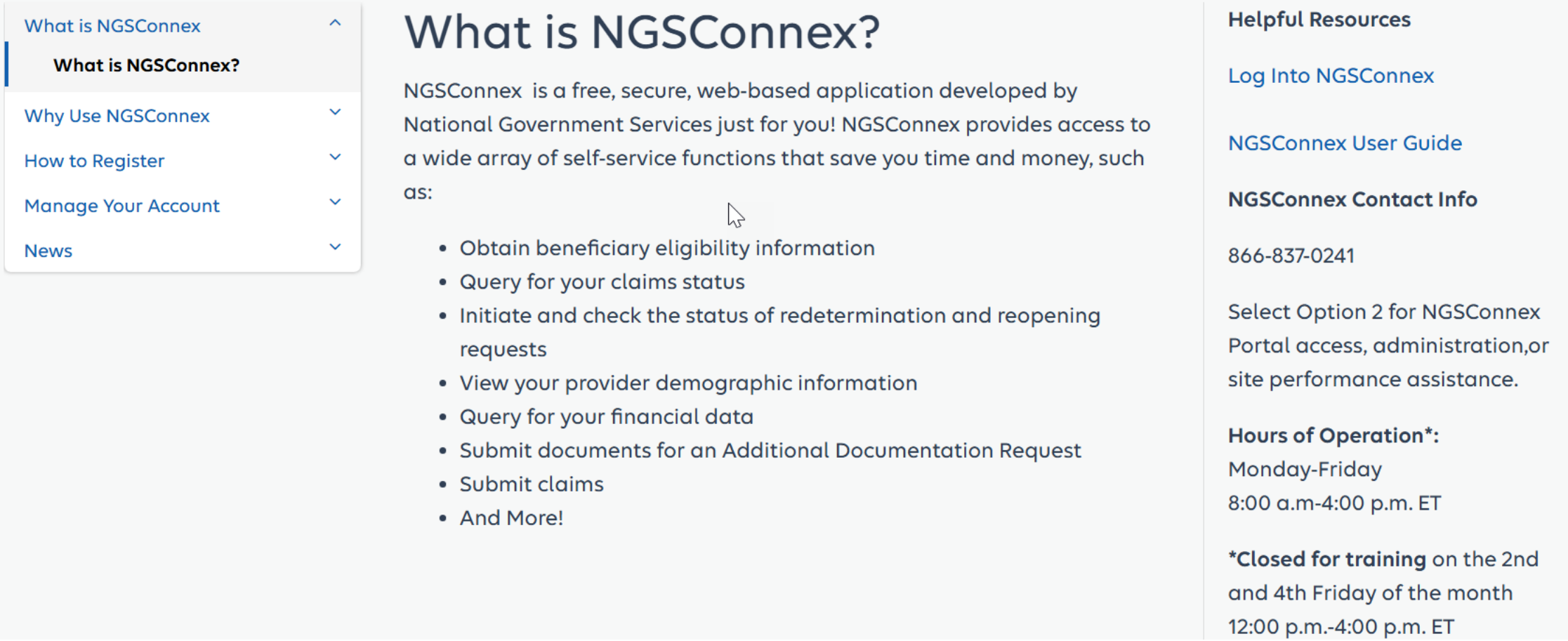
- Documentation
  - Legible
  - Copy both sides
  - Signatures
  - Do not bind records together
  - Do not highlight records
  - Do not tab records
  - Make sure the ADR request matches the records sent

Medical Documentation Signature Requirements

- Requires that services provided/ordered/certified be authenticated by the person responsible for the care of the beneficiary
- Handwritten or electronic signatures accepted
  - Stamped signatures are not acceptable
  - Credentials and the date of signing should be included
  - Signature must be legible
    - Consideration for illegible signatures will be given to a signature log or attestation statement
  - Claims not meeting the signature requirements will be denied
  - MLN® Fact Sheet *Complying With Medicare Signature Requirements ICN 905364*

