Part B Insider (Multispecialty) Coding Alert

Chiropratic Coding: 3 Takeaways From CMS's Recent Chiropractic Directives

Hint: Make PART your friend.

Both the OIG and CMS have repeatedly announced that chiropractic claims have been responsible for millions of dollars in inappropriately billed services over the past few years, and are under scrutiny by auditors. If you're trying to find out where to turn to get the lowdown on how to report these services correctly, CMS may have some resources for you.

Last month, the agency issued three different documents to guide practices that perform chiropractic services and help them bill more accurately. We've combed through the directives for the information that's most applicable to Part B providers, so read on to get the scoop on how to report your chiropractic claims properly.

1. Let the 'AT' Modifier Be Your Friend

If you want to collect for chiropractic codes 98940-98942 (Chiropractic manipulative treatment), you'll need to prove to your Medicare payer that you were addressing active treatment and not a maintenance issue. The best way to do that, CMS says in its recent MLN Matters article SE1602, is to append the AT modifier (Active treatment) to your claims.

"The AT modifier is required under Medicare billing to receive reimbursement for CPT® codes 98940-98942," the agency says. "Every chiropractic claim for 98940, 98941, or 98942, with a date of service on or after Oct. 1, 2004, should include the AT modifier if active/corrective treatment is being performed." If you're performing maintenance treatment, do not use the AT modifier but you should expect claim denials, because Medicare does not cover maintenance therapy, the agency adds.

What is maintenance therapy? You know that maintenance therapy isn't payable under the Medicare guidelines, but do you know what it is? CMS defines maintenance treatment by noting, "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."

For example: A 71-year-old patient makes a standing appointment for a chiropractic adjustment for every Thursday morning because she believes it keeps her healthy and staves off viruses and infections. In this situation, insurers would consider this maintenance therapy, and it would not be reimbursable under the Medicare guidelines.

If you treat a patient for maintenance therapy, ask the patient to sign an advance beneficiary notice (ABN) to show that she understands that the service isn't payable and that she will be responsible for paying you directly for it.

Resource: To read more about the AT modifier, visit www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1602.pdf.

2. Get to Know the PART System

Like any other service, chiropractic visits must be documented appropriately if you want to be able to support the codes you report. However, scrutiny may be more focused on chiropractor's visits than those of other specialists because of the

high 54 percent error rate that the OIG has encountered on chiropractic claims. Therefore, you must follow CMS's documentation guidelines to the letter when it comes to your chiropractic notes.

You'll need a well-documented history, a record of the present illness, and notation of the diagnosis which must be subluxation if you want reimbursement from Medicare. Include the level of subluxation and the site in your notes. For instance, "Neck misalignment to the C1 vertebrae with abnormal spacing and limited range of motion," with the appropriate code such as M99.01 (Segmental and somatic dysfunction of cervical region), CMS explains in its recently-released MLN Matters article SE1601.

In addition, you should thoroughly document the physical exam, and the exam must meet two of the following four criteria from the "PART" requirements. One of the two criterion must be asymmetry/misalignment or range of motion abnormality:

- **P:** Pain/tenderness: The chiropractor must evaluate the pain/tenderness in terms of location, quality, and intensity, CMS advises.
- **A:** Asymmetry/misalignment: The doctor can identify the asymmetry/misalignment using observation, static palpation, and/or diagnostic imaging.
- **R:** Range of motion abnormality: The chiropractor should record whether any range of motion issues are present, identified via motion palpation, observation, stress diagnostic imaging, range of motion, and/or measurement(s).
- **T:** Tissue tone, texture, and temperature abnormality: The doctor should record any soft tissue changes via observation, palpation, use of instrumentation, and/or test of length and strength.

"The PART evaluation process is recommended as the examination alternative to the previously mandated demonstration of subluxation by x-ray/MRI/CT for services beginning Jan. 1, 2000," CMS says in the new directive. "The acronym PART identifies diagnostic criteria for spinal dysfunction (subluxation)."

Resource: For more in-depth details about the PART system, visit www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1601.pdf.

3. Use All Resources Available.

CMS has no shortage of guidance for chiropractic services, and reading them thoroughly can certainly help bring down that 54 percent error rate. In its latest document, CMS offers scores of resources as part of its MLN Matters special edition, "Educational Resources to Assist Chiropractors with Medical Billing."

For example, the document offers information on how to enroll in the Medicare program, along with specifics on documentation, billing, and claims processing. Spending about an hour just clicking through the links and reading them can help you slash your error rate and stop worrying about denials.

Resource: To read the CMS educational document, visit www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1603.pdf.