

PART B



Chiropractic Billing Guide July 2010

NHIC, Corp.

J14 A/B MAC

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INTRODUCTION

The Provider Outreach and Education Team at NHIC, Corp. developed this guide to provide you with Medicare Part B Chiropractic billing information. It is intended to serve as a useful supplement to other manuals published by NHIC, and not as a replacement. The information provided in no way represents a guarantee of payment. Benefits for all claims will be based on the patient's eligibility, provisions of the Law, and regulations and instructions from Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. All information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by the Centers for Medicare & Medicaid Services (CMS), are revised or implemented.

This information guide, in conjunction with the NHIC website (www.medicarenhic.com), *Medicare B Resource* (monthly provider newsletter), and special program mailings, provide qualified reference resources. We advise you to check our website for updates to this guide. To receive program updates, you may join our mailing list by clicking on "Join Our Mailing List" on our website. Most of the information in this guide is based on **Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services Sections 30.5 & 240 Chiropractor's Services**. The CMS IOM provides detailed regulations and coverage guidelines of the Medicare program. To access the manual, visit the CMS website at <http://www.cms.gov/manuals/>

If you have questions or comments regarding this material, please call the Customer Service Center at 866-801-5304.

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GENERAL INFORMATION

A chiropractor must be licensed or legally authorized to render chiropractic services by the State or jurisdiction in which the services are rendered. Coverage extends only to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray or physical exam, provided such treatment is legal in the State where performed. All other services rendered or ordered by a chiropractor are considered **non-covered**.

Licensure and Authorization to Practice

Prior to July 1, 1974

Chiropractors licensed or authorized to practice prior to July 1, 1974, and those individuals who commenced their studies in a chiropractic college before that date must meet all of the following three minimum standards to render payable services under the program:

- Preliminary education equal to the requirements for graduation from an accredited high school or other secondary school;
- Graduation from a college of chiropractic approved by the State's chiropractic examiners that included the completion of a course of study covering a period of not less than three school years of six months each year in actual continuous attendance covering adequate course of study in the subjects of anatomy, physiology, symptomatology and diagnosis, hygiene and sanitation, chemistry, histology, pathology, and principles and practice of chiropractic, including clinical instruction in vertebral palpation, nerve tracing, and adjusting; and
- Passage of an examination prescribed by the State's chiropractic examiners covering the subjects listed above.

After June 30, 1974

Individuals commencing their studies in a chiropractic college after June 30, 1974, must meet all of the above three standards and all of the following additional requirements:

- Satisfactory completion of two years of pre-chiropractic study at the college level;
- Satisfactory completion of a 4-year course of 8 months each year (instead of a 3-year course of 6 months each year) at a college or school of chiropractic that includes not less than 4,000 hours in the scientific and chiropractic courses specified in the second bullet under "**Prior to July 1, 1974**" above, plus courses in the use and effect of x-ray and chiropractic analysis; and
- The practitioner must be over 21 years of age.

Manual Manipulation

Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation (i.e., by use of hands) of the spine for the purpose of correcting a subluxation. Additionally, manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. However, no additional payment is available for the use of the device, nor does Medicare recognize an extra charge for the device itself.

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The word “correction” may be used in lieu of “treatment”. Other common terminology for chiropractic manipulation includes:

- Spine or spinal adjustment by manual means;
- Spine or spinal manipulation;
- Manual adjustment; and
- Vertebral manipulation or adjustment.

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 a chiropractor.

SUBLUXATION

Definition

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 may be demonstrated by an x-ray or by a physical examination.

Location of Subluxation

The precise level of the subluxation must be specified in the medical record to substantiate a claim for manipulation of the spine. This designation is made in relation to the part of the spine in which the subluxation is identified:

Area of Spine	Names of Vertebrae	Number of Vertebrae	Short Form or Other Name
Neck	Occiput	7	Occ, C0
	Cervical		C1 thru C7
	Atlas		C1
	Axis		C2
Back	Dorsal or	12	D1 thru D12
	Thoracic		T1 thru T12
	Costovertebral		R1 thru R12
	Costotransverse		R1 thru R12
Low Back	Lumbar	5	L1 thru L5
Pelvis	Ilii, R and L		I, Si
Sacral	Sacrum, Coccyx		S, SC

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 which would be appropriate for chiropractic manipulative treatment.

There are two ways in which the level of the subluxation may be specified.

- The exact bones may be listed, for example: C5, 6, etc.
- The area may suffice if it implies only certain bones such as: occipito-atlantal (occiput and C1 (atlas)), lumbo-sacral (L5 and Sacrum), sacro-iliac (sacrum and ilium).

Following are 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, hyper mobility, hypo motility, aberrant

Other terms may be used, if they are understood clearly to refer to bone or joint space or position (or motion) changes of vertebral elements.

Demonstration by X-ray

An x-ray is not required to demonstrate subluxation. An x-ray may, however, be used for this purpose if the chiropractor so chooses. If the chiropractor chooses to use an x-ray to demonstrate the subluxation, then the documenting x-ray must have been taken at a time reasonably proximate to the initiation of a course of treatment.

Unless Medicare concludes that 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** 3 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 that the condition is permanent. A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated.

As with all diagnostic tests for beneficiaries, Medicare regulations require that x-rays be ordered by a physician. Further, except for x-rays, diagnostic tests must be ordered by the physician actually treating the patient's specified condition at the time. To this point, Medicare considers tests not ordered by the beneficiary's treating physician to be neither reasonable nor necessary.

The only exception to this "treating physician" rule is the plain x-ray. Medicare does allow a physician other than the one actually treating the beneficiary for the disorder of the spine (such as the radiologist or beneficiary's primary care physician) to order an x-ray to be used by a chiropractor for patient treatment.

