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Medicare Coverage for Chiropractic Services – Medical Record Documentation Requirements for Initial and Subsequent Visits

Provider Types Affected

This MLN Matters® Special Edition article is intended for Chiropractors and other practitioners who submit claims to Medicare Administrative Contractors (MACs) for chiropractic services provided to Medicare beneficiaries.

This article is part of a series of Special Edition (SE) articles prepared for Chiropractors by CMS in response to the request for educational materials at the September 24, 2015, Special Open Door Forum titled: “Improving Documentation of Chiropractic Services”. Other articles in the series are SE1602, which details the use of the AT modifier on chiropractic claims and SE1603, which identifies other useful resources to help chiropractors bill Medicare correctly for covered services.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is providing this Special Edition article to help clarify the CMS policy regarding Medicare coverage of chiropractic services for Medicare beneficiaries and documentation requirements for the beneficiary’s initial visit and subsequent visits to the Chiropractor.

Be aware of these policies along with any Local Coverage Determinations (LCDs) for these services in your area that might limit circumstances under which Medicare pays for active/corrective chiropractic services.

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Background

In 2014, the Comprehensive Error Testing Program (CERT) that measures improper payments in the Medicare Fee-For-Service (FFS) program reported a 54 percent error rate on claims for Chiropractic services. The majority of those errors were due to insufficient documentation or other documentation errors.

Medicare coverage of chiropractic services is specifically limited to treatment by means of manual manipulation (that is, by use of the hands) of the spine to correct a subluxation. The patient must require treatment by means of manual manipulation of the spine to correct a subluxation, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. Additionally, manual devices (that is, those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. However, no additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself.

Chiropractors are limited to billing three Current Procedural Terminology (CPT) codes under Medicare: 98940 (chiropractic manipulative treatment; spinal, one to two regions), 98941 (three to four regions), and 98942 (five regions). When submitting manipulation claims, chiropractors must use an Acute Treatment (AT) modifier to identify services that are active/corrective treatment of an acute or chronic subluxation. The AT modifier, when applied appropriately, should indicate expectation of functional improvement, regardless of the chronic nature or redundancy of the problem.

Documentation Requirements

The Social Security Act states that “no payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.” See the Social Security Act ([Section 1833\(e\)](#)) on the Internet.

In addition, the “Medicare Benefit Policy Manual” requires that the initial visit and all subsequent visits meet specific documentation requirements. See Chapter 15 ([Section 240.1.2](#)) on the CMS website.

Documentation Requirements for the Initial Visit

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

1. History: The history recorded in the patient record should include the following:

- Chief complaint including the symptoms causing patient to seek treatment;
- Family history if relevant; and

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- Past medical history (general health, prior illness, injuries, or hospitalizations; medications; surgical history).

2. Present Illness: Description of the present illness including:

- Mechanism of trauma;
- Quality and character of symptoms/problem;
- Onset, duration, intensity, frequency, location, and radiation of symptoms;
- Aggravating or relieving factors;
- Prior interventions, treatments, medications, secondary complaints; and
- Symptoms causing patient to seek treatment.

Note: Symptoms must be related to the level of the subluxation that is cited. A statement on a claim that there is “pain” is insufficient. The location of the pain must be described and whether the particular vertebra listed is capable of producing pain in that area.

3. Physical Exam: Evaluation of musculoskeletal/nervous system through physical examination. To demonstrate a subluxation based on physical examination, two of the following four criteria (one of which must be asymmetry/misalignment or range of motion abnormality) are required and should be documented:

- **P - Pain/tenderness:** The perception of pain and tenderness is evaluated in terms of location, quality, and intensity. Most primary neuromusculoskeletal disorders manifest primarily by a painful response. Pain and tenderness findings may be identified through one or more of the following: observation, percussion, palpation, provocation, etc. Furthermore, pain intensity may be assessed using one or more of the following: visual analog scales, algometers, pain questionnaires, and so forth.
- **A - Asymmetry/misalignment:** Asymmetry/misalignment may be identified on a sectional or segmental level through one or more of the following: observation (such as, posture and heat analysis), static palpation for misalignment of vertebral segments, diagnostic imaging.
- **R - Range of motion abnormality:** Changes in active, passive, and accessory joint movements may result in an increase or a decrease of sectional or segmental mobility. Range of motion abnormalities may be identified through one or more of the following: motion palpation, observation, stress diagnostic imaging, range of motion, measurement(s).
- **T - Tissue tone, texture, and temperature abnormality:** Changes in the characteristics of contiguous and associated soft tissue including skin, fascia, muscle, and ligament may be identified through one or more of the following procedures: observation, palpation, use of instrumentation, test of length and strength.

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Note: The P.A.R.T. (**P**ain/tenderness; **A**symmetry/misalignment; **R**ange of motion abnormality; and **T**issue tone, texture, and temperature abnormality) evaluation process is recommended as the examination alternative to the previously mandated demonstration of subluxation by x-ray/MRI/CT for services beginning January 1, 2000. The acronym P.A.R.T. identifies diagnostic criteria for spinal dysfunction (subluxation).

