

Documenting the Medical Necessity of Chiropractic Services

During the course of your career as a Doctor of Chiropractic there is a high degree of probability that you will receive a denial from a health plan claiming that you performed a service that was not “medically necessary.” It can be a frustrating experience when you get a denial letter. In order to alleviate the feeling of frustration, and to prevent or reduce the number of insurance claim denials, it is imperative that you understand the concept of medical necessity, maintain daily office notes that demonstrate clinical progression and code your bills properly. The purpose of this comprehensive twelve hour seminar is to enhance the Doctor of Chiropractic’s knowledge of medically necessary treatment methodologies and to improve their ability to properly document their services and utilize accurate billing codes for maximum reimbursement.

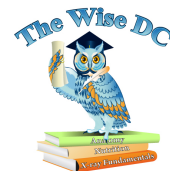
Definitions of Medical Necessity

Receiving maximum reimbursement for chiropractic services is predicated on the DC’s ability to document the reasonableness and medical necessity of the chiropractic services provided a patient. Utilization questions posed by insurance companies are most often relative to the duration, frequency, and efficacy of the chiropractic treatment rendered in response to a particular diagnosis.

The American Chiropractic Association’s Commentary

The American Chiropractic Association provided the following commentary in order to assist its members to better understand the Medicare PART clinical documentation guidelines:

- “The Centers for Medicare and Medicaid Services (CMS) guidelines apply to Medicare only. CMS guidelines are not endorsed or approved by the ACA and the commentary was reportedly provided only for informational assistance and is strictly advisory in nature.
- Policies developed by the Centers for Medicare and Medicaid Services (CMS) indicate that coverage of chiropractic services is specifically limited to **manual manipulation of the spine to correct a subluxation**. Unless a



subluxation is properly documented, medical necessity has not been established and claims may be rejected by Medicare”. (1)

“Utilization guidelines for chiropractic services require the following **three components** in order to establish medical necessity:

1) Presence of a Subluxation

The subluxation must cause a significant neuromusculoskeletal condition. Medicare will not pay for treatment unless it is by manual manipulation of the spine to correct a subluxation. The subluxation must be consistent with the complaint/condition.

2) Documentation of a Subluxation

A subluxation may be demonstrated by one of two methods: **x-ray** or **physical examination**. If documented by physical examination, the PART system must be used.

3) Documentation of the Initial and Subsequent Visits

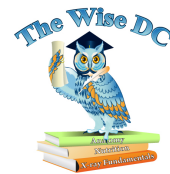
Specific documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination”.(2)

Medicare.gov

According to Medicare.gov, “medically necessary” is defined as “health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.”

Medicare covers services that it views as medically necessary to diagnose or treat a health condition. Services must also meet criteria supplied by national coverage determinations and local coverage determinations. These determinations are decided by the federal government (for the national level) and private Medicare contractors (for the local level), to determine whether or not Medicare will pay for a specific item or service. (3)

According to Medicare, medical necessity involves the “**diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.**” According to section 1862(a)(1)(A) of the Social Security Act, Medicare



will not cover services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

The Medicare Claims Processing Manual

The Medicare Claims Processing Manual defines medical necessity as the “overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.”

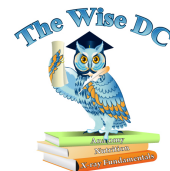
If Medicare or other payers determine that services were medically unnecessary after payment has already been made, they treat it as an overpayment and demand that the money paid be refunded, with interest. Moreover, if a pattern of such claims can be shown and the physician knows or should know that the services are not medically necessary, the provider of care may face exclusion from provider panels, fines, and even criminal prosecution.(4)

American Medical Association

“AMA defines medical necessity as: Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider”.(5)

Cigna HealthCare Definition of Medical Necessity for Physicians

"Medically Necessary" or "Medical Necessity" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

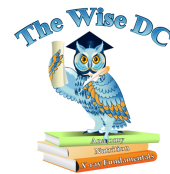


1. in accordance with the generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. not primarily for the convenience of the patient or Physician, or other Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. (6)

Aetna's Definition of Medical Necessity

Aetna considers chiropractic services medically necessary when ***all*** of the following criteria are met:

- The member has a neuromusculoskeletal disorder.
- The medical necessity for treatment is clearly documented.
- Improvement is documented within the initial 2 weeks of chiropractic care.
- If no improvement is documented within the initial 2 weeks, additional chiropractic treatment is considered not medically necessary unless the chiropractic treatment is modified.
- If no improvement is documented within 30 days despite modification of chiropractic treatment, continued chiropractic treatment is considered *not* medically necessary.
- Once the maximum therapeutic benefit has been achieved, continuing chiropractic care is considered not medically necessary.
- Chiropractic manipulation in asymptomatic persons or in persons without an identifiable clinical condition is considered not medically necessary.
- Chiropractic care in persons, whose condition is neither regressing nor improving, is considered not medically necessary.
- Manipulation is considered experimental and investigational when it is rendered for non-neuromusculoskeletal conditions (e.g., attention-deficit hyperactivity disorder, dysmenorrhea, epilepsy; and gastro-intestinal

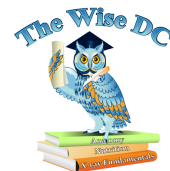


disorders, not an all inclusive list) because its effectiveness for these indications is unproven.

- Manipulation of infants is considered experimental and investigational for non-neuromusculoskeletal indications (e.g., infants with constipation).
- Chiropractic manipulation has no proven value for treatment of idiopathic scoliosis or for treatment of scoliosis beyond early adolescence, unless the member is exhibiting pain or spasm, or some other medically necessary indications for chiropractic manipulation are present.

Aetna considers the following chiropractic procedures experimental and investigational:

- Active Release Technique
- Active Therapeutic Movement
- Advanced Biostructural Correction (ABC) Chiropractic Technique
- Applied Spinal Biomechanical Engineering
- Atlas Orthogonal Technique
- Bioenergetic Synchronization Technique
- Blair Technique
- Bowen Technique
- Chiropractic Biophysics Technique
- Coccygeal Meningeal Stress Fixation Technique
- Cranial Manipulation
- Directional Non-Force Technique
- FAKTR (Functional and Kinetic Treatment with Rehab) Approach
- Gonzalez Rehabilitation Technique
- Koren Specific Technique
- Manipulation for infant colic
- Manipulation for internal (non-neuromusculoskeletal) disorders (Applied Kinesiology)
- Manipulation Under Anesthesia
- Moire Contourographic Analysis
- Network Technique



- Neural Organizational Technique
- Neuro Emotional Technique
- Sacro-Occipital Technique
- Spinal Adjusting Devices (Activator)
- Therapeutic (Wobble) Chair
- Cranio-Sacral Therapy

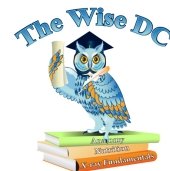
Aetna considers the following diagnostic procedures experimental and investigational:

- Computerized radiographic mensuration analysis for assessing spinal mal-alignment
- Dynamic spinal visualization (including digital motion x-ray and videofluoroscopy, also known as cineradiography)
- Neurocalometer/Nervoscope .
- Para-spinal electromyography (EMG)/Surface scanning EMG -.
- Spinoscopy .
- Thermography.(7)

Observations Regarding Medical Necessity

In a futile attempt to document medical necessity, some DC's find themselves over-documenting with the hope of producing the perfect documentation that will meet medical necessity. On the other extreme, some DC's look for short cuts and produce cookie cutter daily office notes and bills. With this scenario the DC's repeated submissions eventually show a pattern that gives them away resulting in a utilization review audit.

It is important for the DC to know that medical necessity is **NOT** the same for all insurance carriers. Medical necessity definitions can vary from payer to payer and on a case by case basis.



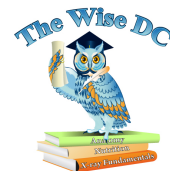
Keys to receiving maximum reimbursement:

- Document the need for a particular service or item in response to a specified diagnosis, disease, injury or defect.
- Document in the patient record, active symptomatology and evidence of disease, injury or defect. Evidence is significant objective deficits from clinical testing that reveal functional impairment.
- Formulate an accurate diagnosis based on positive orthopedic, neurologic, and chiropractic examination findings. Support the accuracy of these findings with positive ancillary diagnostic test results when indicated.
- In order for care to be medically necessary, there must be the expectation of improvement. You must provide the documentation of positive outcomes (progress).
- Know the insurance company's reimbursement guidelines.

The following is a compilation of observations that apply to most Chiropractic insurance reimbursement guidelines:

- Chiropractic services are medically necessary when the patient has a neuromusculoskeletal disorder diagnosis.
- The medical necessity for treatment must be clearly documented.
- Improvement in the condition within the first two weeks of chiropractic care must be documented.
- When no improvement is documented within the first two weeks, additional chiropractic care is considered not medically necessary unless the chiropractic care has been modified.
- If the chiropractic treatment has been modified, improvement in the condition should be documented within 30 days.
- If the DC documents medical necessity with significant objective deficits, and improvement in the condition within two weeks, they have a high probability of getting paid for all medically services until their patient reaches maximum medical improvement (MMI) or pre-injury status.