Specifically, Medicare may not reimburse for x-rays that chiropractors order, regardless of the qualifications or status of the provider who takes and interprets it. To ensure that all providers are reimbursed for that chiropractors use in patient care, refer the beneficiary to a radiologist, or other physician, who would then order the x-ray.

The documentation for the x-ray should be maintained by that physician, in the beneficiary's medical records.

Demonstrated by Physical Examination (PART)

To demonstrate a subluxation based on physical examination, two of the four criteria mentioned below are required, one of which must be **asymmetry/misalignment** or **range of motion abnormality**.

- Pain/tenderness evaluated in terms of location, quality, and intensity;
- Asymmetry/misalignment identified on a sectional or segmental level;
- Range of motion abnormality (changes in active, passive and accessory joint movements resulting in an increase or decrease of sectional or segmental mobility); and
- Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

NECESSITY FOR TREATMENT

Chiropractic treatment is covered when **all** the following criteria are met:

- 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, **and**
- The patient **must have** a subluxation of the spine as demonstrated by x-ray or physical exam.

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, or arrest of progression, 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.
1. **New Injury** - a recent initial injury that has never been treated in the past identified by x-ray or physical exam as specified above. This is covered when all other criteria is met.

2. **Re-injury/Recurrence** – return of symptom of a previously treated condition that has been quiescent or asymptomatic for a period of time, e.g. 30 or more days. Reinstitution of therapy is payable when all other criteria are met.
3. **Exacerbation** – a temporary marked deterioration of the patient’s condition due to a flare up of:
 - A condition being treated, in which case additional treatment may be allowed but would not necessitate a whole new course of treatment.
 - A chronic condition (after having achieved maximum therapeutic benefit and stabilized functional status for a reasonable period of time) where the patient experiences a marked increase in symptoms from baseline. This may warrant an initiation of a new course of treatment.

Exacerbation must be documented in the patient’s clinical record; including the date of occurrence, nature of the onset, or other pertinent factors that will support the reasonableness and necessity of treatment.

Maintenance Therapy

Chiropractic maintenance therapy is not considered to be medically reasonable or necessary under the Medicare program, and is therefore not payable. 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 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.

Dynamic Thrust

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 odontoideum;
- 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; and
- A significant major artery aneurysm near the proposed manipulation.

FREQUENCY GUIDELINES

Chiropractors will be afforded appropriate time to effect improvement and arrest or retard deterioration of subluxation within a reasonable and generally predictable period of time.

Acute subluxation (i.e., strains and sprains) problems may require as many as 3 months of treatment but some require very little treatment. In the first several days treatment may be quite frequent but decreasing in frequency with time, or as improvement is obtained.

Whereas, chronic spinal joint condition (i.e., loss of joint mobility or other joint problems) implies the condition has existed for a longer period of time and that, in all probability, the involved joints have already “set” and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

Reimbursement under Medicare will be limited to no more than one treatment per day unless documentation of the reasonableness and necessity for additional treatment is submitted with the claim. The need for a service should be based upon the reasonableness and necessity of each individual patient encounter, and not based on a specific “covered” number. In other words, each treatment billed to Medicare is subject to the same requirement to be reasonable and necessary under general program rules. NHIC may apply stricter guidelines to numbers of treatments that we believe may indicate that the services are no longer reasonable and necessary; however, our application of any frequency guidelines is an internal matter, and is not subject to disclosure. Refer to the Local Coverage Determination for more information:

http://www.medicarenhic.com/ne_prov/policies.shtml

CODING GUIDELINES

Diagnosis Requirement

As per 42 CFR §410.22 (b) Medicare Part B pays only for a chiropractor’s manual manipulation of the spine to correct a subluxation. The level of subluxation must be specified on the claim and

must be listed as the **primary** diagnosis. The neuromusculoskeletal condition necessitating the treatment must be listed as the **secondary** diagnosis.

ICD-9 Codes that Support Medical Necessity

Two diagnostic codes must be listed on the claim to support medical necessity:

- The level of subluxation must be specified on the claim and must be listed as the **primary diagnosis**. The level of subluxation identified and under treatment will be in the range 739.X.
- The associated neuromusculoskeletal condition necessitating the treatment must also be listed as the **secondary diagnosis**

Simply listing a diagnostic code from the secondary diagnosis group does not determine that the treatment is covered as a reasonable and necessary therapy.

739.0 NONALLOPATHIC LESIONS OF HEAD REGION NOT ELSEWHERE CLASSIFIED

739.1 NONALLOPATHIC LESIONS OF CERVICAL REGION NOT ELSEWHERE CLASSIFIED

739.2 NONALLOPATHIC LESIONS OF THORACIC REGION NOT ELSEWHERE CLASSIFIED

739.3 NONALLOPATHIC LESIONS OF LUMBAR REGION NOT ELSEWHERE CLASSIFIED

739.4 NONALLOPATHIC LESIONS OF SACRAL REGION NOT ELSEWHERE CLASSIFIED

739.5 NONALLOPATHIC LESIONS OF PELVIC REGION NOT ELSEWHERE CLASSIFIED

739.8 NONALLOPATHIC LESIONS OF RIB CAGE NOT ELSEWHERE CLASSIFIED

The secondary diagnosis must reflect the neuromusculoskeletal condition necessitating the treatment.

