TrailBlazer
HEALTH ENTERPRISES, LLC

Chiropractic Services

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Part B

☆ ☆ IMPORTANT ☆ ☆

The information provided in this manual was current as of March 2010. Any changes or new information superseding the information in this manual, provided in newsletters/eBulletins, MLN articles, listserv notices, Local Coverage Determinations (LCDs) or CMS Internet-Only Manuals with publication dates after March 2010, are available at:

http://www.trailblazerhealth.com/Medicare.aspx

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INTRODUCTION TO CHIROPRACTIC SERVICES

A chiropractor must be licensed or legally authorized to furnish chiropractic services by the state or jurisdiction in which the services are furnished. In addition, a licensed chiropractor must meet uniform minimum standards to be considered a physician for Medicare coverage. Coverage extends only to treatment by means of manual manipulation of the spine to correct a subluxation provided such treatment is legal in the state where performed. All other services furnished or ordered by chiropractors are not covered.

If a chiropractor orders, takes or interprets an X-ray or other diagnostic procedure to demonstrate a subluxation of the spine, the X-ray can be used for documentation. However, there is no coverage or payment for these services or for any other diagnostic or therapeutic service ordered or furnished by the chiropractor.

Chiropractic service, which is eligible for reimbursement, is specifically limited by Medicare to the treatment by means of manual manipulation (i.e., by use of the hands or use of manual devices that are hand-held, with the thrust of the force of the device being controlled manually) of the spine for the purpose of correcting a subluxation. Other services such as lab tests, X-rays, nutritional supplements, modalities, traction, office visits, examinations, supports, etc., are services that Medicare will not consider for payment when performed by a chiropractor.

Payment is based on the physician fee schedule. The fee schedule can be found online at:

http://www.trailblazerhealth.com/Payment/Fee Schedules/Default.aspx

HCPCS CODES

98940©	Chiropractic manipulation
98941©	Chiropractic manipulation
98942©	Chiropractic manipulation
98943©	Chiropractic manipulation

Note: CPT code 98943©, CMT, extraspinal, one or more regions, is not a Medicare benefit.

INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY

For the purpose of Medicare, subluxation means 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 usually falls into one of two categories:

- Acute, such as strains and sprains.

- Chronic, such as loss of joint mobility.

Note: No other diagnostic or therapeutic service furnished by a chiropractor or under his order is covered under the Medicare program.

Acceptable terminology for the Chiropractic Manipulative Treatment (CMT) being provided includes:

- Spinal adjustment by manual means.
- Spinal manipulation.
- Manual adjustment or manipulation.
- Vertebral manipulation or adjustment.

Manual devices (those devices that are hand-held with the thrust of the force of the device being controlled manually) may be used by a chiropractor in performing manual manipulation of the spine. However, no additional payment is allowed for the use of the device or for the device itself.

The five spinal regions referred to in this policy on CMT are:

- Cervical region.
- Thoracic region.
- Lumbar region.
- Sacral region.
- Pelvic.

MEDICAL NECESSITY

Refer to the “Chiropractic Services” Local Coverage Determination (LCD) on the TrailBlazer Health Enterprises® Web site at:

http://www.trailblazerhealth.com/Tools/LCDs.aspx

LOCATION OF SUBLUXATION

The mere statement or diagnosis of “pain” is not sufficient to support medical necessity for the treatments. The precise level of the subluxation must be documented by the chiropractor in the medical records.

Area of Spine	Names of Vertebrae	Number of Vertebrae	Short Form or Other Name
Neck	Occiput Cervical Atlas Axis	7	Occ, CO C1 through C7 C1 C2
Back	Dorsal or Thoracic Costovertebral Costotransverse	12	D1 through D12 T1 through T12 R1 through R12 R1 through R12
Low Back	Lumbar	5	L1 through L5
Sacral	Sacrum, Coccyx		S, SC
Pelvic	Ilia, R and L		I, Si

In addition to the vertebrae and pelvic bones listed, the ilii (R and L) are included with the sacrum as an area where a condition may occur that would be appropriate for CMT.

There are two ways the level of the subluxation may be specified:

- The exact bones may be listed, for example, C5, C6, etc.
    - Or,
- The area may suffice if it implies only certain bones such as:
    - Occipito-atlantal (occiput and C1 (atlas)).
    - Lumbosacral (L5 and sacrum).
    - Sacroiliac (sacrum and ilium).