Here is some helpful advice. To document medical necessity, the provider must submit evidence of significant objective deficits that identify functional impairment through accepted objective diagnostic testing methods compatible with the current AMA's *Guides for the Evaluation of Permanent Impairment*. Incorporating diagnostic testing methods into your practice will increase your



chances of getting paid. Since the number-one reason an insurance company can deny your claims is for the lack of documentation supporting medical necessity, build your practice on the clinically accepted foundation of objective diagnostic testing.

Utilization Management / Review

The Utilization Review Accreditation Commission defines utilization management/ review as the evaluation of the medical necessity, appropriateness and efficient use of health care services, procedures and facilities under the provisions of the patient's health benefits plan. Health plans consider utilization management / review important for quality assurance and cost control.

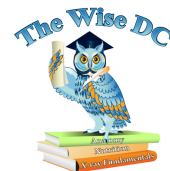
Common Utilization Questions

- Is the diagnosis consistent with the mechanism of injury, the patient's presenting symptomatology and the examination findings?
- Does the frequency, duration and total number of visits provided correlate with the diagnosis?
- Did the DC use functional outcome assessments to quantify clinical progression and the medical necessity of care?
- Does the treatment plan have a focus on active care and rehabilitation?
- Where ancillary diagnostic tests which were ordered clinically indicated and medically necessary?
- Do the daily office notes justify the medical necessity of treatment on every date of service?

Utilization management / review can include pre-certifications, independent chiropractic examinations, and concurrent and retrospective peer reviews.

Submit the following when your patient is undergoing a Peer Review:

- ☐ Initial Narrative Report
- ☐ Initial Examination Findings
- ☐ Roentgenological Report
- ☐ Periodic Re-Examination Findings
- ☐ Daily Office Notations
- ☐ Billing Statements
- ☐ Cross Discipline Examination Findings



- ☐ Ancillary Diagnostic Test Results
- ☐ Letters of Medical Necessity
- ☐ Discharge Summary
- ☐ Follow Up / Final Narrative Reports.

Recording a History of Care

- ☐ Each document must have the date of the procedure
- ☐ Date of injury / mechanism of injury / emergency room treatment, hospitalization records.
- ☐ Treatment history prior to chiropractic treatment
- ☐ Synopsis of chiropractic treatment to include duration / frequency of care, total number of visits, type of treatment
- ☐ Synopsis of treatment rendered by other providers of care, and ancillary diagnostic test results
- ☐ Current frequency of care, diagnosis, type of treatment, concurrent treatment, recent diagnostic tests, provider's rationale for treatment and recommendations for future care

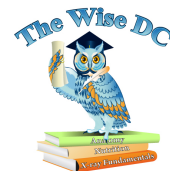
Pre-certification

A health plan's pre-certification (or prior authorization) process usually begins with a nurse employed by the health plan completing an initial review of the patient's clinical information, which is submitted by the practice, to make sure the requested service meets established guidelines. If it does, the nurse authorizes the request and the health plan will cover the service. If the service does not meet the guidelines, the nurse refers the case to the health plan's chiropractic physician reviewer who decides whether to approve or deny the request based on the information provided to the health plan. The physician reviewer may also “pend” the request and ask the physician for additional information before making a final decision.

HMO's use pre-certifications more often than other managed care organizations. Utilization management / management forces physicians to make cost-effective decisions and abide by the plan's rules.

Pre-certification tips:

- Become familiar with chiropractic guidelines.
- Ask the health plans what guidelines they use. Request a copy of the guidelines if the licensing agreement allows it. Medicare makes its coverage guidelines available on its Web site.



- Submit legible documentation clearly stating the reason for the requested service.
- Follow up with the health plan if it hasn't responded in a timely manner. Most large health plans are required to follow standards set by the National Committee for Quality Assurance which stipulate that precertification decisions must be made within 15 calendar days of receipt of the request, if the request is not urgent.

Common Reasons for Denial of Services

- 1) The services are not medically appropriate.
- 2) The health plan lacks information to approve coverage of the service.
- 3) The service is a non-covered benefit.

When denying a claim for reimbursement, health plans are required to state the exact reason for the denial and provide an opportunity for the physician to discuss the denial with the reviewer. This applies only to denials due to a lack of medical necessity, not to denials due to benefits being excluded in the patient's contract.

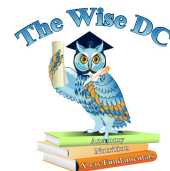
Health plans are required to inform their members of services that are excluded. But how many patients look at the fine print? Physicians usually learn about the excluded benefits when they receive the denial letter after the services have been provided.

Denial tips:

- Use proper coding. Accurate coding decreases denial rates.
- Document the medical necessity of services.
- Avoid treatment that deviates from accepted chiropractic guidelines.
- Inform patients up front that experimental or investigational treatment could be denied. Example, cold laser therapy.

Appeals

Whether a denial is based on medical necessity or benefit limitations, patients or their authorized representatives (such as their treating physicians) can appeal to health plans to reverse adverse decisions. In most cases, patients have up to 180



days from the service denial date to file an appeal. Health plans are required to notify their members of their appeal rights.

In some situations, physicians do have an obligation to file an appeal on the patient's behalf. For example, if a physician directed a patient to the emergency department for an acute problem because the practice could not fit the patient in on a Friday afternoon, the practice bears some of the responsibility if the service is denied.

Appeals are classified as either pre-service appeals (for services not yet provided), post-service appeals (for services already provided) or expedited appeals (for services thought to be urgent). If the health plan agrees to expedite an appeal, it must make a decision within 72 hours of the request.(8)

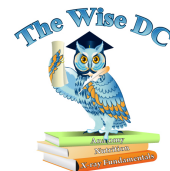
Appeal Process

The Legal Standard

Several court decisions, such as *Wickline v State of California*, 192 Cal App 3d 1630, 239 Cal Rptr 810 (2d Dist 1986), unequivocally hold physicians responsible for doing everything possible to see that their patients receive appropriate care, regardless of a health plan's decisions and in spite of the fear of annoying plan representatives or being deselected. In particular, *Wickline* clarified that a physician who complies without protest with limitations on treatment imposed by a third-party payer when the physician's medical judgment dictates otherwise cannot avoid his or her ultimate responsibility for the patient's care. The legal standard is that the doctor has to take care of the patient.(9)

Federal mandates

- For federal insurance programs, all executive agencies are required to implement grievance and appeal procedures recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. (10)
- Managed care plans that contract with Medicare must follow mandated grievance and appeal procedures as part of their Medicare contracts



State regulations

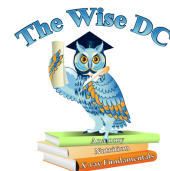
- Many states require that a health care professional with appropriate expertise participate in the appeals process, and some states explicitly limit the authority of nonphysicians to deny claims.
- States have also adopted an array of policies to promote the physician's role in informing patients and assisting them in the appeals process. Laws in some states specify a role for physicians, recognizing that they may appeal a claim on behalf of a patient.
- Many states protect a physician's right to advocate for medically appropriate care by prohibiting plans from disciplining a provider who advocates for such care and by defining advocacy broadly enough to include the appeal of a plan's denial of treatment.
- Some states have consumer groups available to assist patients with appeals.

NCQA standards

- The National Committee for Quality Assurance's (NCQA) current standards for accreditation of managed care organizations include a requirement that physicians review any denial of care and that health plans provide members with the right to independent external appeals of denied care.(11)

Appeal Tips:

- Know when to pick your battles. Not every denial demands an appeal.
- Review any relevant health plan information before you appeal.
- Find out how many levels of appeal are available to you.
- Be aware of any state or federal regulations about the appeals process.
- Handle appeals for your patient in a timely fashion, and document that you've done so.
- Request a face-to-face appeal hearing or direct phone contact with a decision maker at the plan.



Independent Chiropractic Examinations and Peer Reviews

Currently, there are in excess of 200 health insurance companies in the United States that hire Doctors of Chiropractic to perform hundreds of thousands of pre-authorizations, peer reviews, and independent chiropractic examinations to determine medical necessity. Additionally, there are many more peer review companies throughout the United States that are outsourced by health insurance companies to perform peer reviews of the medical necessity of chiropractic treatment services. TheWiseDC, Inc. has been credentialing Doctors of Chiropractic as Certified Chiropractic Insurance Consultants since 1995.

TheWiseDC.com prides itself on teaching its students how to provide fair-minded and ethical clinical opinions regarding the medical necessity of chiropractic treatment.