307.81 TENSION HEADACHE

333.83 SPASMODIC TORTICOLLIS

[346.00](#) - MIGRAINE WITH AURA, WITHOUT MENTION OF INTRACTABLE MIGRAINE
[346.93](#) WITHOUT MENTION OF STATUS MIGRAINOSUS - MIGRAINE, UNSPECIFIED, WITH INTRACTABLE MIGRAINE, SO STATED, WITH STATUS MIGRAINOSUS

350.1 TRIGEMINAL NEURALGIA

350.2 ATYPICAL FACE PAIN

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353.1	LUMBOSACRAL PLEXUS LESIONS
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353.3	THORACIC ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.4	LUMBOSACRAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
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715.21	OSTEOARTHRISIS LOCALIZED SECONDARY INVOLVING SHOULDER REGION
715.22	OSTEOARTHRISIS LOCALIZED SECONDARY INVOLVING UPPER ARM

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715.25	OSTEOARTHRISIS LOCALIZED SECONDARY INVOLVING PELVIC REGION AND THIGH
715.28	OSTEOARTHRISIS LOCALIZED SECONDARY INVOLVING OTHER SPECIFIED SITES
715.80	OSTEOARTHRISIS INVOLVING OR WITH MORE THAN ONE SITE BUT NOT SPECIFIED AS GENERALIZED AND INVOLVING UNSPECIFIED SITE
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716.10 - 716.19	TRAUMATIC ARTHROPATHY SITE UNSPECIFIED - TRAUMATIC ARTHROPATHY INVOLVING MULTIPLE SITES
716.68	UNSPECIFIED MONOARTHRITIS INVOLVING OTHER SPECIFIED SITES
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780.99	OTHER GENERAL SYMPTOMS
781.0	ABNORMAL INVOLUNTARY MOVEMENTS
781.2	ABNORMALITY OF GAIT
781.3	LACK OF COORDINATION
781.8	NEUROLOGICAL NEGLECT SYNDROME
781.99	OTHER SYMPTOMS INVOLVING NERVOUS AND MUSCULOSKELETAL SYSTEMS
784.0	HEADACHE
839.00 - 839.08	CLOSED DISLOCATION CERVICAL VERTEBRA UNSPECIFIED - CLOSED DISLOCATION MULTIPLE CERVICAL VERTEBRAE
839.20 - 839.21	CLOSED DISLOCATION LUMBAR VERTEBRA - CLOSED DISLOCATION THORACIC VERTEBRA
839.40 - 839.49	CLOSED DISLOCATION VERTEBRA UNSPECIFIED SITE - CLOSED DISLOCATION OTHER VERTEBRA
839.61 - 839.69	CLOSED DISLOCATION STERNUM - CLOSED DISLOCATION OTHER LOCATION
846.0	LUMBOSACRAL (JOINT) (LIGAMENT) SPRAIN
846.1	SACROILIAC (LIGAMENT) SPRAIN

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846.2	SACROSPINATUS (LIGAMENT) SPRAIN
846.3	SACROTUBEROUS (LIGAMENT) SPRAIN
846.8	OTHER SPECIFIED SITES OF SACROILIAC REGION SPRAIN
846.9	UNSPECIFIED SITE OF SACROILIAC REGION SPRAIN
847.0	NECK SPRAIN
847.1	THORACIC SPRAIN
847.2	LUMBAR SPRAIN
847.3	SPRAIN OF SACRUM
847.4	SPRAIN OF COCCYX
848.5	PELVIC SPRAIN
850.9	CONCUSSION UNSPECIFIED
905.7	LATE EFFECT OF SPRAIN AND STRAIN WITHOUT TENDON INJURY
905.8	LATE EFFECT OF TENDON INJURY
907.3	LATE EFFECT OF INJURY TO NERVE ROOT(S) SPINAL PLEXUS(ES) AND OTHER NERVES OF TRUNK
953.0	INJURY TO CERVICAL NERVE ROOT
953.1	INJURY TO DORSAL NERVE ROOT
953.2	INJURY TO LUMBAR NERVE ROOT
953.3	INJURY TO SACRAL NERVE ROOT
953.4	INJURY TO BRACHIAL PLEXUS
953.5	INJURY TO LUMBOSACRAL PLEXUS
954.0	INJURY TO CERVICAL SYMPATHETIC NERVE EXCLUDING SHOULDER AND PELVIC GIRDLES
954.1	INJURY TO OTHER SYMPATHETIC NERVE EXCLUDING SHOULDER AND PELVIC GIRDLES
954.8	INJURY TO OTHER SPECIFIED NERVE(S) OF TRUNK EXCLUDING SHOULDER AND PELVIC GIRDLES
954.9	INJURY TO UNSPECIFIED NERVE OF TRUNK EXCLUDING SHOULDER AND PELVIC GIRDLES
956.0	INJURY TO SCIATIC NERVE

956.1	INJURY TO FEMORAL NERVE
956.2	INJURY TO POSTERIOR TIBIAL NERVE
956.3	INJURY TO PERONEAL NERVE
956.4	INJURY TO CUTANEOUS SENSORY NERVE LOWER LIMB
956.5	INJURY TO OTHER SPECIFIED NERVE(S) OF PELVIC GIRDLE AND LOWER LIMB
956.8	INJURY TO MULTIPLE NERVES OF PELVIC GIRDLE AND LOWER LIMB
956.9	INJURY TO UNSPECIFIED NERVE OF PELVIC GIRDLE AND LOWER LIMB

Symptoms Associated with Subluxation

A secondary diagnosis consisting of symptoms necessitating the patient to seek treatment must be indicated. These symptoms must have a direct relationship to the level of subluxation stated in the primary diagnosis.

These symptoms should refer to the spine (spondylo or vertebral), muscle (mayo), bone (osseo or osteo), rib (costo or costal), joint (arthro) and be reported as pain (algia), inflammation (it is), 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. A statement on a claim that there is "pain" is insufficient. The location of the pain must be described and whether that particular vertebra is listed as capable of producing pain in that area.

