FACT SHEET

Chiropractic Services

Medicare allows only services that are medically necessary, except as mandated by statute. For chiropractic services, this means 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 a 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."

Definitions

Manual manipulation: treatment by means of manual manipulation of the spine to correct a subluxation (that is, by use of the hands).

- Patient must require treatment by means of manual manipulation.
- Manipulation services rendered must have direct therapeutic relationship to the patient's condition.
- There must be a reasonable expectation of recovery or improvement of function resulting from the planned treatment.

Scope: Services Other than Manual Manipulation of the Spine

When required criteria are met, Medicare covers manual manipulation of the spine by chiropractors. NO other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's order is covered. This includes orders for, performing, or interpreting x-rays or other diagnostic tests. The tests can be used for claims processing purposes, but Medicare does not cover them when performed by chiropractors.

Terms

Terms used to describe manual manipulation include:

- Spine or spinal adjustment by manual means
- Spine or spinal manipulation
- Manual adjustment
- Vertebral manipulation or adjustment

Documentation Requirements:

All Visits – Subluxation and History

Precise level and location of subluxation associated with the signs/symptoms for which the beneficiary is being treated

- Documented through x-ray OR exam
- If documented through x-ray:
  - X-ray demonstrates subluxation at level specified in medical records
  - X-ray was taken no more than 12 months prior or 3 months following initiation of treatment (exception: for certain chronic conditions, e.g., scoliosis, older x-ray OR previous CT or MRI is acceptable evidence if subluxation of the spine is demonstrated)
- If documented through exam, use P.A.R.T. guidelines:
  - P: Pain/tenderness, evaluated in terms of location, quality, & intensity
  - A: Asymmetry/misalignment identified on sectional or segmental level

  OR

  - R: Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in increase or decrease of sectional or segmental mobility)

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Documentation Requirements: Subsequent Visits

- History
  - Review of chief complaint
  - Changes since last visit
  - System review (if relevant)
- Physical exam
  - Exam of area of spine involved in diagnosis
  - Assessment of change in the patient's condition since last visit
  - Evaluation of treatment effectiveness
- Documentation of treatment given on day of visit

  - T: Tissue, tone changes in characteristics of contiguous or associated soft tissues, including skin, fascia, muscle, and ligament
- For all visits: documentation of history is also required
  - SFPMQOAP: Some Fine People May Quibble Over Apple Pie
  - S: Symptoms causing patient to seek treatment
    - Must be bear direct relationship to level of subluxation
    - Subluxation must be causal
  - F: Family history, if relevant
  - P: Past health history
  - M: Mechanism of trauma
  - Q: Quality and character of symptoms/problem
  - O: Onset, duration, intensity, frequency, location, and radiation of symptoms
  - A: Aggravating or relieving factors
  - P: Prior interventions, treatments, medications, and secondary complaints

Documentation Requirements: Initial Visits

- History (see blue box)
- Description of 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, and secondary complaints
- Evaluation of musculoskeletal/nervous system through physical exam
- Diagnosis: primary diagnosis must be subluxation, including level of subluxation
- Treatment plan, which should include:
  - Recommended level of care (duration and frequency of visits)
  - Specific treatment goals
  - Objective measures to evaluate treatment effectiveness
- Date of initial treatment

Active Treatment

- Medicare **only** pays for active/corrective treatment to correct acute or chronic subluxation. Medicare does not pay for maintenance therapy.
  - Active treatment: submit HCPCS modifier AT.
  - Supporting documentation is **required** in the patient's medical record (do not submit additional documentation with your claims; submit supporting documentation only if requested).

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Location of Subluxation:
Required in Medical Records

Neck

- **Occiput or Cervical:** C1, C2, C3, C4, C5, C6, C7
- **Atlas:** C1
- **Axis:** C2

Back

- **Dorsal:** D1, D2, D3, D4, D5, D6, D7, D8, D9, D10, D11, D12
- **Thoracic:** T1, T2, T3, T4, T5, T6, T7, T8, T9, T10, T11, T12

Low Back

- **Lumbar:** L1, L2, L3, L4, L5

Sacral

- **Sacrum, Coccyx:** S, SC

- Acute: Patient is being treated for new injury, identified by x-ray or physical exam. Result of chiropractic manipulation is expected to be improvement in, or arrest of progression, of patient's condition.
- Chronic: Is not expected to significantly improve or be resolved without further treatment (as is the case with acute conditions), but where continued therapy can be expected to result in some functional improvement.
  - Once 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.
- Maintenance therapy: includes "services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and chiropractic treatment becomes supportive rather than corrective in nature, treatment is then considered maintenance therapy."
  - Maintenance therapy: **Do not** submit HCPCS modifier AT.
  - Consult the CMS website for guidance on asking patients to sign an Advance Beneficiary Notice of Noncoverage (ABN) for maintenance therapy: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html

Claim Submission & Coverage

- Refer to CGS's Local Coverage Determination (LCD) 31862 for detailed coverage requirements:
  - Ohio providers: http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=31862&ContrId=238&ver=16&ContrVer=2&CntrctrSelected=238*2&Cntrctr=238&name=CGS+Administrators%2c+LLC+(15202%2c+MAC+-+Part+B)&DocType=Active&s=42&bc=AggAAAIAAAAAAA%3d%3d&
  - Kentucky providers: http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=31862&ContrId=228&ver=16&ContrVer=2&CntrctrSelected=228*2&Cntrctr=228&name=CGS+Administrators%2c+LLC+(15102%2c+MAC+-+Part+B)&DocType=Active&DocStatus=Active&s=22&bc=AggAAAIAAAAAAA%3d%3d&
- Claims must include a primary diagnosis of subluxation **and** a secondary diagnosis reflecting the patient's neuromusculoskeletal condition. The patient's medical record must support the services submitted.
- Medicare only pays for active treatment of acute or chronic subluxations. Submit claims for active treatment with HCPCS modifier AT. (Medicare does not cover maintenance therapy; do not submit claims for maintenance therapy with HCPCS modifier AT.)

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Signatures in Medical Records

- ALL services ordered or rendered to Medicare beneficiaries must be signed. Signatures may be handwritten or electronic; exceptions for stamped signatures are described in CMS MLN Matters article MM8219. (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8219.pdf)
- You should NOT add late signatures to a medical record but instead make use of the signature authentication process outlined in CMS MLN Matters article MM6698. (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf) A sample attestation statement is available on the CGS website. (http://www.cgsmedicare.com/partb/cert/attestation_form.pdf)
- Guidelines regarding signature requirements are located in the CMS Program Integrity Manual (Pub. 100-08), chapter 3, section 3.3.2.4 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf).

References:

- CMS Medicare Learning Network, “Chiropractic Services” informative booklet: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Chiropractic_Services_Booklet_ICN906143.pdf
- CMS Medicare Learning Network, “Misinformation on Chiropractic Services:” http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Chiropractors_fact_sheet.pdf
- CMS Medicare Benefit Policy Manual (Pub. 100-02), chapter 15, sections 30.5 and 240: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
- CMS Medicare Claims Processing Manual (Pub. 100-04), chapter 12, section 220: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

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