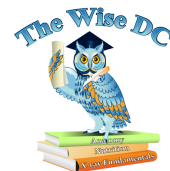
The Certified Chiropractic Insurance Consultant Certification is a 100 hour preparatory course of study which trains Doctors of Chiropractic to perform peer reviews and independent chiropractic examinations. The services of Certified Chiropractic Insurance Consultants are in great demand nationally by insurance carriers, peer review and IME companies, plaintiff and defense lawyers and state board review committees.

This comprehensive, 100 hour certification program is a compilation of 4 modules of Peer Review course materials totaling 50 hours of study and 4 modules of Independent Chiropractic Examination course materials also totaling 50 hours.

The Certified Chiropractic Insurance Consultant Certificate program is credentialed by Texas Chiropractic College, a C.C.E. accredited institution.

For more information click on

http://www.thewisedc.com/?_page=account:100_hr_certification_courses



ICD-10 Coding

Introduced in the late 1970s, the ICD-9 code set was replaced by the more detailed ICD-10 code set on October 1, 2015.

ICD stands for the International Classification of Diseases. Healthcare professionals use ICD codes to record and identify health conditions.

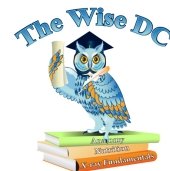
ICD-9 included 13,800 three-to-five-digit, primarily numeric diagnostic codes; the ICD-10 code set contains roughly five times that number, a total of approximately 69,000 three-to-seven-digit, alphanumeric codes. That expansion satisfies a level of medical detail that ICD-9 currently doesn't. For instance, the ICD-9 code set did not:

- Offer accurate medical descriptions
- Differentiate risk and severity
- Distinguish symptoms of diseases
- Efficiently reimburse claims

The transition to ICD-10 reflected a five-fold increase in diagnosis codes, to roughly 69,000 codes and the transition to ICD-10 codes was required for anyone covered by the Health Insurance Portability Accountability Act (HIPAA)—this includes doctors, hospitals and health insurance companies, all of whom rely on these codes for diagnosing patients and billing for services.(12)

Important ICD-10 highlights:

1. “The concept of matching a “primary code” [subluxation] with a “secondary code” [symptom or underlying disease] is retained.
2. The “primary code” will change from 739.1-739.5 to M99.01-M99.05. This is as anticipated, and is a direct crosswalk from ICD-9 to ICD-10.
3. The “secondary code” has grown from 71 codes in ICD-9 to 251 codes in ICD-10. Much of the growth in the number of codes is due to the increased specificity of the new codes.
4. A codes [infectious] = 1
5. G codes [neurology] = 8
6. M codes [musculoskeletal] = 207 including 26 new biomechanical lesion codes [M99-]



7. Q codes [congenital] = 8
8. S codes [acute injury] = 27 These are all new codes, and denote an acute injury in the “secondary code” location.

Primary Codes [Subluxation]: The primary diagnosis must be subluxation, and must indicate the level of the subluxation

- M99.01 Segmental and somatic dysfunction of cervical region
- M99.02 Segmental and somatic dysfunction of thoracic region
- M99.03 Segmental and somatic dysfunction of lumbar region
- M99.04 Segmental and somatic dysfunction of sacral region
- M99.05 Segmental and somatic dysfunction of pelvic region

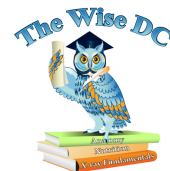
Secondary Codes: The secondary diagnosis must reflect the neuromusculoskeletal condition necessitating the treatment”.(13)

ICD-10 Code List for Common Secondary Chiropractic Diagnosis Codes

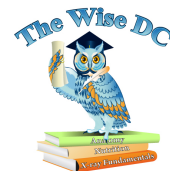
ICD-10 Diagnosis Code	Code name/Description
R51	Headache
G44.201	Tension-type headache, unspecified, intractable
G44.209	Tension-type headache, unspecified, not intractable
G43.001	Migraine without aura, not intractable, with status migrainosus
G43.009	Migraine without aura, not intractable, without status migrainosus
G43.011	Migraine without aura, intractable, with status migrainosus
G43.019	Migraine without aura, intractable, without status migrainosus
G43.101	Migraine with aura, not intractable, with status migrainosus
G43.109	Migraine with aura, not intractable, without status migrainosus
G43.111	Migraine with aura, intractable, with status migrainosus
G43.119	Migraine with aura, intractable, without status migrainosus
M54.2	Cervicalgia
M99.01	Segmental and somatic dysfunction of cervical region
S13.4XXA	Sprain of ligaments of cervical spine, initial encounter
S16.1XXA	Strain of muscle, fascia and tendon at neck level, initial encounter
M50.11	Cervical disc disorder with radiculopathy, occipito-atlanto-axial region



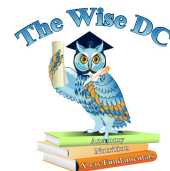
M50.12	Cervical disc disorder with radiculopathy, mid-cervical region
M50.13	Cervical disc disorder with radiculopathy, cervicothoracic region
M50.31	Other cervical disc degeneration, occipito-atlanto-axial region
M50.32	Other cervical disc degeneration, mid-cervical region
M50.33	Other cervical disc degeneration, cervicothoracic region
M48.01	Spinal stenosis, occipito-atlanto-axial region
M48.02	Spinal stenosis, cervical region
M48.	Spinal stenosis, cervicothoracic region
M43.6	Torticollis
M47.811	Spondylosis without myelopathy or radiculopathy
M47.812	Spondylosis without myelopathy or radiculopathy
M47.813	Spondylosis without myelopathy or radiculopathy
M41.112	Juvenile idiopathic scoliosis, cervical region
M41.113	Juvenile idiopathic scoliosis, cervicothoracic region
M41.122	Adolescent idiopathic scoliosis, cervical region
M41.123	Adolescent idiopathic scoliosis, cervicothoracic region
M41.41	Neuromuscular scoliosis, occipito-atlanto-axial region
M41.42	Neuromuscular scoliosis, cervical region
M41.43	Neuromuscular scoliosis, cervicothoracic region
M53.81	Other specified dorsopathies, occipito-atlanto-axial region
M53.82	Other specified dorsopathies, cervical region
M53.83	Other specified dorsopathies, cervicothoracic region
M54.11	Radiculopathy, occipito-atlanto-axial region
M54.12	Radiculopathy, cervical region
M53.1	Cervicobrachial syndrome
G54.0	Brachial plexus disorders
M54.6	Pain in thoracic spine
M99.02	Segmental and somatic dysfunction of thoracic region
M99.08	Segmental and somatic dysfunction of rib cage
S23.3XXA	Sprain of ligaments of thoracic spine, initial encounter
S23.41XA	Sprain of ribs, initial encounter
S23.421A	Sprain of chondrosternal joint, initial encounter
M51.14	Intervertebral disc disorders with radiculopathy, thoracic region
M53.84	Other specified dorsopathies, thoracic region
M41.114	Juvenile idiopathic scoliosis, thoracic region
M41.124	Adolescent idiopathic scoliosis, thoracic region
M41.44	Neuromuscular scoliosis, thoracic region



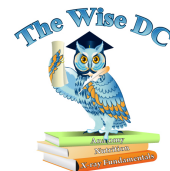
M54.5	Low back pain
M99.03	Segmental and somatic dysfunction of lumbar region
M99.04	Segmental and somatic dysfunction of sacral region
M99.05	Segmental and somatic dysfunction of pelvic region
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
S33.6XXA	Sprain of sacroiliac joint, initial encounter
S33.8XXA	Sprain of other parts of lumbar spine and pelvis, initial encounter
S33.9XXA	Sprain of unspecified parts of lumbar spine and pelvis, initial encounter
S39.012A	Strain of muscle, fascia and tendon of lower back, initial encounter
M51.15	Intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M53.3	Sacrococcygeal disorders, not elsewhere classified
M53.85	Other specified dorsopathies, thoracolumbar region
M53.86	Other specified dorsopathies, lumbar region
M48.06	Spinal stenosis, lumbar region
M48.07	Spinal stenosis, lumbosacral region
M41.115	Juvenile idiopathic scoliosis, thoracolumbar region
M41.116	Juvenile idiopathic scoliosis, lumbar region
M41.117	Juvenile idiopathic scoliosis, lumbosacral region
M41.125	Adolescent idiopathic scoliosis, thoracolumbar region