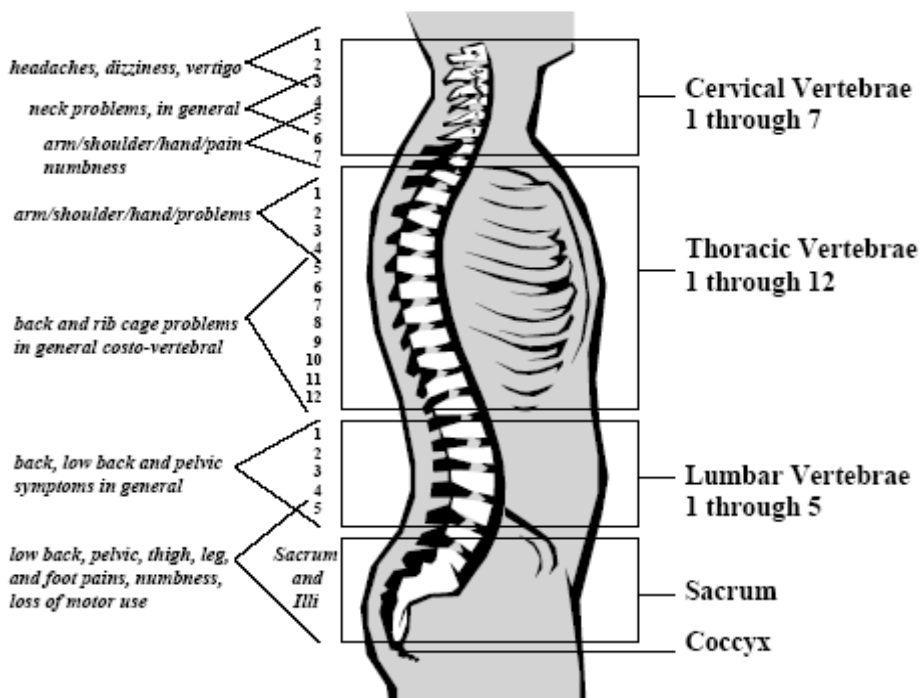
Spinal Axis, aches, strains, sprains, nerve pains, and functional mechanical disabilities of the spine are considered to provide therapeutic grounds for chiropractic manipulative treatment. There may be secondary or complicating conditions such as spinal ankylosis, curvature, or other chronic deformities that determine the reasonableness and necessity of the number of visits Medicare will cover for chiropractic care. Some other disease and pathological disorders do not provide the therapeutic grounds for chiropractic manipulative treatment. Examples of these are rheumatoid arthritis, muscular dystrophy, multiple sclerosis, pneumonia and emphysema.

Consistency in the pattern and frequency or in the use of diagnosis codes will be monitored. Continued repetitive treatment *without* a clearly defined clinical end point **is considered maintenance therapy and is not covered**. Coverage will be denied if there is not a reasonable expectation that the continuation of treatment would result in improvement of the patient's condition.

While another joint problem anywhere in the spine is obviously able to produce symptoms at that immediate place, other areas of the body and the vertebrae related to them follow the general

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scheme shown in the chart below. Please note that while these areas of the spine and the related body structures, as well as the symptoms listed, are generalized, they can serve as a useful guide.



Documentation Requirements

The following documentation requirements apply whether the subluxation is demonstrated by an x-ray or physical examination.

1. The need for the specific treatment must be clearly documented in the patient record.
2. The date of occurrence, nature of the onset, or other pertinent factors that will support the necessity of chiropractic treatments must be documented in the patient's record.
3. Failure to completely document the necessity of the chiropractic manual spinal manipulation(s) may result in denial of claim(s).
4. Documentation must be legible and made available to the Contractor upon request.
5. Medicare limits reimbursement to no more than one treatment per day unless documentation of the reasonableness and necessity for additional treatment is submitted with the claim. [CMS Manual System, Pub 100-2, Medicare Benefit Policy Manual, Chapter 15, Sec 240]
6. The patient's record must document a specific level of subluxation (which may be demonstrated by an x-ray or by physical examination) as described by X-ray (6A) or by physical

exam (6B). The claim will document the area of subluxation by ICD-9 codes coded to the highest level of specificity (see "ICD-9 Code that support medical necessity.") The practitioner's documentation should record the precise level of subluxation.

A. Demonstrated by x-ray. [Medicare Benefit Policy Manual, Chapter 15, Sec 240] An x-ray may be used to document subluxation. The x-ray 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 3 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 patient's record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent. A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated.

B. Demonstrated by physical examination. [Medicare Benefit Policy Manual, Chapter 15, Sec 240]:

- **(P)** Pain/tenderness evaluated in terms of location, quality, and intensity;
- **(A)** Asymmetry/misalignment identified on a sectional or segmental level;
- **(R)** Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility; and
- **(T)** Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

Note: To demonstrate a subluxation based on physical examination, **two** of the four criteria mentioned under "physical examination are required, **one of which must be** asymmetry/misalignment **or** range of motion abnormality. Some examination procedures provide more than one type of information, and therefore a single finding may have significance in two or more categories. It is possible, therefore, that a single test may satisfy documentation of subluxation by physical exam in a given case. Further guidance is provided at the end of this section.

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

A. History as stated above.

B. 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; and
- Symptoms causing patient to seek treatment.

Symptoms should bear a direct relationship to the level of subluxation as discussed in the “Indications” section above.

C. Evaluation of musculoskeletal/nervous system through physical examination.

D. 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.

E. Treatment Plan: The treatment plan should include the following:

- Recommended level of care (duration and frequency of visits);
- Specific treatment goals; and
- Objective measures to evaluate treatment effectiveness.

F. Date of the initial treatment.

8.Documentation Requirements: Subsequent Visits

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

A. History

- Review of chief complaint;
- Changes since last visit;
- System review if relevant.