There are three categories of conditions:

- Acute – A patient’s condition is considered to be acute when the patient is being treated for a new illness or injury. The result of chiropractic treatment is expected to be an improvement in, arrest or retardation of the patient’s condition.
- Chronic – A patient’s condition is considered chronic when it is not expected to completely significantly improve or be resolved with further treatment (as is the case with an acute condition), but where continued therapy can be expected to

result in some functional improvement. Once the clinical status has remained stable for a given condition without expectation of additional functional improvement, further manipulation treatment is considered maintenance therapy and is not covered.

- Maintenance Therapy – A treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition is not a Medicare benefit. Once the maximum clinical benefit has been achieved for a given condition, ongoing maintenance therapy is not considered to be medically reasonable or necessary and is not payable under the Medicare program. An Advance Beneficiary Notice of Noncoverage (ABN) is required.

BILLING FOR ACTIVE/CORRECTIVE TREATMENT

Chiropractic services that provide acute or chronic active/corrective treatment must be billed with the AT modifier. However, the presence of the AT modifier may not in all instances indicate the service is reasonable and necessary.

If codes 98940–98942 are billed without the AT modifier, the treatment will be considered maintenance therapy and will not be covered.

BILLING FOR MAINTENANCE THERAPY

Maintenance therapy is not a Medicare benefit. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life or therapy, which is performed to maintain or prevent deterioration of a chronic condition. Once the maximum therapeutic benefit has been achieved for a given condition, ongoing maintenance therapy is not covered under the Medicare program. Chiropractic maintenance therapy is not medically reasonable or necessary and is not payable under the Medicare program.

The AT modifier **must not** be placed on the claim when maintenance therapy has been provided. Claims without the AT modifier are considered maintenance therapy and will be non-covered.

Since maintenance therapy is not a Medicare benefit and is considered not medically necessary, the beneficiary will need to sign an ABN form. Complete instructions regarding the ABN may be found on the TrailBlazer[SM] Web site at:

http://www.trailblazerhealth.com/Publications/Training Manual/abn.pdf

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DOCUMENTATION REQUIREMENTS

A subluxation may be demonstrated by an X-ray or by physical examination. (If the X-ray is used to demonstrate the subluxation, it is required on the claim form. Refer to the "Claim Requirements" section of this manual.) If the X-ray is to be used to document the subluxation, it must have been taken at a time reasonably proximate to the initiation of a course of treatment. Unless more specific X-ray evidence is warranted, an X-ray is considered reasonably proximate if it was taken no more than 12 months prior to or three months following the initiation of a course of chiropractic treatment. In certain cases of chronic subluxation (e.g., scoliosis), an older X-ray may be accepted provided the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding the condition is permanent.

A previous Computed Tomography (CT) scan and/or MRI are acceptable evidence if a subluxation of the spine is demonstrated.

INITIAL VISIT

The following documentation requirements apply whether the subluxation is demonstrated by X-ray or physical examination:

1. **History:**
   - Family history if relevant.
   - Past health history (general health, prior illness, injuries or hospitalizations, medications, surgical history).
   - Chief complaint including the symptoms present that caused the patient to seek chiropractic treatment.
   - Mechanism of trauma.
   - Quality and character of symptoms/problem.
   - Onset, duration, intensity, frequency, location and radiation of symptoms.
   - Aggravating or relieving factors.
   - Prior interventions, treatments, medications, secondary complaints.

2. **Description of the present illness including:**
   - Mechanism of trauma.
   - Quality and character of symptoms/problem.
   - Onset, duration, intensity, frequency, location and radiation of symptoms.
   - Aggravating or relieving factors.
   - Prior interventions, treatments, medications, secondary complaints.
   - Symptoms causing patient to seek treatment.

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These symptoms must bear a direct relationship to the level of subluxation. The symptoms refer to the spine (spondyle or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal) and joint (arthro) and would 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.

3. **Evaluation of musculoskeletal nervous system through physical examination *(PART exam)* is required to identify:**
   - ***P***ain/tenderness evaluated in terms of location, quality and intensity.
   - ***A***symmetry/misalignment identified on a sectional or segmental level.
   - ***R***ange of motion abnormality (changes in active, passive and accessory joint movements resulting in an increase or a decrease in sectional or segmental mobility).
   - ***T***issue tone changes in the characteristics of contiguous or associated soft tissues, including skin, fascia, muscle and ligament.

