Codify by AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Payment: Documentation Must Be Clear and Complete to Ensure Chiropractic Claims Are Accepted

With chiropractic claims, it is wise to consult your MAC on documentation requirements.

Documentation—it is the cornerstone of thoughtful medicine, and the details of these expert reports help providers and coders alike prevent denials and overturn audits. The notes determine whether the treatment is medically necessary, and with chiropractic care, that can be the difference between collecting for your services or facing a denial.

Background. There is no subtlety associated with coding chiropractic services under Medicare, and the CMS policy clearly states that services must be deemed medically necessary for payment. Here lies the importance of the provider's documentation.

The Medicare Internet-only Manual (IOM) outlines what must be in the notes for coverage, but your Local Coverage Determination (LCD) also has a say on the details to be included. But keep in mind that "the LCD cannot contradict the IOM," **Judy Brown, CPC**, NGS Medicare provider outreach and education consultant, said in an August 11, 2016 webinar. "So check the IOM first, then toggle over to your LCD."

Check the CRs. MLN Matters articles often explain policies in simpler terms with language that allows providers to apply the policies to their practices, Brown suggests. This is definitely the case for a better understanding of documentation expectations for chiropractic care to be covered.

The grey area of subluxation x-rays. For Medicare to cover chiropractic services, the patient must have a subluxation. However, on an initial visit, performing an x-ray is up to the provider. "As of January 1, 2000, an x-ray is not required by Medicare to demonstrate the subluxation," MLN Matters® article SE1601 states. "However, an x-ray may be used for this purpose if you so choose." CMS is fairly clear, though, that if you use an x-ray to confirm a subluxation, it must be performed 12 months prior to the start of treatment or within the three months after treatment has begun.

For coverage to be met, the chiropractic documentation must include:

- The primary complaint that concerns the need for the service, any related family occurrence to the issue, and a comprehensive overview of the patient's medical history
- An explanation of the illness that has led the patient to seek care including the source of the trauma, the type and circumstances surrounding the symptoms, treatment that exacerbates or soothes the pain, prior interventions to stop the symptoms, and why the patient has finally sought chiropractic care.
- A P.A.R.T. physical exam to determine subluxation of the spine.

3 CPT® Codes Help with Manipulation

Medicare pays chiropractors for spinal manipulation with CPT® codes 98940–98942, when these services are reasonable and considered medically necessary, falling in line with all CMS coverage guidelines. The descriptors are as follows:

- 98940 (Chiropractic manipulative treatment (CMT); spinal, 1-2 regions)
- 98941 (Chiropractic manipulative treatment (CMT); spinal, 3-4 regions)
- 98942 (Chiropractic manipulative treatment (CMT); spinal, 5 regions)

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Don't forget the modifier. When you are logging your data and submitting your claims, don't forget to append modifier AT (Acute treatment). This modifier is always used with CPT® codes 98940□98942, and the claims will be denied without it.

Acute care only. "A patient's condition is considered acute when the patient is being treated for a new injury," MLN Matters® article SE1602 says. "The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression of, the patient's condition." This is important to review because only acute subluxation is covered by Medicare. If the condition becomes chronic and the treatment needs to be continued, then it is considered maintenance therapy and CMS does not pay for that under chiropractic coverage.

Be Aware of These ICD-10 Choices

As the ICD-10 grace period comes to a close this Oct. 1, providers will have a broader list of diagnosis code options to choose from, adding clarity to their claims. These will help chiropractors discern between the different regions, but "any additional diagnosis must be in your medical records," Brown warns," or you can expect your billing to be returned.

- M99.01 (Segmental and somatic dysfunction cervical region)
- M99.02 (Segmental and somatic dysfunction thoracic region)
- M99.03 (Segmental and somatic dysfunction lumbar region)
- M99.04 (Segmental and somatic dysfunction sacral region)
- M99.05 (Segmental and somatic dysfunction pelvic region)

Familiarize Yourself with Your MAC's Policies

A thorough look at the LCD policies of your Medicare carrier will help you stay up to date on codes and changes. Although the LCDs may vary by region, the general code set and determinations will likely be similar with common policy threads. This is particularly true with chiropractic services and the definitions by the MAC concerning whether care is medically necessary and how it is documented.

"We call these our Medicare cookbooks, and that is really what they are," Brown says. "Just as a cookbook gives instructions on how to cook, the LCD gives you the instructions on how to bill your services expertly to Medicare."

How to find the LCD: Whether you are a provider, practice manager, or coder, checking the MAC in your jurisdiction frequently is a good idea. There are often weekly updates to Part B, which is what chiropractic services are covered under. Choose your state or jurisdiction and go to the LCD link. This is where you will find the chiropractic reimbursement policies and a list of primary and secondary diagnosis codes in the latter half of the document.

Resources: For more information about Chiropractic services covered under Medicare, visit https://www.medicare.gov/coverage/chiropractic-services.html.

What is Medicare P.A.R.T. Documentation?

When evaluating musculoskeletal and nervous system issues for chiropractic claims the documentation provided to Medicare must include what is commonly known at the P.A.R.T. exam. This four part physical assessment is required to help determine subluxation through the outcome of two of the four specific areas.

The P.A.R.T. physical examination are divided into these four sections, according to MLN Matters® article SE1601:

- P □ pain and tenderness
- A □ asymmetry and misalignment
- R □ range of motion abnormality
- T □ tissue tone, texture, and temperature abnormality

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Resource: For more information on P.A.R.T., visit https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1601.pdf.

To take a look at the NGS Medicare website and other educational materials, visit https://www.ngsmedicare.com.

To read the MLN Matters® article SE1602, visit https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1602.pdf.

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