M41.126	Adolescent idiopathic scoliosis, lumbar region
M41.127	Adolescent idiopathic scoliosis, lumbosacral region
M99.07	Segmental and somatic dysfunction of upper extremity
G56.01	Carpal tunnel syndrome, right upper limb
G56.02	Carpal tunnel syndrome, left upper limb
M75.01	Adhesive capsulitis of right shoulder
M75.02	Adhesive capsulitis of left shoulder
M75.51	Bursitis of right shoulder
M75.52	Bursitis of left shoulder
M77.01	Medial epicondylitis, right elbow
M77.02	Medial epicondylitis, left elbow
M77.11	Lateral epicondylitis, right elbow
M77.12	Lateral epicondylitis, left elbow
S43.51XA	Sprain of right acromioclavicular joint, initial encounter
S43.52XA	Sprain of left acromioclavicular joint, initial encounter
S43.411A	Sprain of right coracohumeral (ligament), initial encounter
S43.412A	Sprain of left coracohumeral (ligament), initial encounter
S43.421A	Sprain of right rotator cuff capsule, initial encounter
S43.422A	Sprain of left rotator cuff capsule, initial encounter
S46.011A	Strain of muscle(s) and tendon(s) of the rotator cuff of right shoulder, initial encounter
S46.012A	Strain of muscle(s) and tendon(s) of the rotator cuff of left shoulder, initial encounter
S46.091A	Other injury of muscle(s) and tendon(s) of the rotator cuff of right shoulder, initial encounter
S46.092A	Other injury of muscle(s) and tendon(s) of the rotator cuff of left shoulder, initial encounter
S46.811A	Strain of other muscles, fascia and tendons at shoulder and upper arm level, right arm, initial encounter
S46.812A	Strain of other muscles, fascia and tendons at shoulder and upper arm level, left arm, initial encounter
S43.81XA	Sprain of other specified parts of right shoulder girdle, initial encounter
S43.82XA	Sprain of other specified parts of left shoulder girdle, initial encounter
M25.511	Pain in right shoulder



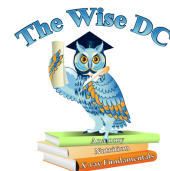
M25.512	Pain in left shoulder
M25.521	Pain in right elbow
M25.522	Pain in left elbow
M25.531	Pain in right wrist
M25.532	Pain in left wrist
M79.601	Pain in right arm
M79.602	Pain in left arm
M79.621	Pain in right upper arm
M79.622	Pain in left upper arm
M79.631	Pain in right forearm
M79.632	Pain in left forearm
M79.641	Pain in right hand
M79.642	Pain in left hand
M79.644	Pain in right finger(s)
M99.06	Segmental and somatic dysfunction of lower extremity
M76.61	Achilles tendinitis, right leg
M76.62	Achilles tendinitis, left leg
M76.811	Anterior tibial syndrome, right leg
M76.812	Anterior tibial syndrome, left leg
M76.819	Anterior tibial syndrome, unspecified leg
M76.821	Posterior tibial tendinitis, right leg
M76.822	Posterior tibial tendinitis, left leg
M76.829	Posterior tibial tendinitis, unspecified leg
S73.191A	Other sprain of right hip, initial encounter
S73.192A	Other sprain of left hip, initial encounter
S76.011A	Strain of muscle, fascia and tendon of right hip, initial encounter
S76.012A	Strain of muscle, fascia and tendon of left hip, initial encounter
S83.401A	Sprain of unspecified collateral ligament of right knee, initial encounter
S83.402A	Sprain of unspecified collateral ligament of left knee, initial encounter
S83.501A	Sprain of unspecified cruciate ligament of right knee, initial encounter
S83.502A	Sprain of unspecified cruciate ligament of left knee, initial encounter
S83.91XA	Sprain of unspecified site of right knee, initial encounter



S83.92XA	Sprain of unspecified site of left knee, initial encounter
S93.411A	Sprain of calcaneofibular ligament of right ankle, initial encounter
S93.412A	Sprain of calcaneofibular ligament of left ankle, initial encounter
S93.432A	Sprain of tibiofibular ligament of left ankle, initial encounter
S96.811A	Sprain of other specified muscles and tendons at ankle and foot level, right foot, initial encounter
S96.812A	Sprain of other specified muscles and tendons at ankle and foot level, left foot, initial encounter
M79.604	Pain in right leg
M79.605	Pain in left leg
M79.651	Pain in right thigh
M79.652	Pain in left thigh
M79.661	Pain in lower right leg
M79.662	Pain in lower left leg
M79.671	Pain in right foot
M79.672	Pain in left foot
M79.674	Pain in right toe(s)
M79.675	Pain in left toe(s)
M25.551	Pain in right hip
M25.552	Pain in left hip
M25.561	Pain in right knee
M25.562	Pain in left knee
M25.571	Pain in right ankle
M25.572	Pain in left ankle
M62.830	Muscle spasm of back
M79.1	Myalgia
M79.7	Fibromyalgia (14)

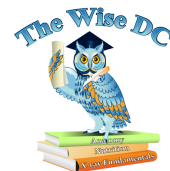
Diagnosis Codes

Proper coding is essential for correct reimbursement. Use the most current diagnosis codes related to the date of service.



Commonly used modifiers

- RT Right side (used to identify procedures performed on the right side of the body)
- LT Left side (used to identify procedures performed on the left side of the body)
- TC Technical component of a procedure
- 25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service. Modifier 25 indicates that the patient's condition requires a significant separate identifiable E&M service above and beyond the usual pre-service and post-service work associated with the CMT service.
- 26 Professional component. Modifier 26 is used when the professional component of a procedure is reported separately.
- 52 It is not appropriate to use modifier 52 with any of the CMT codes or timed therapy codes.
- Modifier 52 identifies a reduced service but should not be used to identify another procedure if there is a specific CPT® code for the reduced service.
 - Codes for spinal manipulations (98940 – 98942) are specific to the number of regions treated. If only two regions are treated, 98940 should be used instead of 98941–52.
 - Modifier 52 should not be used for therapy services less than 15 minutes. At least eight minutes of a physical therapy timed service must be provided in order to use a therapy procedure code (i.e. 97140 – manual therapy techniques, one or more regions, each 15 minutes). If the therapy service is less than eight minutes, it is not billable as those codes require a minimum of eight minutes. Procedure code 97140 can be submitted with one unit for services that span 8-22 minutes. An additional 8 minutes must be provided beyond the 15-minute increment to submit a second unit. If 12 minutes of 97140 is provided, it is not appropriate to append modifier 52.
 - Modifier 52 should not be used to identify reduced charges. It should only be used to identify a service or procedure that has been reduced or eliminated at the provider's discretion.



- 59 Identifies procedures and services, other than E&M services, that are not normally reported together but are appropriate under the circumstances
- 76 Repeat procedure or service by same physician
- 77 Repeat procedure or service by another physician

1500 Billing Form

Beginning in 2014 the **1500 form** allows 12 diagnoses in block 21. Previously, block 21 was limited to four codes. This change was instituted to accommodate the ICD-10 CM coding set.

The CPT / HCPCS codes for Chiropractic services are as follows:

Supervised Modalities - Do not require direct individual contact with the health care provider and are eligible only once per date of service.

97010 Application of a modality to one or more areas; hot or cold packs

97012 Application of a modality to one or more areas; traction, mechanical

97014 Application of a modality to one or more areas; electrical stimulation

97016 Application of a modality to one or more areas; vasopneumatic devices

97018 Application of a modality to one or more areas; paraffin bath

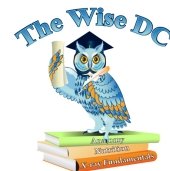
97022 Application of a modality to one or more areas; whirlpool

97024 Application of a modality to one or more areas; diathermy (e.g., microwave)

97026 Application of a modality to one or more areas; infrared

97028 Application of a modality to one or more areas; ultraviolet

Constant Attendance Modalities - Time-based and requires direct one-on-one individual contact with the health care provider.



97032 Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes

97033 Application of a modality to one or more areas; iontophoresis, each 15 minutes

97034 Application of a modality to one or more areas; contrast baths, each 15 minutes

97035 Application of a modality to one or more areas; ultrasound, each 15 minutes

97036 Application of a modality to one or more areas; Hubbard tank, each 15 minutes

97039 Unlisted modality (specify type and time if constant attendance)

Therapeutic Procedures

97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

97112 Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

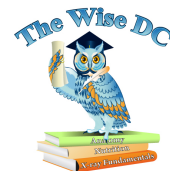
97113 Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises

97116 Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)

97124 Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)

97139 Unlisted therapeutic procedure (specify)

97140 Manual therapy techniques (eg, mobilization/ manipulation, manual



lymphatic drainage, manual traction), 1 or more regions, each 15 minutes

97150 Therapeutic procedure(s), group (2 or more individuals)

97530 Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

97532 Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes

97533 Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes

97535 Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes

97537 Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes

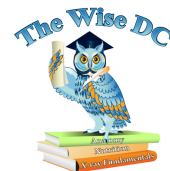
97542 Wheelchair management (eg, assessment, fitting, training), each 15 minutes

97545 Work hardening/conditioning; initial 2 hours

97546 Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)

Electrical Stimulation Procedures (unattended)

G0281 Electrical stimulation, (unattended), to one or more areas, for chronic Stage III and Stage IV pressure ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days conventional care, as part of a therapy plan of care



G0282 Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281

G0283 Electrical stimulation (unattended), to one or more areas for indications other than wound care, as part of a therapy plan of care.

