

Local Coverage Article: Billing and Coding: Chiropractor Services (A57913)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	A and B MAC	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions, LLC	A and B MAC	01182 - MAC B	J - E	California - Southern
Noridian Healthcare Solutions, LLC	A and B MAC	01212 - MAC B	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01312 - MAC B	J - E	Nevada

Article Information

General Information

Article ID

A57913

Original Effective Date

01/01/2020

Article Title

Billing and Coding: Chiropractor Services

Revision Effective Date

N/A

Article Type

Billing and Coding

Revision Ending Date

N/A

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

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Retirement Date

N/A

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CMS National Coverage Policy

Title XVIII of the Social Security Act, 1862(a)(1)(A). Allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act, 1833(e). Prohibits Medicare payment for any claim, which lacks the necessary information to process the claim.

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, §§30.5 and 240, 240.1, 240.1.1, 240.1.2, 240.1.3, 240.1.4. 240.1.5. Addresses Chiropractor's Services and Chiropractic Services - General, respectively.

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 12, §220. Addresses Chiropractic Services.

National policy limits the coverage of chiropractic services to the "hands on" manual manipulation of the spine for symptomatology associated with spinal subluxation. Accordingly, CPT code 98943, CMT, extraspinal, one or more regions, is not a Medicare benefit.

Article Guidance

Article Text:

As Noridian has recently retired the Chiropractic Services LCD, this article is offered to help guide in the billing, coding and documentation of chiropractic services, as supplementary to the provisions of the Medicare Benefit Policy

Manual, Chapter 15, Section 30.5, and the Medicare Claims Processing Manual, Chapter 12, Section 220.

The following information must be documented in the medical record.

I. History:

- chief complaint including the symptoms present that caused the patient to seek chiropractic treatment.

II. Present Illness: This can include any of the following as appropriate:

- mechanism of trauma;
- quality and character of problem/symptoms;
- intensity of symptoms;
- frequency of symptoms occurring;
- location and radiation of symptoms;
- onset of symptoms;
- duration of symptoms;
- aggravating or relieving factors of symptoms;
- prior interventions, treatments, including medications;
- secondary complaints; and
- symptoms causing patient to seek treatment.

III. Family History: If pertinent

IV. Pertinent past health history which may include:

- general health statement
- prior illness(es)
- surgical history
- prior injuries or traumas
- past hospitalizations (as appropriate)
- medications

V. Physical examination: Evaluation of musculoskeletal/nervous system through physical examination to identify:

- a. Pain/tenderness evaluated in terms of location, quality and intensity;
- b. Asymmetry/misalignment identified on a sectional or segmental level;
- c. Range of motion abnormality (changes in active, passive and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); and
- d. Tissue, tone changes in the characteristics of contiguous or associated soft tissues, including skin, fascia, muscle and ligament.

To demonstrate a subluxation based on physical examination, two of the four criteria mentioned under physical examination are required, one of which must be asymmetry/misalignment or range of motion abnormality.

VI. Diagnosis: The primary diagnosis must be subluxation, including the level of subluxation either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named.

VII. Treatment Plan: The treatment plan should include the following:

- Therapeutic modalities to effect cure or relief (patient education and exercise training).
- The level of care that is recommended (the duration and frequency of visits).
- Specific goals that are to be achieved with treatment.
- Objective measures to evaluate treatment effectiveness.
- Date of initial treatment.

VIII. Subsequent Visits:

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination for subsequent visits:

1. History:

Review of chief complaint;

Interval history, and system review if relevant.

2. Physical exam:

Exam of area of spine involved in diagnosis;

Assessment of change in patient condition since last visit;

Evaluation of treatment effectiveness.

3. Documentation of treatment given on day of visit.

Medical Necessity of Treatment:

Failure to document that the chiropractic spinal manipulation is reasonable and necessary may result in denial of claim(s). This requirement may be fulfilled by indicating the Date of Service as a component of an ordered sequence of treatments in the treatment plan, i.e. #4 of ten planned adjustments".

Reasonable and necessary requirements may be additionally fulfilled by a comparative assessment of clinical treatment goals, compared to the assessment at the initial visit, and at the conclusion of a course of treatment.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary.

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes:

CODE	DESCRIPTION
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

CPT/HCPCS Modifiers

N/A

ICD-10 Codes that Support Medical Necessity

N/A

ICD-10 Codes that DO NOT Support Medical Necessity

N/A

Additional ICD-10 Information

N/A

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

CODE	DESCRIPTION
999x	Not Applicable

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

N/A

Other Coding Information

N/A

Revision History Information

N/A

Associated Documents

Related Local Coverage Document(s)

N/A

Related National Coverage Document(s)

N/A

Statutory Requirements URL(s)

N/A

Rules and Regulations URL(s)

N/A

CMS Manual Explanations URL(s)

240.1 - Coverage of Chiropractic Services

Other URL(s)

220 Chiropractic Services

Public Version(s)

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Keywords

N/A