NGSConnex

What is NGSConnex



Hours of Availability

- NGSConnex is available 24/7
- Information obtained from the local system is only available
  - Monday–Friday: 7:00 a.m.–6:00 p.m. ET
  - Saturday: 7:00 a.m.–3:00 p.m. ET
- Not available during system upgrades or maintenance

Resources

Coverage and Billing Resources

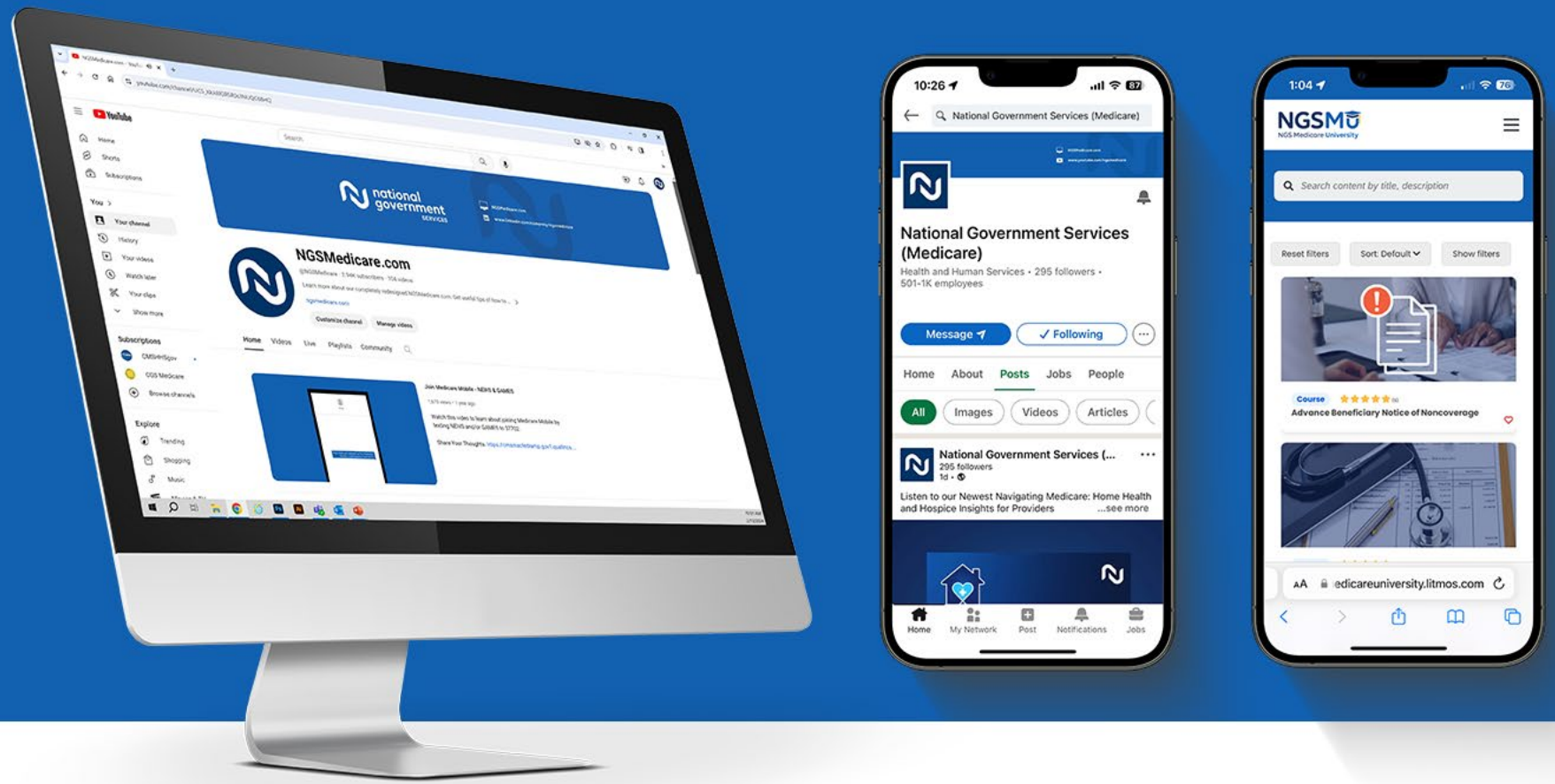
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15
  - Section 30.5, “Chiropractor’s Services”
  - Section 240, “Chiropractic Services-General”
  - Section 240.1.1, “Manual Manipulation”
  - Section 240.1.2, “Subluxation May Be Demonstrated by X-ray or Physician’s Exam”
  - Section 240.1.3, “Necessity for Treatment”
  - Section 240.1.4, “Location of Subluxation”
  - Section 240.1.5, “Treatment Parameters”

