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Part B Insider (Multispecialty) Coding Alert

Part B Mythbuster: Know the Ropes to Collect for Chiropractic Treatment

Give your claims the backbone they deserve by properly documenting and billing accurate diagnoses.

Myth: Collecting from Medicare for chiropractic services is next to impossible.

Reality: If you know how to bill your services ethically and correctly, you can smoothly navigate the Medicare landscape. Exactly one year ago, the OIG released its report entitled, "Inappropriate Medicare Payments for Chiropractic Services," which stunned many practices who were surprised to learn that 47 percent of the claims that the OIG reviewed were paid inappropriately.

The OIG identified many errors, such as miscoding, lack of documentation, or maintenance therapy billed as chiropractic manipulative correction (CMT) during its review, leading many practices scratching their heads regarding how to ethically bill these services. "A lot of practices were calling and asking forreviews of their documentation after that," says **Jay Neal,** an Atlanta-based coding consultant. "People were nervous about reporting any chiropractic services at all."

The facts: Medicare will not reimburse chiropractors for any treatment other than CMT using codes 98940-98942 (most Medicare carriers will not allow payment for extraspinal CMT [98943]). Section 2251 of the Medicare Carriers Manual (MCM) states, "Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation, listing examples of manual manipulation as spine or spinal adjustment by manual means; spine or spinal manipulation; manual adjustment; and vertebral manipulation or adjustment."

In addition, Medicare and most private insurers require a diagnosis of subluxation of the spine to demonstrate medical necessity for CMT billing.

"The precise level of subluxation must be specified through use of the appropriate diagnosis code(s) on the claim," notes a policy from Palmetto GBA, a Part B payer in eight states.

"Secondary diagnoses must be present on the claim to indicate the significant neuromuscular health problem necessitating treatment," the policy indicates.

A similar policy from Noridian Medicare, another Part B MAC, advises chiropractors to enter up to four diagnosis codes in priority order (two primary and two secondary conditions). "If you need to document more than four diagnosis codes, as will be the case any time there are more than two regions billed, the additional diagnoses must be present in the medical record," the policy states.

Here's how: Suppose a patient presents with a subluxation of the lumbar and sacral spine with degeneration of disc(s) in the lumbar region, and the chiropractor performs CMT to the lumbar and sacral spine (one to two regions, 98940). You'll report 739.3 (Nonallopathic lesions, not elsewhere classified, lumbar region) as the primary diagnosis, followed by a secondary diagnosis of 722.52 (Degeneration of lumbar or lumbosacral intervertebral disc), and a tertiary diagnosis of 739.4 (Nonallopathic lesions, not elsewhere classified, sacral region), advises **Kenny Marvin, DC, CCSP,** of Marvin Family Chiropractic in Pearl River, N.Y. "In the past, Medicare required that chiropractors needed to have an x-ray that demonstrated the subluxation, but that is no longer required," Marvin says. "You have to make sure you document all the essential features of your examination of the patient so you can demonstrate the diagnosis code choice (P.A.R.T.)," he says.

In black and white: According to CMS Transmittal 137, dated April 9, 2004, "Effective for claims with dates of service on and after January 1, 2000, the x-ray is no longer required. However, the x-ray may still be used to demonstrate

subluxation for claims processing purposes." In lieu of the x-ray, the transmittal indicates that the chiropractor must specify "the precise spinal location and level of subluxation giving rise to the diagnosis and symptoms" in the patient's record.