4. 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. The precise level of the subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine. This designation is made in relation to the part of the spine in which the subluxation is identified as shown in the following table:

Area of Spine	Names of Vertebrae	Number of Vertebrae	Short Form or Other Name	Subluxation ICD-10 code
Neck	Occiput Cervical Atlas Axis	7	Occ, CO C1-C7 C1 C2	M99.00 M99.01
Back	Dorsal or Thoracic Costovertebral Costotransverse	12	D1-D12 T1-T12 R1-R12 R1-R12	M99.02
Low Back	Lumbar	5	L1-L5	M99.03
Pelvis	Ilii, R and L (I, Si)		I, Si	M99.05
Sacral	Sacrum, Coccyx		S, SC	M99.04

In addition to the vertebrae and pelvic bones listed, the Ilii (R and L) are included with the sacrum as an area where a condition may occur which would be appropriate for chiropractic manipulative treatment.

There are two ways in which the level of the subluxation may be specified in patient's record.

- The exact bones may be listed, for example: C 5, 6;
- The area may suffice if it implies only certain bones such as: occipito-atlantal (occiput and C1 (atlas)), lumbo-sacral (L5 and Sacrum) sacro-iliac (sacrum and ilium).

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Following are some common examples of acceptable descriptive terms for the nature of the abnormalities:

- Off-centered;
- Misalignment;
- Malpositioning;
- Spacing - abnormal, altered, decreased, increased;
- Incomplete dislocation;
- Rotation;
- Listhesis - antero, postero, retro, lateral, spondylo; and
- Motion - limited, lost, restricted, flexion, extension, hypermobility, hypomotility, aberrant.

Other terms may be used. If they are understood clearly to refer to bone or joint space or position (or motion) changes of vertebral elements, they are acceptable.

X-rays

As of January 1, 2000, an x-ray is not required by Medicare to demonstrate the subluxation. However, an x-ray may be used for this purpose if you so choose.

The x-ray must have been taken reasonably close to (within 12 months prior or 3 months following) the beginning of treatment. In certain cases of chronic subluxation (for example, scoliosis), an older x-ray may be accepted if the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent.

A previous CT scan and/or MRI are acceptable evidence if a subluxation of the spine is demonstrated.

5. Treatment Plan: The treatment plan should always include the following:

- Recommended level of care (duration and frequency of visits);
- Specific treatment goals; and
- Objective measures to evaluate treatment effectiveness.

Date of the initial treatment.

The patient's medical record.

- Validate all of the information on the face of the claim, including the patient's reported diagnosis(s), physician work (CPT code), and modifiers.
- Verify that all Medicare benefit and medical necessity requirements were met.

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Documentation Requirements for Subsequent Visits

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

1. History

- a. Review of chief complaint;
- b. Changes since last visit; and
- c. Systems review if relevant.

2. Physical examination

- a. Examination of area of spine involved in diagnosis;
- b. Assessment of change in patient condition since last visit;
- c. Evaluation of treatment effectiveness.

3. Documentation of treatment given on day of visit.

Necessity for Treatment of Acute and Chronic Subluxation

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function.

The patient must have a subluxation of the spine as demonstrated by x-ray or physical examination, as described below.

Most spinal joint problems fall into the following categories:

- **Acute subluxation**-A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical examination as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.
- **Chronic subluxation**-A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition); however, the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

You must place the HCPCS (Healthcare Common Procedure Coding System) modifier AT on a claim when providing active/corrective treatment to treat acute or chronic subluxation.

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However, the presence of the HCPCS modifier AT may not in all instances indicate that the service is reasonable and necessary.

ICD-10 Codes that Support Medical Necessity for Chiropractor Services

The chiropractic Local Coverage Determinations (LCDs) for MACs include ICD-10 Coding Information for ICD-10 Codes that support the medical necessity for Chiropractor services. There may be additional documentation information in your LCD. There are links to the chiropractic LCDs in the Additional Information section of this article.

The **Group 1 (primary) codes** are the only covered ICD-10-CM codes that support medical necessity for Chiropractor services.

- Primary: ICD-10-CM Codes (Names of Vertebrae)
- The precise level of subluxation must be listed as the primary diagnosis.

The Groups 2, 3, and 4 ICD-10-CM codes support the medical necessity for diagnoses and involve short, moderate, and long term treatment:

- **Group 2 Codes:** Category I - ICD-10-CM Diagnosis (diagnoses that generally require **short term treatment**)
- **Group 3 Codes:** Category II - ICD-10-CM Diagnosis (diagnoses that generally require **moderate term treatment**)
- **Group 4 Codes:** Category III - ICD-10-CM Diagnosis (diagnoses that may require **long term treatment**)

ICD-10 Codes that DO NOT Support Medical Necessity are **all** ICD-10-CM codes **not** listed in LCDs under *ICD-10-CM Codes That Support Medical Necessity*.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

To review MM3449, Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR3063 go to: [MM3449](#) on the CMS website.

Other articles in this series on chiropractic services are [SE1602](#), which discusses the use of the AT modifier and [SE1603](#), which lists a wide array of other materials to assist chiropractors in delivering covered services to Medicare beneficiaries and correctly billing for those services..

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