B.Physical exam

- Exam of area of spine involved in diagnosis;

- Assessment of change in patient condition since last visit;
- Evaluation of treatment effectiveness.

Failure to meet the required documentation for chiropractic spinal manipulation may result in denial of claim(s). Documentation must be legible and made available to Medicare upon request. Acronyms used must be universal or accompanied by a legend.

MEDICAL RECORD DOCUMENTATION

What is Documentation and Why is it Important?

The primary purpose of medical documentation is to ensure that patient treatment is recorded for the quality of care and continuity of treatment. Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments and outcomes.

The medical record chronologically documents the care of the patient and is an important element in contributing to high quality care. The medical record facilitates:

- The ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time;
- Communication and continuity of care among the physicians and other health care professionals involved in the patient's care;
- Accuracy and timeliness of claims review and payment;
- Appropriate utilization review and quality of care evaluations; and
- Collection of data that may be useful in research and education.

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

What do Payers Want and Why?

Because payers have a contractual obligation to enrollees, they may require documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- The site of service;
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- That services provided have been reported accurately.

Section 1833 (e) of Title XVIII of the Social Security Act requires that legible documentation be made available to the Medicare Contractor upon Request. The documentation must validate the claim(s) submitted to Medicare for reimbursement of covered services. A claim for Medicare

benefits is considered valid when there is sufficient documentation in the providers', physicians' or hospitals' files to substantiate the service billed.

When the medical necessity of a service is questionable, the burden of proof lies with the provider of service who must provide the appropriate complete medical records and/or charts that support the need for the service.

To be reasonable and necessary, items and services must have been established safe and effective. That is:

- Consistent with symptoms or diagnosis of the illness under treatment;
- Necessary and consistent with the generally accepted professional medical standards (i.e., not experimental or investigational);
- Not furnished primarily for the convenience of the patient, the attending physician, or other medical professionals, or family members; and
- Furnished at the most appropriate level, which can be provided safely and effectively to the patient.

Complete records are those that contain all pertinent and essential information related to the patient's status. Each entry must be "stand-alone" (i.e., must support the fact that the level of service billed was rendered.)

Furthermore, these records must substantiate the services performed and indicate the proper treatment plan.

Documentation Tips

In documenting medical records to support services provided to patients, special emphasis should be placed on assuring that they:

- Are consistent with the clinical descriptors and definitions contained in CPT;
- Would be widely accepted by clinicians and minimize any changes in record-keeping practices; and
- Would be interpreted and applied uniformly by users across the country.

The use of non-standardized medical abbreviations is not acceptable.

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include the reason for the encounter and relevant history, physical examination findings and prior diagnostic test results; assessments, clinical impression or diagnosis; plan for care; and date and legible identity of the observer.

3. If not documented, the rationale for ordering the diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, responses to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be documented.
8. The signature of the person documenting the medical record should always be identifiable (i.e., legible), and the documentation should be authenticated and dated. In some instances, especially during inpatient hospitalization, a sample of the physician's/provider's signature may be requested. This is done to ensure that the requested records are correctly distinguished.

For Medicare reimbursement purposes, a rubber stamp signature on the medical record is not sufficient as evidence of the physician's presence unless initialed by the physician. The rationale for this policy is that the rubber stamp signature does not afford the required degree of assurance of the physician's involvement in the patient's care to qualify as the attending physician. This system affords no security that others will not use the stamp in the absence of the physician.

Computerized signatures are, under certain circumstance, acceptable. The contractor must be assured that the individual in question has his or her own confidential code or password to generate a computerized signature. The department heads of hospitals, clinic managers, and medical record departments can provide these assurances. These systems are subject to inspection by Medicare if it is suspected that security has been broken.

Note: Any reimbursement made for services that are not substantiated by sufficient documentation are considered an overpayment and must be refunded to the Medicare Program.

Administrative Costs for Document Retrieval

Section 1833 (e) of the Social Security Act authorizes NHIC, Medicare to retrieve all pertinent medical records of Medicare Part B claimants in order to ensure that Medicare payments are made only in accordance with Section 1862 (a). In accordance with Part 424 of Title 42 Code of Federal Regulations, when a claim is submitted to Medicare requesting to receive Federal funds, it is the responsibility of the health care provider (doctor, medical group, hospital, etc.) to furnish the Medicare Contractor sufficient information to determine whether payment is due and the amount of such payment. Any cost(s) incurred by them in making this information available to the Contractor is considered part of their administrative costs(s).

CLAIMS SUBMISSION REQUIREMENTS

Payment is based on the Medicare Physicians' Fee Schedule **not** the charge a provider bills for the service. The Medicare fee schedule amounts, for participating and non-participating providers, are issued annually.

These items refer to fields on the Form CMS-1500 (08-05) or electronic equivalent primarily affecting chiropractors. For complete claim for completion instructions, see [the CMS 1500 Claim Form Instructions](#) on the NHIC website..

Item 14 For chiropractic services, enter a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date of the initiation of the course of treatment and enter a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date in item 19.

Item 17 Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data. When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician.

Referring Physician is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering Physician is a physician or, when appropriate, a non-physician practitioner, who orders non-physician services for the patient. See Pub. 100-02, Chapter 15 for non-physician practitioner rules. Example of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's services.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. All claims for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. See Item 17b below for further guidance on reporting the referring/ordering provider's NPI. The following Medicare services /situations require the submission of the referring / ordering provider information:

- Medicare covered services and items that are the result of a physician's order or referral;
- Parenteral and enteral nutrition;

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- Immunosuppressive drug claims;
- Hepatitis B claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services; and
- Durable medical equipment
- When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests);
- When service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17;
- When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner;

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE JOE FEELGOOD , MD	17a.		
	17b.	NPI	1234567890

Item 17b Enter the NPI of the referring/ ordering physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data.