SOURCE: <http://www.codingahead.com/2011/11/cpt-codes-for-chiropractic-services.html>

Evaluation and Management Services

When submitting an Evaluation and Management (E&M) service (CPT® codes 99201-99215), the following documentation must be included in the medical record:

- Comprehensive history and examination
- Counseling/anticipatory guidance/risk factor reduction interventions
- Ordering of appropriate laboratory/diagnostic procedures

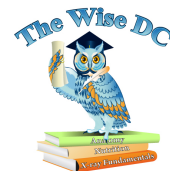
Note: These are not time-dependent; they are based on the complexity of the case. BCBSND may audit medical records on a prepayment or retrospective basis to verify that documentation supports the claim submitted.

A **New Patient** is defined as one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

An **Established Patient** is defined as one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years. The established patient must have a new condition, new injury, aggravation, or exacerbation which warrants further examination above and beyond what is included in CMT services.

Evaluation and Management Codes Changes 2015

Three new codes have been added to the Evaluation and Management (E&M) section in 2015. These are in the Care Management and Advance Care planning subsections.



Care Management Section

This subcategory is for the management and support services provided by clinical staff, under the direction of a physician, to patients at home, in a domiciliary, or in assisted living.

Chronic Care Management Services

"Complex Chronic Care Coordination" title has been changed to "Care Management Services" with an addition of a new subsection, "Chronic Care Management Services" to better reflect the management services described by new code 99490. This E&M code will be utilized to capture chronic care management services for the establishment, implementation, revision, or monitoring of the care plan for patients with at least two chronic conditions, expected to last at least 12 months, and may place the patient at risk of death, exacerbation, or functional decline. This code is reported if, during the calendar month, at least 20 minutes of clinical staff time is spent on care management activities.

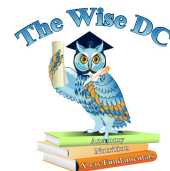
Advance Care Planning E&M Section

The two new advanced care planning codes (99497 and 99498) are used to report the face-to-face service between a physician or other qualified healthcare professional (QHCP) and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. The CPT manual defines advanced directive as:

A document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time.

Advance Care Planning is a new subsection in the E/M section. Two E&M codes were placed in this subsection. The codes are used to report face-to-face discussion of advance directives:

- E&N Code 99497: Advanced care planning for the first 30 minutes
- E&N Code 99498: Add-on code assigned for each additional 30 minutes



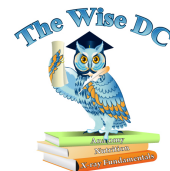
These are time-based codes, with 99497 to be billed for the first 30 minutes, and 99498 for each additional 30 minutes. Because the purpose of the visit is the discussion, no active management of the patient's problem(s) is performed during the time of these visits. Additionally, these code(s) can be billed in for the following E/M services:

- New and established patient office visits (99201-99215)
- Observation initial, subsequent and discharge care codes (99217-99220, 99224-99226)
- Initial, subsequent and discharge hospital service codes (99221-99233, 99238-99239)
- Observation or inpatient admit and discharge on the same date (99234-99236)
- Outpatient and inpatient consultations (99241-99255)
- Emergency department visit codes (99281-99285)
- Initial, subsequent and discharge nursing facility care codes (99304-99316)
- Annual nursing facility assessment code (99318)
- New, established and discharge domiciliary or rest home visit codes (99234-99337)
- New and established patient home visit codes (99341-99350)
- initial and periodic preventive medicine codes (99381-99397)
- Transitional Care Management Service codes (99495-99496)

However, these codes cannot be billed with:

- Critical care codes (99291, 99292)
- Inpatient neonatal and pediatric critical care codes (99468-99476)
- Initial and continuing intensive care services (99477-99480)

Medicare has indicated that it will NOT pay for codes 99497 or 99498 in 2015. Check with your commercial payers to see if they are reimbursing for these codes.



SOURCE: <http://www.medicalbillingcodings.org/2015/04/em-evaluationandmanagement-codes-changesandupdates.html>

New Patient Evaluation & Management Codes

99201

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

99202

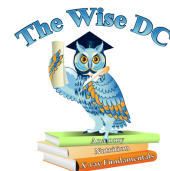
Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

99203

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a detailed history; a detailed examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99204

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are



provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

99205

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Established Patient Evaluation & Management Codes

99211

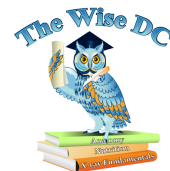
Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

99212

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

99213

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the



problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99214

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99215

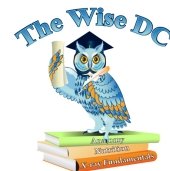
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Evaluation & Management and CMT (CPT® codes 99201–99215 with 98940–98943)

E&M is necessary when performing the initial exam. An E&M service may once again be necessary if there is a change in condition or treatment protocol. It is not appropriate to bill for routine scheduled E&M service (every 12 days of treatment).

Use modifier 25 to identify the E&M service separately when performed with CMT.

Documentation must be complete as to the level of E&M services provided according to CPT® guidelines.



CMT codes include a pre-manipulation patient assessment component for each visit, which must be supported by appropriate documentation. Therefore, it is not appropriate to bill an E&M service with each CMT service. If billed inappropriately, the E&M service will be denied as provider liable.

It is appropriate to bill for the CMT and E&M service if one of the following has occurred:

- A new patient visit
- An established patient visit. The established patient must have a new condition, new injury, aggravation, or exacerbation which warrants further examination above and beyond what is included in CMT services.
- Periodic re-evaluation to determine if a change in the treatment plan is necessary

Documentation of Evaluation & Management Services

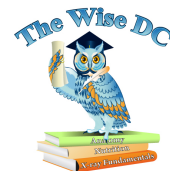
The physician must choose the level of detail contained in the documentation, which will also determine the code, whether the patient is new or established, and the level of complexity. The requirements for proper coding of evaluation and management codes will be determined according to how many elements of the history are utilized. The physician must determine whether it is necessary to include all of the following elements in the records of patients with less severe problems. The elements of the subjective portion of the clinical record could include the following:

History of the present illness: (HPI)

These factors are used to complete the history of the present illness. The mnemonic O, P1, P2, Q, R, S, T, U can also be used:

- History of trauma or incident
- Description of the chief complaint(s)
- O-Onset of symptoms
- P1-Palliative factors
- P2-Provocative factors

- Q-Quality of pain which can include burning, numbness, and tingling, etc.
- R-Radiation of pain
- S-Severity of pain on a scale from 0-10
- T-Timing or frequency of complaint
- U-Previous episodes of chief complaint.



Past History

- Prior major illnesses and injuries
- Prior operations
- Prior hospitalizations
- Current medications
- Allergies to food or drug
- Age appropriate immunization status
- Age appropriate feeding and dietary status
- Current vitamin and mineral usage including herbs and homeopathy

Social History

- Current employment
- Occupational history
- Use of drugs, alcohol, or tobacco
- Relevant social factors

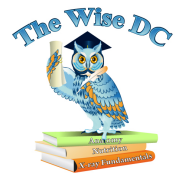
Family History

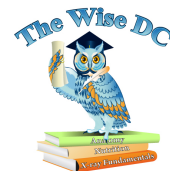
Any significant health factors that may be congenital or familial in nature.

Review of Systems (ROS)

The following areas relate to a review of systems:

- Constitutional symptoms (fever, weight loss/gain, or fatigue, etc.)
- Eyes
- Ears, nose or throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integument which includes skin or breast
- Neurological
- Psychiatric
- Endocrine
- Hematology and lymphatic
- Allergies and immunologic





Eight-Minute Rule

Providers should not bill for services if less than a total of eight minutes is spent with the patient.

- One Unit $\geq$ 8-22 minutes
- Two Units $\geq$ 23-37 minutes
- Three Units $\geq$ 38-52
- Four Units $\geq$ 53-67
- Five Units $\geq$ 68-82
- Six Units $\geq$ 83-97

Ultrasound/Electric Muscle Stimulation Combination Therapy

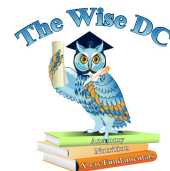
- When performing ultrasound (CPT® 97035) and electric muscle stimulation, constant, attended (CPT® 97032) the services are duplicate and therefore only the higher reimbursed code is allowed to represent the total service
- 97035 and 97032 should not be billed together
- Ultrasound/electric muscle stimulation is billed appropriately with CPT® 97035

Chiropractic Manipulative Treatment (CMT)

Chiropractic Manipulative Treatment (CMT) Codes

98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions
98941	Chiropractic manipulative treatment (CMT); spinal, three to four regions
98942	Chiropractic manipulative treatment (CMT); spinal, five regions
98943	Chiropractic manipulative treatment (CMT); extraspinal, one or more regions

Chiropractic manipulative treatment procedures (CPT® codes 98940-98943) use high-velocity, short-lever, low-amplitude thrust by hand or instrument to remove structural dysfunction in joints and muscles that may be associated with neurologic



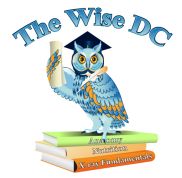
or mechanical dysfunction of the spinal joints and surrounding tissue. These procedures are specifically and primarily used by chiropractors to mobilize, adjust, manipulate, apply traction, massage, stimulate or otherwise influence the spine and paraspinal tissues to affect the patient's health.