   To demonstrate a subluxation based on the physical examination, two of the four described criteria (pain/tenderness, asymmetry/misalignment, range of motion abnormality and tissue tone changes) are required, one of which must be asymmetry/misalignment or range of motion abnormality.

4. **Diagnosis:**
   The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named.

5. **Treatment plan:**
   - The treatment plan should include the following:
     - o Recommended level of care (duration and frequency of visits).
     - o Specific treatment goals.
     - o Objective measures to evaluate treatment effectiveness.

6. **Date of the initial treatment.**

SUBSEQUENT VISITS

The following documentation requirements apply whether the subluxation is demonstrated by X-ray or physical examination:

1. **History:**
   - Review of chief complaint.
   - Changes since last visit.
   - System review if relevant.

2. **Physical exam:**
   - Exam of area of spine involved in diagnosis.
   - Assessment of change in patient condition since last visit.
   - Evaluation of treatment effectiveness.

3. **Documentation of treatment given on day of visit.**

   Failure to document the medical necessity of the chiropractor's manual spinal manipulation(s) may result in denial of claim(s).

NECESSITY FOR TREATMENT

A. The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the 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 or physical exam, as described above.

Most spinal joint problems may be categorized as follows:

- 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, arrest or retardation of the patient's condition.
- Chronic Subluxation: A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), 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 without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

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B. Maintenance Therapy: A treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. Once the maximum therapeutic benefit has been achieved for a given condition, ongoing chiropractic treatment is not considered to be medically reasonable or necessary and is not payable under the Medicare program.

C. Contraindications: Dynamic thrust is the therapeutic force or maneuver delivered by the physician during manipulation in the anatomic region of involvement. A relative contraindication is a condition that adds significant risk of injury to the patient from dynamic thrust but does not rule out the use of dynamic thrust. The doctor should discuss this risk with the patient and record this in the chart. The following are relative contraindications to dynamic thrust:

- Articular hypermobility and circumstances where the stability of the joint is uncertain.
- Severe demineralization of bone.
- Benign bone tumors (spine).
- Bleeding disorders and anticoagulant therapy.
- Radiculopathy with progressive neurological signs.

Dynamic thrust is absolutely contraindicated near the site of demonstrated subluxation and proposed manipulation in the following:

- Acute arthropathies characterized by acute inflammation and ligamentous laxity and anatomic subluxation or dislocation, including acute rheumatoid arthritis and ankylosing spondylitis.
- Acute fractures and dislocations or healed fractures and dislocations with signs of instability.
- An unstable os odontoedeum.
- Malignancies that involve the vertebral column.
- Infection of bones or joints of the vertebral column.
- Signs and symptoms of myelopathy or cauda equina syndrome.
- For cervical spinal manipulations, vertebrobasilar insufficiency syndrome.
- A significant major artery aneurysm near the proposed manipulation.

X-RAYS ORDERED/REFERRED BY A CHIROPRACTOR

Coverage of chiropractic services is specifically limited to treatment by means of manual manipulation. No other diagnostic or therapeutic service furnished by a chiropractor or under his order is covered. The X-ray may be used for documentation, but Medicare will make no payment to the Doctor of Medicine (MD) or Doctor of Osteopathy (DO) if the chiropractor orders the X-ray.

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This clarifies the current policy regarding payment of diagnostic X-rays either ordered by or referred by a chiropractor. If a chiropractor directs or refers the patient to the radiologist to obtain an X-ray to demonstrate a subluxation prior to beginning treatment, and the radiologist performs the X-ray based upon the chiropractor's evaluation of the patient, the radiologist should report the chiropractor as the ordering provider on the claim form. Medicare will deny the service as non-covered, the beneficiary will be responsible for payment, the ABN will not apply, and advance written notice will not be required.