CONTRACTOR NOTE: The only time that Item 17 needs to be completed for chiropractic services is when an x-ray service is billed on the claim form for denial purposes, since it is an ordered service.

Item 19

Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for the course of a chiropractic treatment in Item 14, the chiropractor is certifying that all the relevant information requirements (including the level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, are on file, along with the appropriate x-ray and all are available for carrier review.

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Item 21 Enter the patient's diagnosis/condition. Use ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four codes in priority order.

CONTRACTOR NOTE: For chiropractic claims use an ICD-9-CM for the primary diagnosis from the diagnosis requirement list and a secondary ICD-9-CM for the symptoms associated with the diagnosis of subluxation. Up to four ICD-9-CM codes can be used. The two most clinically significant primary diagnoses (listed as 1st and 2nd diagnoses) and the two accompanying secondary diagnoses (listed as 3rd and 4th diagnoses respectively) must be listed. Although Item 21 can only contain the diagnoses for two regions treated and its corresponding symptoms, the clinical record **MUST** document the additional primary and secondary diagnoses justifying treatment of the additional regions billed.

Item 24D Enter the procedures, services or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code. The Form CMS-1500 (08-05) has the ability to capture up to four modifiers.

Enter the specific procedure code without a narrative description. However when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise an attachment shall be submitted with the claim. This is a required field.

The contractor will return as unprocessable if an "unlisted procedure code" or an (NOC) code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

CONTRACTOR NOTE: Enter the appropriate CPT code that best describes the service
98940 Chiropractic manipulative treatment (CMT); spinal, one to two regions
98941 spinal, three to four regions
98942 spinal, five regions

CONTRACTOR NOTE: Procedure code 98943 (chiropractic manipulative treatment (CMT); extraspinal, one or more regions) is **not covered by Medicare**.

Use of these codes must indicate treatment of appropriate number of regions involved and not the number of the vertebral joints. Thus, CPT Code 98940 will involve one or two regions (i.e. 4th & 5th cervical and/or 3rd & 4th thoracic) and not one or two vertebral joints (i.e. 2nd & 3rd cervical and/or 4th & 5th cervical).

When acute or chronic active/corrective treatment to Medicare patients is provided, modifier **AT** must be added to HCPCS codes 98940, 98941, or 98942. If this modifier is not used, the claim will

be considered maintenance therapy and services will be denied. Maintenance chiropractic therapy is not medically reasonable or necessary under Medicare.

Additionally, be aware of any local coverage determination for these services that might limit the frequency or circumstances under which active/corrective chiropractic can be paid. If that limit is exceeded, the AT modifier should not be used. Local coverage determinations are available on the NHIC Website at: http://www.medicarenhic.com/ne_prov/policies.shtml

NONCOVERED SERVICES

An excluded service from Medicare coverage is any service other than manual manipulation for treatment of subluxation of the spine. The chiropractic physician is not required to bill excluded services; however, the provider may bill these services to Medicare in order to obtain a denial for secondary insurance purposes.

Medicare does not cover the following services performed by a Chiropractor:

- Initial physical examinations
- Evaluation and Management Services
- X-Rays
- Acupuncture
- Physical therapy
- Vitamin, mineral and/or food supplements, other supplies
- Orthopedic Devices
- CPT code 98943 (chiropractic manipulative treatment (CMT); extraspinal, one or more regions)

If any of these services are billed, add the modifier GY.

NATIONAL CORRECT CODING INITIATIVE

The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have an MUE. The published MUE will consist of most of the codes with MUE values of 1-3. CMS will update the MUE values on its website on a quarterly basis. Although CMS publishes most MUE values on its website, other MUE values are confidential and are for CMS and CMS Contractors' use only. The latter group of MUE values should not be released since CMS does not publish them. For the latest version of the MUEs, refer to:

http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage

If you have concerns regarding specific MUEs, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions, LLC
P.O. Box 907
Carmel, IN 46082-0907

LIMITATION OF LIABILITY (ADVANCE BENEFICIARY NOTICE)

Services denied as not reasonable and medically necessary, under section 1862(a)(1) of the Social Security Act, are subject to the Limitation of Liability (Advance Beneficiary Notice (ABN)) provision. The ABN is a notice given to beneficiaries to convey that Medicare is not likely to provide coverage in a specific case. Providers must complete the ABN and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice.

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the provider must retain the original notice on file.

Complete instructions and the ABN form (CMS-R-131) can be found on the CMS website at the following address: <http://www.cms.gov/BNI/>

ABN Modifiers

- GA Waiver of liability statement issued, as required by payer policy
- GX Notice of liability issued, voluntary under payer policy

- GY Item or service statutorily excluded or does not meet the definition of any Medicare benefit
- GZ Item or service expected to be denied as not reasonable and necessary (forgot to issue ABN to patient)

LOCAL COVERAGE DETERMINATION (LCD)

Local Coverage Determinations are developed by the local Medicare contractor in the absence of a national Medicare payment policy. These policies describe specific criteria which determine whether an item or service is covered by Medicare and under what circumstances. LCDs are updated as new information and technology occurs in the field of medicine. NHIC has Local Coverage Determinations providing guidelines for various types of services. The LCDs can be found on the CMS website. The links for each state can be found on our website at:

http://www.medicarenhic.com/ne_prov/policies.shtml

NATIONAL COVERAGE DETERMINATION (NCD)

National Coverage Determinations are policies developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. NCDs are the same for all contractors across the country. More information about national coverage can be obtained through this website: <http://www.cms.gov/mcd/search.asp>

MEDICARE FRAUD AND ABUSE

As the CMS J14 A/B MAC for Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont, NHIC fully supports the CMS initiative for program safeguards and shares the following information for your use:

Fraud is the intentional deception or misrepresentation that the individual knows to be false, or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent line of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. Attempts to defraud the Medicare program may take a variety of forms. Some examples include:

- Billing for services or supplies that were not provided;
- Misrepresenting services rendered or the diagnosis for the patient to justify the services or equipment furnished;
- Altering a claim form to obtain a higher amount paid;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider; and

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- Use of another person's Medicare card to obtain medical care.