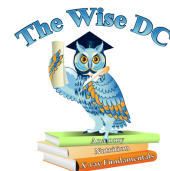
Each CPT® code reflects a specific number of regions, regardless of how many manipulations are performed in that region. For example, chiropractic manipulation applied to C3 and C5 during the same visit represent treatment to only one region (cervical) and should be reported with CPT® code 98940.

All CPT® codes for CMT must have a supporting ICD-10-CM diagnosis code to justify the level of care provided. For example, when billing CPT® 98941, there must be at least three ICD-10-CM codes indicating the three different regions treated. If the proper diagnosis code is not provided to support each CPT® code, claims will be returned to the provider for correction.

CMT Components	Pre-Service	A brief evaluation of the patient documentation and chart review, imaging review, test interpretation and care planning
	Intra-Service	Treatment applied Pre-manipulation (e.g., palpation, etc.) Manipulation, Post-manipulation (e.g., assessment, etc.)
	Post-Service	Chart entry and documentation, including subjective, objective, assessment, plan consultation reporting

The CPT® code includes a "work per unit of time" which is reflected in the Relative Value Units (RVUs). The RVUs take into consideration the work expense (work unit), practice expense, and malpractice expense. The reimbursement amount is calculated by multiplying the RVU times the conversion factor. The conversion factor is a base dollar amount that applies to all physician codes with RVUs. Since RVUs can change from year to year, the conversion factor is recalculated annually to remain budget neutral for total physician payments.





Spinal Manipulative Treatment

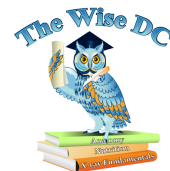
Spinal manipulative treatment body regions include: Cervical	All manipulations performed to the atlanto-occipital joint, and C1 through C7
Thoracic	All manipulations performed to T1 through T12, including the posterior ribs (costotransverse and costovertebral junctions)
Lumbar	All manipulations performed to L1 through L5
Sacral	All manipulations performed to the sacrum, including the sacroccygeal junction
Pelvic	All manipulations performed to the sacroiliac joint and other pelvic articulations

Extraspinal Manipulative Treatment (CPT® code 98943)

Manipulative treatment of the appendicular skeleton should be billed with CPT® code 98943 regardless of how many individual extraspinal manipulations are performed. CPT® code 98943 can be billed alone or in conjunction with a spinal CMT code.

When an extraspinal region manipulation (98943) is performed on the same patient on the same day as a spinal manipulation (98940, 98941, 98942), reimbursement for the extraspinal manipulation will not be reduced. Reimbursement will be based on the full Physician fee schedule amount for spinal and extraspinal manipulations when billed together.

Extraspinal manipulative treatment body regions include: Head	All manipulations performed to the head, including the TMJ, excluding the atlanto- occipital joint
Lower extremities	All manipulations performed to the hip, leg, knee, ankle and foot
Upper extremities	All manipulations performed to the shoulder, arm, elbow, wrist and hand



Rib cage	All manipulations performed to the anterior rib cage, including the costosternal junction
Abdomen	All manipulations performed to the abdominal area

Manual Therapy Performed with CMT (CPT® codes 97140 and 98940-98943)

Manual therapy techniques (CPT® 97140) may be performed in addition to CMT when a separate therapeutic benefit is being achieved. However, manual therapy should only be performed when necessary. Some indications for utilization of manual therapy may include, but are not limited to, limited range of motion, muscle spasm, pain, scar tissue or contracted tissue and/or soft tissue swelling, inflammation or restriction, etc.

Manual therapy includes, but is not limited to, connective tissue massage, joint mobilization, manual traction, passive range of motion, soft tissue mobilization and manipulation, and therapeutic massage. The code descriptor states this is a manual hands-on administration.

CPT® code 97140 is reported for each 15 minutes of manual therapy technique provided to one or more regions. Manual therapy is not a mutually exclusive procedure when it is billed for different body regions separate from CMT codes 98940 - 98943. Medical documentation may be requested to review appropriateness.

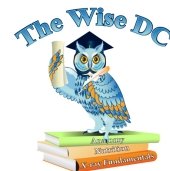
When manual therapy is performed to the same region as the CMT with similar outcomes, it will not be reimbursed separately.

When manual therapy is performed on the same date of service as CMT and is separate from the CMT procedure, a separate diagnosis related to the treatment must be identified by a specific ICD-10-CM diagnosis code; CPT® code 97140 must be billed with modifier 59.

Radiology Services

Radiology Codes

72010 Radiologic examination, spine, entire, survey study, anteroposterior



	and lateral
72020	Radiologic examination, spine, single view, specify level
72040	Radiologic examination, spine, cervical; 2 or 3 views
72050	Radiologic examination, spine, cervical; minimum of 4 views
72052	Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies
72069	Radiologic examination, spine, thoracolumbar, standing (scoliosis)
72070	Radiologic examination, spine; thoracic, 2 views
72072	Radiologic examination, spine; thoracic, 3 views
72074	Radiologic examination, spine; thoracic, minimum of 4 views
72080	Radiologic examination, spine; thoracolumbar, 2 views
72090	Radiologic examination, spine; scoliosis study, including supine and erect studies
72100	Radiologic examination, spine, lumbosacral; minimum of 2 or 3 views
72110	Radiologic examination, spine, lumbosacral; minimum of 4 views
72114	Radiologic examination, spine, lumbosacral; complete, including bending views
72120	Radiologic examination, spine, lumbosacral, bending views only, minimum of 4 views

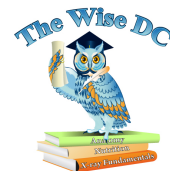
Proper billing

The number of units on the claim is based on the code description, not the number of views taken. The code description provides the number of views taken.

- Example: 71010 (chest x-ray, single view) - Units should be 1 71020 (chest x-ray; 2 views) - Units should be 1
- CPT® code must be billed with supporting ICD-10-CM codes

CPT® code 76140 (Consultation on X-ray examination made elsewhere, written report)

- CPT ® code 76140 should only be used when a provider requests the opinion or advice of another provider to interpret and consult on a radiograph image
- Requires a written report



Radiology Documentation

Effective communication is a critical component of diagnostic imaging. Tips to consider and remember when documenting and communicating any type of diagnostic imaging result:

- Quality patient care can only be achieved when study results are given in a timely manner to those responsible for the treatment decisions.
- An official interpretation (final report) should be completed following any examination, procedure or consultation regardless of the performance site (hospital, physician office, mobile unit, imaging center, etc.).
- Final reports are the definitive means of communicating to the referring physician(s).
- Documentation of radiological studies should be completed on the day the image is read.

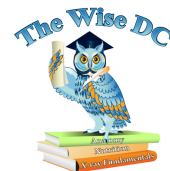
Recommended documentation components for radiology reports:

Demographics:

- Patient's name and personal identifier
- Date and time of service
- Name/type of examination
- Facility or location where study was performed
- Name(s) of referring physician(s)
- Name and signature of interpreting provider
- Inclusion of the following additional items is encouraged:
 - Dictation date
 - Date and time of transcription
 - Birth date and/or age
 - Gender

Clinical information should include the following:

- Indication(s) for examination: reason why the study is being performed.
- Procedures performed/materials used: description of the studies and/or procedures performed and any contrast media (including concentration, volume and administration route), medications, catheters or devices used.



- Record of the views taken.

Findings:

- Appropriate anatomic, pathologic and radiologic terminology should be used to describe findings
- Indication of study quality, i.e. if results are unable to be obtained due to inadequacy of image(s)
- Pertinent positive findings and/or pertinent negative findings
- Impression (conclusion or diagnosis):
- A precise diagnosis should be given when possible
- If appropriate, a differential diagnosis should be rendered
- Significant patient reaction or complication, if applicable

Radiological findings can be listed using the mnemonic “A, B, Cs”:

- Alignment
- Bone
- Cartilage
- Soft tissue

Recommendations: Follow-up or additional studies needed should be indicated when applicable.

