Addressing Misinformation Regarding Chiropractic Services and Medicare

Information for Medicare Fee-for-Service Health Care Professionals

Background

This fact sheet is being provided by the Centers for Medicare & Medicaid Services (CMS) to correct misinformation in the chiropractic community relating to Medicare and its regulations as they relate to chiropractic services. This fact sheet is informational only and represents no changes to existing Medicare policy.

In order to correct misinformation about Medicare and its regulations which exist in the chiropractic community, the American Chiropractic Association (ACA) works to check the validity of all claims and provide accurate information based on the Medicare manual system maintained by CMS, as well as information in regulatory and statutory language. CMS is providing this fact sheet which it hopes will clarify certain issues, around which there may be some confusion. The specific issues being addressed are:

Misinformation #1: There is a 12 visit cap or limit for chiropractic services.

Correction: There are no caps/limits in Medicare for covered chiropractic care rendered by chiropractors who meet Medicare's licensure and other requirements as specified in the *Medicare Benefit Policy Manual*, Chapter 15, Section 30.5. (This manual is available at *http://www.cms.hhs.gov/manuals/IOM/list.asp* on the CMS website.) There may be review screens (numbers of visits at which the Medicare Carrier or A/B MAC may require a review of documentation), but caps/limits are not allowed.

Misinformation #2: If you are a non-participating (non-par) provider, you do not have to worry about billing Medicare.

Correction: Being non-par does not mean you don't have to bill Medicare. All Medicare covered services must be billed to Medicare, or the provider could face penalties.

A non-par provider is actually a provider involved in the Medicare program who has enrolled to be a Medicare provider but chooses to receive payment in a different method and amount than Medicare providers classified as participating. Non-par providers may receive reimbursement for rendered services directly from their Medicare patients. They submit a bill to Medicare so the beneficiary may be reimbursed for the portion of the charges for which Medicare is responsible.

The Social Security Act (Section 1862 (a)(1) at http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the Internet) provides that Medicare will only pay for items or services it determines to be "reasonable and necessary," and if those items or services can be shown to be "reasonable and necessary," then those items or services are covered and will be paid by Medicare.

It is important to note that non-par providers may choose to accept assignment, therefore, the amount paid by the beneficiary must be reported in Item 29 of the CMS 1500 claim form or its electronic equivalent. This ensures that the beneficiary is reimbursed (if applicable) prior to Medicare sending payment to the provider. Whether or not non-par providers choose to accept assignment on all claims or on a claim-by-claim basis, their Medicare reimbursement is five percent less than a participating provider, as reflected in the annual Medicare Physician Fee Schedule.

You can find a copy of the Medicare Participating Provider Agreement at *http://www.cms.hhs.gov/cmsforms/downloads/cms460.pdf* on the CMS website. The form contains important information regarding the participation process and the annual opportunity you have to make or change your participation decision. Additional information is available in the *Medicare Benefit Policy Manual* (Chapter 15; Covered Medical and Other Health Services) at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* and the *Medicare Claims Processing Manual* (Chapter 12; Physician/Nonphysician Practitioners) at *http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf* on the CMS website.

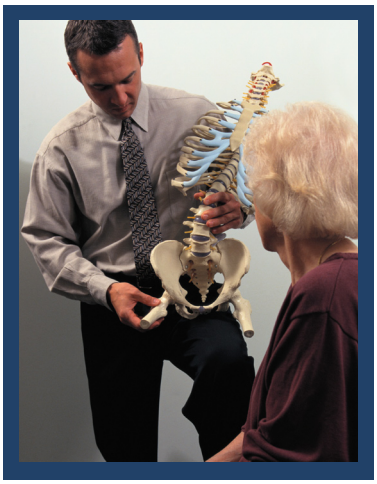
Misinformation #3: If you are a non-par provider, you will never be audited nor have claims reviewed, etc.