Abuse describes incidents or practices of providers that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse takes such forms as, but is not limited to:

- Unbundled charges;
- Excessive charges;
- Medically unnecessary services; and
- Improper billing practices.

Although these practices may initially be considered as abuse, under certain circumstances they may be considered fraudulent. Any allegations of potential fraud or abuse should be referred to Safeguard Services (SGS).

If you wish to report fraud, or have any questions on Medicare Fraud and Abuse, please contact:

Maureen Akhouzine, Manager
Safeguard Services (SSG)
75 William Terry Drive
Hingham, MA 02043
Phone 1-781-741- 3282
Fax 1-781-741-3283
maureen.akhouzine@hp.com

A single number to report suspected fraud is the national OIG fraud hot line: **1-800-HHS-TIPS (1-800-447-8477)**. Information provided to hotline operators is sent out to state analysts and investigators.

RECOVERY AUDIT CONTRACTOR

The Centers for Medicare & Medicaid Services (CMS) has retained Diversified Collection Services (DCS) to carry out the Recovery Audit Contracting (RAC) program for Region A. The RAC program is mandated by Congress aimed at identifying Medicare improper payments. As a RAC, DCS will assist CMS by working with providers in reducing Medicare improper payments through the efficient detection and recovery of overpayments, the identification and reimbursement of underpayments and the implementation of actions that will prevent future improper payments. For more information please click on <http://www.dcsrac.com/>

COMPREHENSIVE ERROR RATE TESTING

In an effort to determine the rate of Medicare claims that are paid in error, CMS developed the Comprehensive Error Rate Testing (CERT) program. This program will determine the paid claim error rates for individual Medicare contractors, specific benefit categories, and the overall national error rate. This is accomplished by sampling random claims on a nationwide basis, while insuring that enough claims are sampled to evaluate

the performance of each Medicare contractor. The CERT program is administered by two contractors:

CERT DOCUMENTATION CONTRACTOR (CDC) - The CDC requests and receives medical records from providers.

CERT REVIEW CONTRACTOR (CRC)-The CRC's medical review staff reviews claims that are paid and validate the original payment decision to ensure that the decision was appropriate. The sampled claim data and decisions of the independent medical reviewers will be entered into a tracking and reporting database.

The outcomes from this project are a national paid claims error rate, a claim processing error rate, and a provider compliance rate. The tracking database allows us to quickly identify emerging trends.

For more information please click on <http://www.cms.gov/CERT/>

If You Are Selected For A CERT Review

Providers who receive requests for Medical records from CDC should send the documentation directly to the CDC at the address listed on the request, not NHIC. It is imperative that if you receive such a request, you respond in a timely manner. If you submit records to the CDC with the wrong date of service, or delay your response beyond the submission time, CERT will presume the service was never done and a refund of payment will be collected.

CERT may also request medical records for the period of the service covering the preceding 6 months prior to the date of service in question for this claim, if the services in those 6 months are associated with the same condition.

Medical record documentation is a key element in payment. Chiropractors often receive refund requests due to CERT requests, because the medical records received by CDC are missing:

- **Plan of treatment**
- **Chief Complaint is not clearly documented**
- **Area being treated is not clearly document**

To avoid refund requests, follow the documentation guidelines previously stated.

NOTE: Late documentation will be received and reviewed by the CERT program. If the review result is favorable, the original CERT decision will be reversed. Appeals for claims reviewed by CERT are to be made to NHIC and not the CERT contractor.

For assistance with CERT appeals call: CERT Hotline 1-866-712-6273

NHIC wants to pay claims correctly the first time and needs your active participation to lower the payment error rate. A favorable payment error rate reflects well on the entire Medicare program.

For additional information:

<http://www.certprovider.org>

TELEPHONE AND ADDRESS DIRECTORY

Provider Interactive Voice Response (IVR) Directory

All actively enrolled providers must utilize the IVR for: **Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date**. The IVR can also assist you with the following information: Seminars, Telephone Numbers, Addresses, Medicare News and Appeal Rights.

CMS requires the National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and the last 5-digits of the tax identification number (TIN) or SSN of the provider to utilize the IVR system.

Available 24 hours/day, 7 days/week (including holidays)

888-248-6950

Provider Customer Service Directory

Our Customer Service representatives will assist you with questions that cannot be answered by the IVR, such as policy questions, specific claim denial questions, 855 application status, and redetermination status. Per CMS requirements, the Customer Service representatives may **not** assist providers with Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date unless we are experiencing IVR system problems.