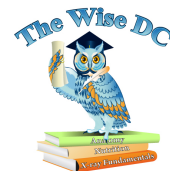
Non-covered Services

Hydrobed

The use of a hydrobed should be billed using 97039 (Unlisted modality [specify type and time if constant attendance]) and modifier GA. This service is considered non-covered and cannot be billed interchangeably with CPT® 97022 (Application of a modality to one or more areas; whirlpool). Whirlpool treatment involves immersing the body or limb into heated water. The heated water facilitates tissue debridement, wound cleaning, and/or exercise. This definition does not describe the use of a hydrobed.

Laser Therapy

- Modality which requires constant attendance
- Often incorrectly coded with CPT® code 97026 (Infrared therapy)



- Supervised therapy vs. constant attendance required for laser therapy
- Bill CPT® code 97039 (unlisted therapy) with notation of laser therapy
- Procedure is currently investigational

Maintenance Care

All services performed for a maintenance care visit are non-covered and are benefit exclusions. When submitting a claim for chiropractic maintenance care use HCPCS code S8990 (Physical or manipulative therapy performed for maintenance rather than restoration).

Hot and Cold Packs

Hot and cold packs are considered integral to other modalities and procedures provided. **The application of hot or cold packs when used alone is not covered.**

After Hours

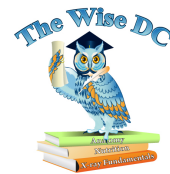
CPT® codes 99050 – 99058 (for after hours services) are valid codes when used in addition to another basic service code; they should never be submitted alone.

BCBS does not reimburse these adjunct codes. When the service is billed by a participating provider, it is considered to be a provider discount.

Mechanical/Vibratory Massage

Massage therapy (CPT® 97124) is a therapeutic procedure requiring constant attendance.

- Procedure may be applied to one or more areas
 - Timed in 15-minute increments
 - Common procedures are effleurage, petrissage and tapotement
-
- It is appropriate to bill CPT® 97124 for the G-5 massager
 - A mechanical vibratory device such as a mechanical chair or table does not require constant attendance and would be incorrectly coded using 97124



Blue Cross and Blue Shield Billing Codes

November 2011

Definitions

Chiropractic Maintenance Care – Elective health care that is typically long-term, by definition not therapeutically necessary, but provided at preferably regular intervals to prevent disease, prolong life, promote health and enhance the quality of life. This care may be provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration, or it may be initiated with patients without symptoms in order to promote health and prevent future problems.

Chiropractic Manipulative Treatment (CMT) – CMT procedures (CPT® codes 98940-98943) use high-velocity, short-lever, low-amplitude thrust by hand or instrument to remove structural dysfunction in joints and muscles that may be associated with neurologic or mechanical dysfunction of the spinal joints and surrounding tissue. There are 2 types of CMT:

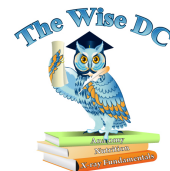
Spinal: manipulative treatment of cervical, thoracic, lumbar, sacral and pelvic regions.

Extraspinal: manipulative treatment of the appendicular skeleton.

WARNINGS ABOUT CMT CODES

Improper CMT coding can lead to unwanted audits. If you use the CMT codes you must provide extensive documentation including the time (number of minutes) the service was provided / performed.

The following information, taken from the ACA's *Clinical Documentation Manual, 2nd Edition*, describes the nine components associated with documenting the CMT codes. CMT codes (98940-98943) include extensive documentation requirements that are time consuming and very difficult to document without diagnostic testing. The times shown represent the time requirements for the appropriate level of Evaluation and Management (E&M) service included in each level of CMT.



Three pre-service components include: documentation and chart review, imaging review, test interpretation and care planning. Three intra-service components include: pre-manipulation and palpation procedures, manipulation procedures and post-manipulation assessment procedures. Three post-service components include: chart documentation, consultation and reporting. Here are the relevant codes:

- 98940 – 12 minutes total time, plus the nine components
- 98941 – 17 minutes total time, plus the nine components
- 98942 – 21 minutes total time, plus the nine components
- 98943 – 14 minutes total time, plus the nine components

Chiropractic Supportive Care – Long-term treatment/care that is therapeutically necessary. This is treatment for patients who have reached maximum therapeutic benefit, but who fail to sustain benefit and progressively deteriorate when there are period trials of treatment withdrawal. Supportive care follows appropriate application of active and passive care including rehabilitation and/or lifestyle modifications. Supportive care is appropriate when alternative care options, including home-based self-care or referral have been considered and/or attempted. Supportive care may be inappropriate when it interferes with other appropriate primary care or when risk of supportive care outweighs its benefit, i.e. physician/treatment dependence, somatization, illness behavior or secondary gain.

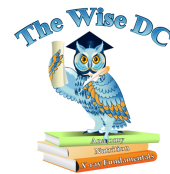
Date of Injury (DOI) – The actual date of the current injury. This information is entered in box 14 of the CMS-1500 claim form.

Dynamic Thrust – The therapeutic force or maneuver delivered by the physician during manipulation.

Exacerbation – An increase in severity of the patient's condition or symptoms.

Initial Treatment Date (ITD) – The first date the patient had the same or similar injury. This information is entered in box 15 of the CMS-1500 claim form.

Manipulation – An adjustment, skillful treatment or procedure involving the use of hands.



Modalities – Any physical agent applied to produce a therapeutic change to biological tissue; includes but is not limited to thermal, acoustic, light, mechanical, or electrical energy.

Supervised: Provider needs to watch over the application, though not necessarily at the patient's side. These are procedure/service based and units are always one (1).

Constant Attendance: Provider must be with the patient at all times. These are time- based, one unit = 15 minutes.

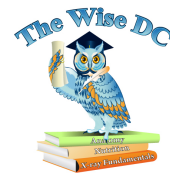
Subluxation –A subluxation is a complex of functional and/or structural and/or pathological articular changes that compromise neural integrity and may influence organ system function and general health. A subluxation is evaluated, diagnosed, and managed through the use of chiropractic procedures based on the best available rational and empirical evidence.

Therapeutic Procedure – A manner of affecting change through the application of clinical skills and/or services that attempt to improve function.(15), (16)

Medicare Coverage of Chiropractic Services

With respect to chiropractic claims, Medicare pays for spinal manipulation only and subluxation must be the primary diagnosis. Additionally, there must be a secondary neuromusculoskeletal condition listed and associated with the primary diagnosis. A subluxation must be demonstrated in the patient's records by an X-ray or physical examination and the specific vertebrae must be documented. Subluxation is defined as a motion segment, in which alignment, movement integrity, and/or physiological function of the spine, are altered, although contact between joint surfaces remains intact. Also, the secondary diagnosis must indicate the most specific diagnosis or reason for the treatment being rendered. Utilize the diagnosis code that is most representative of the patient's condition as this will result in less scrutiny and optimal reimbursement.

Manual devices, such as an Activator device, may be used by chiropractors in performing manual manipulation of the spine. However, Medicare does not reimburse the DC for using the device.



No other diagnostic (such as x-ray) or therapeutic service provided by a chiropractor is covered.

Chiropractic manipulation codes must be appended with the modifier AT to indicate the care is corrective or active. Omission of the modifier will result in an automatic denial of services.

A chiropractic patient can choose to receive care beyond what Medicare allows but they are responsible for paying for these services. In this scenario, the patient is required to sign an Advance Beneficiary Notice (ABN), accepting responsibility and the chiropractic manipulation code must be billed with modifier GA. Use of this modifier will result in a denial of payment from Medicare, but does allow and make the patient responsible for those services.

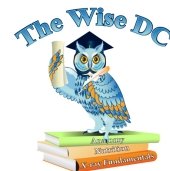
For services that are excluded for chiropractic (everything but spinal manipulation), the chiropractic provider need not bill to Medicare. The patient is liable for those services and they cannot be provided at no charge or discount, as Medicare views this as inducement. However, there can be instances whereby the patient has a secondary insurance that will pay not only the 20 percent not paid by Medicare for manipulation, but also has provision for excluded services. When that is the case, those services would be billed to Medicare; however, they are appended with modifier GY (97035 GY, 97124 GY, G0283 GY, etc.).

This GY modifier indicates it is an excluded service and will result in patient responsibility for those services and allow payment from the secondary payer. In most instances, Medicare will also forward the claim directly to the secondary payer, meaning no additional work by the chiropractor. The secondary insurance information should be included on the claim block 9a-d.

There are a number of claim form nuances for Medicare that the DC should be familiar with, such as:

Block 11 should have "none" indicated, as this is the indication that there is no other insurance primary to Medicare. If this is left blank, Medicare will deny the claim, indicating it cannot ascertain the primary insurance.

Block 14 must have a date, and it is not necessarily a date of injury or first symptom, but the date of the first visit for the current episode. For instance, a



patient has an injury on a Saturday and visits the office on the following Tuesday. The date in block 14 should reflect Tuesday's date.