Correction: Any Medicare claim submitted can be audited/reviewed; the non-par or participating (par) status of the physician does not affect the possibility of this occurring. CMS audits/reviews are intended to protect Medicare trust funds and also to identify billing errors so providers and their billing staff can be alerted of errors and educated on how to avoid future errors. Correct coverage, reimbursement, and billing requirements are readily available to assist you in understanding Medicare requirements.

This information is in Medicare manuals that are at *http://www.cms.hhs.gov/Manuals/* on the CMS website. In addition, an excellent way to stay informed about changes to Medicare billing and coverage requirements is to monitor *MLN Matters Articles*, which are available at *http://www.cms.hhs.gov/MLNMattersArticles/* on the same site.

Misinformation #4: You can opt out of Medicare.

Correction: Opting out of Medicare is not an option for Doctors of Chiropractic. Note that opting out and being non-participating are not the same things. Chiropractors may decide to be participating or non-participating with regard to Medicare, but they may not opt out.

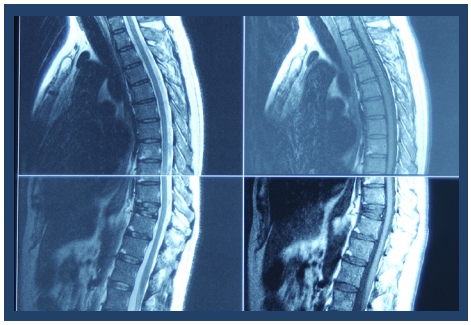


For further discussions of the Medicare "opt out" provision, see the *Medicare Benefit Policy Manual* (Chapter 15, Section 40; Definition of Physician/Practitioner) at *http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf* on the CMS website.

Misinformation #5: You should get an Advance Beneficiary Notification (ABN) signed once for each patient, and it will apply to all services, all visits.

Correction: The decision to deliver an **ABN must be based on a genuine reason to expect that Medicare will not pay for a particular service on a specific occasion** for that beneficiary due to lack of medical necessity for that service. The ABN then allows the beneficiary to make an informed decision about receiving and paying for the service. Should the beneficiary decide to receive the service, you must then submit a claim to Medicare even though you expect the beneficiary to pay and you expect that Medicare will deny the claim. For further information, see the *Medicare Claims Processing Manual* (Chapter 30) at *http://www.cms.hhs.gov/manuals/downloads/clm104c30.pdf* and

the *Medicare Benefit Policy Manual* (Chapter 15) at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* on the CMS website. Also see "What Doctors Need to Know about the Advance Beneficiary Notice (ABN)" at *http://www.cms.hhs.gov/MLNProducts/downloads/ABN_READERS.pdf* on the CMS website.



Misinformation #6: Maintenance care is not a covered service under Medicare.

Correction: Spinal manipulation is a covered service under Medicare, no matter which phase of care you may be in; however, maintenance care is not **medically reasonable and necessary and therefore not reimbursable by Medicare.** Acute, chronic, and maintenance adjustments are all "covered" services, but only acute and chronic services are considered active care and may, therefore, be reimbursable. Maintenance therapy is defined (per Chapter 15, Section 30.5.B. of the *Medicare Benefit Policy Manual*) 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.

See MM3449 (Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy) at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3449.pdf* on the CMS website. This article contains important information on completing claims and how to identify acute and chronic adjustments as opposed to maintenance adjustments. **The article also recommends you consider issuing an ABN to the Medicare beneficiary when you provide maintenance services.** Additional details are available in the *Medicare Benefit Policy Manual,* Chapter 15, Section 30.5 (Chiropractor's Services) at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* on the CMS website.

Misinformation #7: Non-par providers do not have the same documentation requirements as par providers.

Correction: Chiropractic care has documentation requirements to show medical necessity. The participating status of the provider is irrelevant to the documentation requirements.

Specific details regarding documentation are in the *Medicare Benefit Policy Manual* (Chapter 15, Sections 30.5 and 240) at *http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf* on the CMS website. Also, see the *Medicare Claims Processing Manual* (Chapter 12, Section 220) at *http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf* on the CMS website.

Additional Information

If you have any questions regarding chiropractic issues and Medicare, please contact your Medicare Carrier or A/B MAC at its toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.