Codify
BY AAPC

Chiropractic Coding & Compliance Alert

Regulatory Update: Use These Strategies to Protect Your Practice From Tough Payer Scrutiny

Here's how to survive audits -- and recoup your pay -- with impeccable documentation.

If you've noticed an increase in the number of payers auditing chiropractic services in the last few years, you're not alone. CMS is paying closer attention to whether Medicare actually covers chiropractic services that are billed and whether they're coded correctly and properly documented. Read on to find out what CMS expects from your next claim.

Bone Up on These Regulations

Here are a few important guidelines regulating chiropractic services and reimbursement that you'll need to understand and abide by:

- Sections 1862(a)(1)(A) and 1833(e) of the Social Security Act that defines chiropractors as physicians eligible for Medicare reimbursement require that "all services billed to Medicare, including chiropractic manipulations, be medically necessary and supported by documentation."
- Federal regulations (42 CFR $410.21(b)) limit the Medicare reimbursement to "treatment of subluxations that result in a neuromuscular condition for which chiropractic manipulation is the appropriate treatment."
- Section 2251.2 of the Medicare Carriers Manual details that the provider should document the existence of a subluxation through "an X-ray or a physical examination and the services must be provided as part of a written plan that should include specific goals and measures to evaluate effectiveness."
- The chiropractic treatment "... must provide a reasonable expectation of recovery or improvement of function," states section 2251.3 of the Manual. "...Ongoing maintenance therapy is not considered to be medically necessary under the Medicare program."

Reality: Practitioners don't seem to be meeting these criteria. "Based on the volume of medically unnecessary, undocumented and noncovered services allowed, chiropractic services represent a significant vulnerability for the Medicare program," according to an OIG report from HHS in June 2005 titled "Chiropractic services in the Medicare Program: Payment vulnerability Analysis".

Silver lining: Medicare's documentation requirements are very specific, but it is possible to seamlessly incorporate these in your daily chart notes. Read on for certain basic tenets to follow for a simple yet effective documentation.

3 Documentation Areas You Can't Afford to Miss

In order to establish medical necessity, you need to ensure specific documentation of the following three components. Failing to document any one of these may lead to denial on grounds of lack of medical necessity.

1. Demonstrating subluxation: CMS requires the presence of a subluxation as a medical necessity. According to CMS, subluxation is "a motion segment in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact." Medicare requires that this be treated using manual manipulation.

Be sure to document that your treatment is specifically directed to the subluxation in the physical examination, initial chart notes, and subsequent notes. Remember to report subluxation as the primary diagnosis in the CMS 1500 form. You often will choose a code from either the 839.xx (Other multiple and ill defined dislocations) or 739.x (Nonallopathic lesions not elsewhere classified) diagnoses series to describe subluxation, based on patient's condition and your carrier's local Medicare review policy.

So, what do you look for in the provider's documentation to help you choose the correct code? "The 739 code family is specific to the musculoskeletal system, explains **Doreen Boivin, CPC, CCA**, with Chiro Practice, Inc., in Saco, Maine. "These codes relate to segmental and somatic dysfunction. Each one refers to a region of the spine starting with 739.0, cervical region and ending with 739.9, Abdomen and other. The 839 code family falls under the injuries."

"Check if the patient hurt themselves due to activities of daily living or due to an external cause," Boivin advises. "An 839 diagnosis code means the patient has had an accident or injury, external cause. A 739 diagnosis code means the patient has an acute or chronic condition to address."

2. Methods of Documenting subluxation: You may document the presence of subluxation by these two methods

Using an X-ray? If you intend to use an X-ray to document the subluxation, ensure that there is not too much of a time lag between the X- ray taken and the initiation of care. It should have been taken within twelve months prior to or three months following the beginning of treatment.

The PART system: This system documents a subluxation based on four criteria related to the physical examination:

- **P**ain/tenderness (P)
- **A**symmetry/misalignment (A)
- **R**ange of motion abnormality (R)
- **T**issue, tone changes (T).

Providers must document two of the four PART criteria, one of which must be asymmetry/ misalignment or range of motion abnormality. These should be documented well so that we can track the patient's progress from visit to visit. Asymmetry/misalignment can be as simple as observing the patient's posture. Other ways to determine this can be the doctor palpating the spine or taking X- rays. The (A) and (R) help to establish the medical necessity for why the patient came to see the doctor. The (R) is identified in quite the same way. The importance here is establishing the medical necessity and to track the patient progress.

3. Penning the initial and subsequent visits: CMS has established specific requirements for documentation of both initial and subsequent visits such as evaluation and documentation of symptoms that make the patient seek treatment, quality and character of the symptoms, any relevant history etc. These should be included in your chart notes. The American Chiropractic Association also offers precise PART documentation guidelines which can be viewed at http://www.acatoday.org/content_css.cfm?CID=1217

Pointers Help You Support Medical Necessity

Uncomplicated conditions would logically tend to resolve in a short duration with chiropractic treatment. So, remember to be able to justify your medical necessity for a treatment that would typically last longer, such as 24 weeks. Moreover, if there is no improvement, your care runs the risk of falling under non-covered maintenance therapy rather than therapeutic. "Use code S8990 for Physical or manipulative therapy performed for maintenance rather than restoration. Have Medicare patients sign an ABN (Advanced Beneficiary Notice)," advises Boivin. "This informs the patient that Medicare may not pay for the service deeming it not medically necessary. The patient then can make an informed decision to accept the care or not knowing they may be responsible for the service provided."

Final diagnosis note: We know that Medicare pays for spinal manipulation only and subluxation must be the primary diagnosis. Remember to incorporate the secondary diagnosis, which is the most specific reason for the encounter.

"While it is acceptable to use as simple a diagnosis as cervical pain 723.1, it is best to differentiate the causation of pain with myalgia 729.1, disc degeneration 722.4, disc displacement 722.0, strain and sprain 847.0, etc., whenever possible," says Samuel A. Collins, expert in chiropractic insurance billing for the H.J. Ross Network, in one of his articles for the website

www.dynamicchiropractic.com. "Codes that have greater differentiation and severity clearly will result in a greater allowance of treatment, as the condition coded clearly warrants such."

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