Hours of Operation:

8:00 a.m. to 4:00 p.m. Monday - Thursday

10:00 a.m. to 4:00 p.m. - Friday

866-801-5304

Dedicated Reopening Requests Only

Hours of Operation:

8:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. Monday - Thursday

10:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. - Friday

877-757-7781

MAILING ADDRESS DIRECTORY

Initial Claim Submission Maine	P.O. Box 2323 Hingham, MA 02044
Massachusetts	P.O. Box 1212 Hingham, MA 02044
New Hampshire	P.O. Box 1717 Hingham, MA 02044
Rhode Island	P.O. Box 9203 Hingham, MA 02044
Vermont	P. O. Box 7777 Hingham, MA 02044
EDI (Electronic Data Interchange)	P.O. Box 9104 Hingham, MA 02044
Written Correspondence	P.O. Box 1000 Hingham, MA 02044
Medicare Reopenings and Redeterminations **See note below	P.O. Box 3535 Hingham, MA 02044
Medicare B Refunds	P.O. Box 5912 New York, NY 10087-5912
Medicare Secondary Payer (Correspondence Only)	P.O. Box 9100 Hingham, MA 02044
Provider Enrollment	P.O. Box 3434 Hingham, MA 02044
Medicare Safeguard Services	P.O. Box 4444 Hingham, MA 02044

Chiropractic Billing Guide

** Reopening requests may be faxed to NHIC at **1-781-741-3534** using the new fax cover sheet that can be downloaded from our Web site:

www.medicarenhic.com

Durable Medical Equipment (DME)

Durable Medical Equipment (DME) Medicare Administrative Contractor:

NHIC, Corp.

Provider Service Line: 1-866-419-9458

Please view the website to find the appropriate address:

<http://www.medicarenhic.com/dme/contacts.shtml>

Reconsideration (Second Level of Appeal)

First Coast Service Options Inc.
QIC Part B North Reconsiderations
P.O. Box 45208
Jacksonville, FL 32232-5208

INTERNET RESOURCES

The Internet is a very valuable tool in researching certain questions or issues. NHIC has a comprehensive website that serves as a direct source to Medicare as well as a referral tool to other related websites that may prove to be beneficial to you.

NHIC, Corp.

<http://www.medicarenhic.com>

Upon entering NHIC's web address you will be first taken straight to the "home page" where there is a menu of information. NHIC's web page is designed to be user-friendly.

We encourage all providers to join our website mailing list. Just click the link on the home page entitled "Join Our Mailing List". You may also access the link directly at:

<http://visitor.constantcontact.com/email.jsp?m=1101180493704>

When you select the "General Website Updates", you will receive a news report every week, via e-mail, letting you know what the latest updates are for the Medicare program. Other Web News selections (Updates, EDI, etc.) will be sent out on an as-needed basis.

Provider Page Menus/Links

From the home page, you will be taken to the License for use of "Physicians' Current Procedural Terminology", (CPT) and "Current Dental Terminology", (CDT). Near the top of the page are two buttons, "Accept" and "Do Not Accept". Once you click "Accept", you will be taken to the provider pages.

On the left side of the web page you will see a menu of topics that are available. Explore each one and bookmark those that you use most often.

Medicare Coverage Database

<http://www.cms.gov/center/coverage.asp>

<http://www.cms.gov/mcd/indexes.asp>

The Medicare Coverage Database is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. It features Local Coverage Determinations (LCDs) developed by Medicare Contractors and National Coverage Determinations (NCDs) developed by CMS. CMS requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with scientific evidence and clinical practice.

Medicare Learning Network

<http://www.cms.gov/MLNGenInfo/>

The Medicare Learning Network (MLN) website was established by CMS in response to the increased usage of the Internet as a learning resource by Medicare health care professionals. This website is designed to provide you with the appropriate information and tools to aid health care professionals about Medicare. For courses and information, visit the web site. For a list of the Training Programs, Medicare Learning Network Matters articles and other education tools available, visit the website.

Open Door Forums

<http://www.cms.gov/OpenDoorForums/>

CMS conducts Open Door Forums. The Open Door Forum addresses the concerns and issues of providers. Providers may participate by conference call and have the opportunity to express concerns and ask questions. For more information, including signing up for the Open Door Forum mailing list, visit the website.

Publications and Forms

<http://www.cms.gov/CMSForms/>

For your convenience CMS has published optional forms, standard forms, and SSA forms. By linking onto this website, you can access numerous CMS forms such as:

- Provider Enrollment CMS 855 forms (CMS 855B, 855I, & 855R)
- Medicare Participating Physician or Supplier Agreement (CMS 460)
- Advanced Beneficiary Notices (ABN) (CMS R-131)
- Medicare Redetermination Request Form (CMS 20027)
- Request for Reconsideration (CMS 20033)
- Medicare Managed Care Disenrollment form (CMS 566)

Advance Beneficiary Notice (ABN)	http://cms.gov/BNI/
American Medical Association	http://www.ama-assn.org/
CMS	http://www.cms.gov http://www.medicare.gov
CMS Correct Coding Initiative	http://www.cms.gov/NationalCorrectCodInitEd/
CMS Physician's Information Resource for Medicare	http://www.cms.gov/center/physician.asp?
Electronic Prescribing	http://www.cms.gov/erx incentive/

Chiropractic Billing Guide

Evaluation and Management Documentation Guidelines

http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp

http://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf

Federal Register

<http://www.archives.gov/federal-register>

<http://www.gpoaccess.gov/index.html>

HIPAA

<http://www.cms.gov/HIPAAGenInfo/>

National Provider Identifier (NPI)

<http://www.cms.gov/NationalProvIdentStand/>

NPI Registry

<https://nppes.cms.gov/NPPES/NPIRegistryHome.do>

Physicians Quality Reporting

<http://www.cms.gov/pqri/>

Provider Enrollment, Chain, and Ownership System (PECOS)

http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPag

Provider Enrollment

<http://www.cms.gov/MedicareProviderSupEnroll/>

U.S. Government Printing Office

<http://www.gpoaccess.gov/index.html>

Revision History:

1.0	7/06/2010	Lori Langevin	Ayanna YanceyCato	Release of document on the new NHIC Quality Portal
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NHIC, Corp.

**75 Sgt. William Terry Drive
Hingham, MA 02044**

Website:

<http://www.medicarenhic.com>

CMS Websites

<http://www.cms.gov>

<http://www.medicare.gov>