Additional Resources

- MLN® Educational Tool *Medicare Documentation Checklist for Chiropractic Doctors*
- Medicare Needs Better Controls to Prevent Fraud, Waste, and Abuse Related to Chiropractic Services

Questions?

Thank you!



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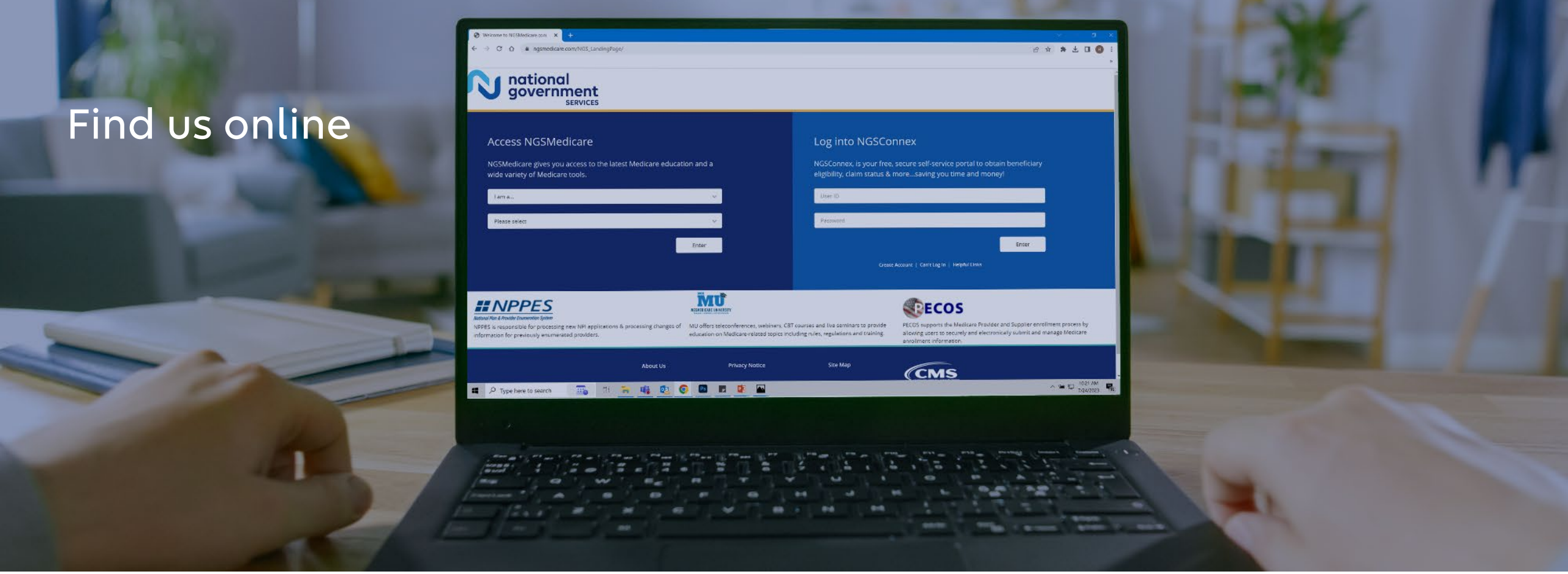

www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

IVR System
The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

NGSConnex
Web portal for claim information

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