If the patient is referred by the chiropractor to the radiologist, and the radiologist then determines that an X-ray is appropriate, the radiologist assumes responsibility for ordering the X-ray and enters his name and ID number as the ordering physician on the claim form; Medicare will not deny the claim. The radiologist is not precluded from ordering a diagnostic X-ray. However, in this case, we would expect the radiologist to maintain adequate documentation to substantiate the medical necessity of the services he has ordered based upon his evaluation of the patient. In the event of a postpayment review of claims, we would request this documentation to validate payments made to the radiologist. In addition, no other diagnostic or therapeutic service performed by a chiropractor or ordered by a chiropractor is covered (e.g., physical therapy).

CHIROPRACTORS BILLING FOR PHYSICAL THERAPY

Chiropractors billing for physical therapy services (CPT codes 97001–97799 and HCPCS code G0283) must bill with the appropriate modifier.

- GN – Services delivered under an outpatient speech-language pathology plan of care.
- GO – Services delivered under an outpatient occupational therapy plan of care.
- GP – Services delivered under an outpatient physical therapy plan of care.

Even though physical therapy billed by a chiropractor is a program exclusion, if one of the above modifiers is omitted from any of the codes referenced, the service will be rejected. This rejection would require the claim to be corrected and resubmitted.

CODING GUIDELINES

- The level of subluxation must be specified on the claim and must be listed as the primary diagnosis, i.e., cervical region (7391). The neuromusculoskeletal condition necessitating the treatment must be listed as the secondary diagnosis.
- Non-covered services provided by a chiropractor need not be billed to Medicare unless the patient requests the services be billed to obtain a denial for his supplemental insurance. The chiropractor may bill the services with specific procedure codes for the non-covered services, e.g., X-rays, laboratory tests, physical examinations or physical therapy. One exception to this situation exists: A chiropractor will still be required to bill Medicare for manipulations that exceed the norm and maintenance therapy.

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CLAIM REQUIREMENTS

- The initial date of treatment must be documented in Item 14 of the CMS-1500 claim form or the electronic equivalent.
- If the subluxation is demonstrated by an X-ray, the X-ray date must be placed in Item 19 of the CMS-1500 claim form or the electronic equivalent.

Complete claim form instructions can be found at:

http://www.trailblazerhealth.com/Publications/Training Manual/claim form instructions.pdf

REASONS FOR DENIAL

- When the number of manipulations exceeds the norm. (This type of denial will still require a claim be submitted to Medicare.)
- Excluded Services: An excluded service from Medicare coverage is any service other than manual manipulation for treatment of subluxation of the spine. The chiropractor is not required to bill excluded services; however, the provider may bill these services to Medicare to obtain a denial for secondary insurance purposes. The following are examples (not an all-inclusive list) of services that, when performed or ordered by the chiropractor, are excluded from Medicare coverage and for which the beneficiary is responsible for payment:
  - Therapy for a chronic condition that does not meet the definition as described in the “Indications and Limitations and/or Medical Necessity” section of this policy.
  - Laboratory tests.
  - X-rays.
  - Office visits (history and physical).
  - Physical therapy.
  - Supplies.
  - Injections.
  - Drugs.
  - EKGs or any diagnostic study.
  - Acupuncture.
  - Orthopedic devices.
  - Nutritional supplements/counseling.
  - Any service ordered by the chiropractor.
- Any manipulation, including low-force technique, where one of the absolute contraindications listed in this policy exists.

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- Mechanical or electric equipment that is used for manipulations and does not meet the definition of "manual device" as specified in the "Description" section of this policy.
- Coverage will be denied for lack of reasonable expectation that the continuation of treatment would result in long-term improvement of the patient's condition; continued repetitive treatment without an achievable and clearly defined goal is considered maintenance therapy and is not covered.
- The service is considered an extraspinal CMT.
- The service does not follow the guidelines of this policy.

SUPPLIES

Supplies (such as braces, corsets, supports, etc.) and Durable Medical Equipment (DME) may be coverable when ordered by an MD or DO and supplied by a chiropractor. Supplies must be billed to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) and the chiropractor must have a DME supplier number with the DME MAC.

REVISION HISTORY

Date	Revision
June 2007	• Removed limited coverage and added the link to the "Chiropractic Services" LCD on the TrailBlazer Web site. • Updated the loops and segments for the claim requirements for electronic claims submission.
March 2009	• Updated Web site links. • Removed loops/segments of the electronic claim form and added a link to the CMS-1500 claim form manual.
April 2010	*Added the term PART exam to the initial visit documentation requirements.*