Novitas PA Chiropractic FAQ for 2020

Chiropractic Medicare Services

1. **What are the differences in the documentation requirements for an acute problem vs. a chronic problem?**

Documentation for an acute problem should indicate the expectation that treatment results in the improvement in or arrest of progression of the patient's condition.

Documentation for a chronic problem should indicate the expectation that stabilization or continued treatment results in some functional improvement in the patient's condition.

2. **Is it acceptable for a chiropractor to use his/her own abbreviations in the medical records; i.e., abbreviations other than those widely used by chiropractors?**

Abbreviations commonly used within any specialty are acceptable. However, if your patients' medical records contain abbreviations not commonly used, and you receive a request for medical records, please provide a key to the abbreviations. Submit the key with the medical records to assist us in the review.

3. **In chiropractic documentation, can regions identified in the exam component be inferred as regions adjusted?**

No, the documentation must state the specific regions adjusted.

4. **In chiropractic documentation, can we use pain levels to support acute or chronic category of subluxation?**

No, you must clearly state the acute or chronic category of subluxation in the patient's medical record.

5. **In chiropractic documentation, must we document the treatment effectiveness for each billed date of service?**

Yes, the documentation must indicate an evaluation of the effectiveness of the treatment provided for subsequent visits.

Reference

Local Coverage Determination (LCD) L35424 - Chiropractic Services

6. **I submitted x-ray reports with subsequent chiropractic visits, but they denied as out of date, why?**

X-rays must be reasonably proximate to the initiation of a course of treatment. Unless more specific x-ray evidence is warranted, an x-ray is considered reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of a course of chiropractic treatment.

In certain cases of chronic subluxation (e.g., scoliosis), an older x-ray may be accepted provided the beneficiary's record indicates the condition existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent.

You may use a previous computed tomography (CT) scan and/or magnetic resonance imaging (MRI) of the spine in lieu of an x-ray when it demonstrates a subluxation of the spine. The time-frame specified for x-rays is applicable for MRIs and CT scans.

Reference

LCD L35424 - Chiropractic Services

7. **I perform a thorough examination of my patient with the initial chiropractic visit, and then refer to the initial exam findings in my subsequent visit notes; is this acceptable?**

Yes, as long as you submit the initial examination findings with each billed subsequent visit when responding to medical records requested by Novitas Solutions or the Comprehensive Error Rate Testing program.

8. **Do Novitas Solutions' medical review nurses deny chiropractic services based on medical necessity.**

When your office receives a request for medical records to substantiate the chiropractic services you rendered and billed to Medicare, our nurse reviewers review the documentation and verify that all the required documentation in the LCD have been met. If you met the documentation requirements, the nurse reviewers will send the documentation to a chiropractic consultant to determine the medical necessity of the services. If you did not meet the documentation requirements, the nurse reviewers will deny the services based on the lack of documentation.

9. **What is modifier AT and when do we report it?**

Modifier AT (active treatment) defines the difference between active treatment and maintenance treatment.

The AT modifier is required under Medicare billing to receive reimbursement for CPT codes 98940-98942. For Medicare purposes, the AT modifier is used only when chiropractors bill for active/corrective treatment (acute and chronic care).

Every chiropractic claim for 98940/98941/98942, should include the AT modifier if active/corrective treatment is being performed. Claims that do not contain modifier AT will deny.

Do not use modifier AT for maintenance therapy.

Reference

Medicare Learning Network (MLN) Matters Special Edition, SE1602 - Use of the AT modifier for Chiropractic Billing (new information along with information in MM3449)

10. **If a Medicare beneficiary used all 30 visits and still comes for treatment, are we obligated to take the Medicare write off on the cash case?**

If the beneficiary completed 30 chiropractic visits and you do not believe additional visits will be covered by Medicare, you must notify the beneficiary that they have completed the number of visits you believe are covered by Medicare.

If the service is excluded from Medicare, you are not required to submit a claim.

If the beneficiary continues to receive services and requests the service(s) be billed to Medicare, you must submit a claim.

Services beyond the coverage limit may be considered maintenance therapy. For maintenance therapy services, you should obtain an Advance Beneficiary Notice (ABN) from the beneficiary and apply the appropriate modifier.

GA - you expect that Medicare will deny a service as not reasonable and necessary and that you do have on file an ABN signed by the beneficiary

GZ - you expect that Medicare will deny an item or service as not reasonable and necessary and that you have not had an ABN signed by the beneficiary

For additional information regarding chiropractic services, including articles and resources, please refer to our Provider Specialty: Chiropractor page.

11. **Are chiropractic services capped at 30 chiropractic manipulation treatments per year?**

LCD L35424 - Chiropractic Services, includes reasonable and necessary frequency limitations. Denials based on the frequency limitations directed in the LCD are appealable with adequate documentation to support that the patient's medical condition required additional services.

12. **Where can I find diagnosis codes for chiropractic services?**

For chiropractic services to be covered, they must be reasonable and necessary, and meet CMS guidelines. You can find diagnosis coding guidelines in our Local Coverage Article, A52987- Billing and Coding: Chiropractic Services.