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Eli's Rehab Report

Get Paid When Physiatrist and Chiropractor Co-manage Patients

To enhance care to physical medicine patients, many physical medicine and rehabilitation (PM&R) practices employ non-physician practitioners in addition to physiatrists. Because many physiatry patients suffer from back pain, these patients frequently are co-managed by a physiatrist and a chiropractor. Knowing the rules for billing chiropractic services can be helpful in streamlining the claims processes for these patients.

Chiropractor and Physiatrist Co-management

Practices that employ both a physiatrist and a chiropractor allow the patient to fluctuate between the two practitioners, depending on the patients needs. Collaborative care is ideal for any complicated case, says **Craig Liebenson, DC,** a practicing chiropractor in Los Angeles. Both might perform initial evaluations, and then they would determine a treatment plan together.

In other instances, says Liebenson, A chiropractor might treat an uncomplicated low back case, but if the patient was not responding and was a candidate for trigger point injections, then referral would be appropriate.

Liebenson suggests that the relationship might work the other way as well. Similarly, if the physiatrist is treating the patient first and medication with injections and simple biomechanical advice is not speeding recovery, then referral for chiropractic adjustments, manual and physical therapy would be indicated.

In Liebensons examples above, the care is most likely fluctuating between the physiatrist and chiropractor on different dates of service, so the practice probably would bill only for one provider per patient session. For example, if an established patient presented to the physician complaining of low back pain (**ICD-9 724.2** , lumbago, low back pain), the physiatrist might perform an evaluation of the patient (99212-99215, office or other outpatient visit for the evaluation and management of an established patient), during which he or she instructs the patient to perform particular exercises and stretches at home to ease the pain. The physiatrist could perform an epidural injection (**CPT 62311**) to reduce the patients pain. The practice should append modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the evaluation and management (E/M) code to indicate that the injection was performed in addition to the E/M visit.

If, after several weeks of epidural injections and home exercises, the patient is still experiencing pain, the physiatrist might recommend that the patient begin seeing the practices chiropractor for chiropractic manipulative treatment (CMT) and physical and manual therapy. In this case, the chiropractor probably has discussed the patients care with the physiatrist and read the patients chart, so he or she would perform only a short pre-manipulation patient assessment, which is included in the CMT codes (98940-98943). The chiropractor could bill for both the lumbar CMT and the manual therapy using just the CMT code, in this case 98940 (chiropractic manipulative treatment, spinal, one to two regions).

For many insurers, including Medicare, the chiropractor should not bill separately for the manual therapy (normally 97140, manual therapy techniques [e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction], one or more regions, each 15 minutes) because of a Correct Coding Initiative (CCI) edit grouping it with the CMT codes. Effective April 1, 2000, Medicare began listing 97140 and the CMT codes 98940 through 98942 as comprehensive codes, with 97140 as the component code. Many private insurers (but not Medicare) will allow payment for both codes if the CMT is performed on a different site than the manual therapy, as long as modifier -59 (distinct procedural service) is appended to the claim.

Medicares Stringent Chiropractic Rules

Medicare will not reimburse chiropractors for any treatment other than CMT using 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. Chiropractors also can bill Medicare for E/M codes when evaluating a patients condition, but Medicare will not pay chiropractors for other physical medicine codes.

In addition, Medicare and most private insurers require a diagnosis of subluxation of the spine to demonstrate medical necessity for CMT billing. The MCM states that claims for CMT must indicate the precise location of the subluxation and lists two ways to specify the level of subluxation: The exact bones may be listed, for example, C5, C6, etc.; or the area may suffice if it implies only certain bones such as sacroiliac (sacrum and ilium).

Private Insurers May Pay Chiropractors for PT

Many private insurers will pay for physical therapy services provided by chiropractors, though this varies depending on state mandates and insurers rules. According to **Patricia Niccoli,** president of ElectroAge Billing, a medical billing firm in Phoenix, the only physical medicine codes that chiropractors specifically are barred from using on a national basis are 97001 through 97004. These codes, says Niccoli, are for physical therapy and occupational therapy evaluations and re-evaluations, because these therapists cannot use the standard E/M codes. In addition, says Niccoli, The scope of some chiropractors licenses may prohibit them from performing physical therapy.

For instance, says Liebenson, in the state of Washington, chiropractors are limited by their scope of practice from using physical therapy modalities such as electrical muscle stimulation (97014) and ultrasound (97035). It should be noted that most insurers who cover therapy performed by chiropractors normally require a subluxation diagnosis, which must be supported by x-rays or the PART method of determining the existence of a subluxation. The PART acronym represents the four criteria for patient examination and documentation to determine the existence of a subluxation without an x-ray:

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 a decrease of sectional or segmental mobility).
Tissue, tone changes in the characteristics of
contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

Note: Medicare no longer mandates that every new chiropractic patient must have an x-ray (and an annual re-x-ray). Instead, the chiropractor may use either a physical examination or an x-ray to document a subluxation. The PART method should be used to demonstrate a subluxation without an x-ray.

Concurrent Care

Co-management can involve the patient seeing both the physiatrist and the chiropractor concurrently, says Liebenson, but this would more likely only occur in complicated cases. In cases where, for example, a patient is suffering from cervical disc degeneration (722.4), the patient might see the physiatrist for an E/M visit to determine progress, and then proceed to the practices chiropractor for CMT on the same day.

Niccoli says that most insurers will pay for the physiatrists E/M code and the chiropractors cervical CMT on the same day, assuming that the diagnosis code was sufficient for the insurer to recognize medical necessity for the services. If the patients record does not reflect a subluxation of the spine (e.g., 739.3 nonallopathic lesions, not elsewhere classified, lumbar region) in addition to the disc degeneration, then the CMT most likely would not be covered.

Liebenson suggests that collaborative care between a physiatrist and a chiropractor in the same practice can be cost-effective for physiatrists because the practice can offer well-orchestrated, complete care. It would also be helpful for the patient because spinal manipulation is the gold standard for achieving pain relief if over-the-counter pain medicine is not

resolving symptoms in a few days, he says.

Physiatry practices considering hiring chiropractors should investigate their state rules on the services that chiropractors may provide. Before billing for any chiropractic services, always check your insurers guidelines.

This article is the first of a series to examine how to organize the billing process when a practice employs practitioners other than physicians (MDs and DOs), such as chiropractors, physical or occupational therapists.