Things that trigger Medicare denials:

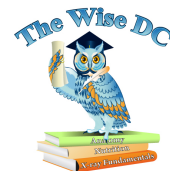
- Illegible notes
- Missing signature: All notes require the signature, not initials, of the chiropractor.
- Not specifying the level of subluxation in daily treatment notes.
- Not specifying areas of manipulation on each visit.
- Treatment plans that do not specify frequency and duration of care.
- No evidence in the documentation of clinical progression.

Demonstrating Subluxation

Two Methods:

Subluxation Demonstrated by X-Ray:

- An x-ray may be used to document subluxation.
- The x-ray must have been taken at a time 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 not 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 health record indicates the condition is permanent.
- A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated.



Subluxation Demonstrated by 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:

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

Analysis of the Components of P.A.R.T.

P - PAIN AND TENDERNESS

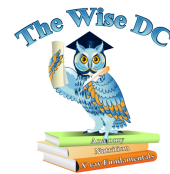
Identify using one or more of the following:

- _ Observation: You can document, by personal observation, the pain that the patient exhibits during the course of the examination. Note the location, quality, and severity of the pain.
- _ Percussion, Palpation, or Provocation: When examining the patient, ask them if pain is reproduced, such as, "Let me know if any of this causes discomfort."
- _ Visual Analog Type Scale: The patient is asked to grade the pain on a visual analog type scale from 0 -10.
- _ Pain questionnaires: Patient questionnaires, such as the McGill pain questionnaire or an in-office patient history form, can be used for the patient to describe their pain.

A - ASYMMETRY/MISALIGNMENT

Identify on a sectional or segmental level by using one or more of the following:

- _ Observation: You can observe patient posture or analyze gait.
- _ Static and Dynamic Palpation: Describe the spinal misaligned vertebrae and symmetry.
- _ Diagnostic Imaging: You can use x-ray, CAT scan and MRI to identify misalignments.



R - RANGE OF MOTION ABNORMALITY

Identify an increase or decrease in segmental mobility using one or more of the following:

- _ Observation: You can observe an increase or decrease in the patient's range of motion.
- _ Motion Palpation: You can record your palpation findings, including listing(s). Be sure to record the various areas that are involved and related to the regions manipulated.
- _ Stress Diagnostic Imaging: You can x-ray the patient using bending views.
- _ Range of Motion Measuring Devices: Devices such as goniometers or inclinometers can be used to record specific measurements.

T - TISSUE, TONE CHANGES

Identify using one or more of the following:

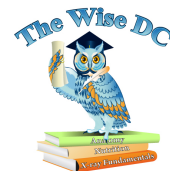
- _ Observation: Visible changes such as signs of spasm, inflammation, swelling, rigidity, etc.
- _ Palpation: Palpated changes in the tissue, such as hypertonicity, hypotonicity, spasm, inflammation, tautness, rigidity, flaccidity, etc. can be found on palpation.
- _ Use of instrumentation: Document the instrument used and findings.
- _ Tests for Length and Strength: Document leg length, scoliosis contracture, and strength of muscles that relate.

Medicare Documentation Requirements

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

1. The history includes the following:

- a. Symptoms causing patient to seek treatment;
- b. Family history if relevant;
- c. Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history);



- d. Mechanism of trauma;
- e. Quality and character of symptoms/problem;
- f. Onset, duration, intensity, frequency, location, and radiation of symptoms;
- g. Aggravating or relieving factors; and
- h. Prior interventions, treatments, medications, secondary complaints.

2. Description of the present illness, including:

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

These symptoms must bear a direct relationship to the level of subluxation. The subluxation must be causal, i.e., the symptoms must be related to the level of the subluxation that has been cited. A statement on a claim that there is “pain” is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.

3. Evaluation of musculoskeletal/nervous system through physical examination

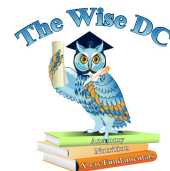
4. Diagnosis

The primary diagnosis must be subluxation. The precise level of the subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine.

5. Treatment Plan should include the following:

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

6. Date of the initial treatment.



7. The patient's medical record must:

- 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.

Documenting History

- ☐ The history recorded in the patient record should include the following:
- ☐ Symptoms causing patient to seek treatment;
- ☐ Family history if relevant;
- ☐ Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history);
- ☐ Mechanism of trauma;
- ☐ Quality and character of symptoms/problem;
- ☐ Onset, duration, intensity, frequency, location and radiation of symptoms;
- ☐ Aggravating or relieving factors; and
- ☐ Prior interventions, treatments, medications, secondary complaints.

Documentation Requirements- Initial Visit

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

a.) History as stated above.

b.) Description of 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; and
- ☐ Prior interventions, treatments, medications, secondary complaints;
- ☐ Symptoms causing the patient to seek treatment.
- ☐ Symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine, muscle, bone, rib, and joint and be reported as pain, inflammation, or as signs such as swelling, spasticity.
- ☐ Evaluation of the musculoskeletal/nervous system through physical examination.
- ☐ 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.

- ☐ Treatment plan: The treatment plan should 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.

Documentation Requirements – Subsequent Visits

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

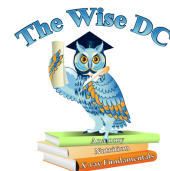
a.) History

- ☐ Review of chief complaint.
- ☐ Changes since last visit.
- ☐ System review if relevant.

b.) Physical exam

- ☐ Exam of area of spine involved in diagnosis.
- ☐ Assessment of change in patient condition since last visit.
- ☐ Evaluation of treatment effectiveness.

c.) Documentation of treatment given on day of visit.



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.

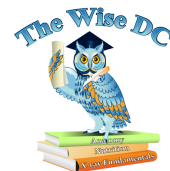
3. Documentation of treatment given on the day of the visit.

Necessity for Treatment for 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.

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.
- 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), but where 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 AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However, the presence of the AT modifier may not in all instances indicate that the service is reasonable and necessary.

Maintenance Therapy

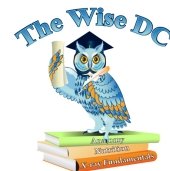
Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

The AT modifier **must not** be placed on the claim when maintenance therapy has been provided. **Claims without the AT modifier will be considered as maintenance therapy and denied.**

Key Billing Requirements

In addition to other billing requirements explained in Medicare's Manuals, it is important that you include the following information on the claim:

- The primary diagnosis of subluxation;
- The initial visit or the date of exacerbation of the existing condition;



- The appropriate Current Procedural Terminology (CPT) code that best describes the service: o **98940:** Chiropractic Manipulative Treatment (CMT); spinal, one or two regions;

- o **98941:** Spinal, three to four regions;

- o **98942:** Spinal, five regions.

NOTE: 98943: CMT, extraspinal, one or more regions, is not covered by Medicare.

- The appropriate modifier that describes the services:

- o **AT modifier*** used on a claim when providing active/corrective treatment to treat acute or chronic subluxation;

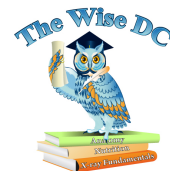
NOTE: You must use the Acute Treatment modifier “AT” to identify services that are active/corrective treatment of acute or chronic subluxation and must document services in accordance with the Centers for Medicare & Medicaid Services’ (CMS) “Medicare Benefit Policy Manual”, Chapter 15, Section 240, when submitting claims.

Beneficiary Responsibility

For Medicare covered services, the beneficiary pays the Part B deductible and then 20 percent of the Medicare-approved amount. The beneficiary also pays all costs for any services or tests ordered by the DC. (17), (18), (19)

Important Take Aways

- Medicare only pays for chiropractic services for active/corrective treatment (those using HCPCS codes 98940, 98941, or 98942). Claims for medically necessary services rendered on or after October 1, 2004 must contain the Acute Treatment (AT) modifier to reflect such services provided, or the claim will be denied.
- Ensure that your billing staff is aware that they must apply the AT modifier to HCPCS codes 98940, 98941, or 98942 when your clinical documentation reflects that the care you provided to a Medicare patient consists of



active/corrective treatment. Additionally, your billing staff should be aware of any local coverage determinations (LCDs) for these services in your area that might limit circumstances under which active/corrective chiropractic can be paid.

Medicare PART Documentation

Familiarize yourself with your Local Coverage Determination (LCD) and Section 240 from Chapter 15 in the *Medicare Benefit Policy Manual*. All of the documentation requirements are found in these two resources. LCDs vary slightly from state to state but they are all based on Section 240.

Medicare only pays for spinal manipulation when the patient is suffering from a "significant neuromusculoskeletal condition" of the spine that is amenable to manipulation in a reasonable period of time. Therefore, for the diagnosis, use *ICD-10* codes that are accepted by Medicare and that reflect the symptom of pain your patient is experiencing. (20), (21), (22)

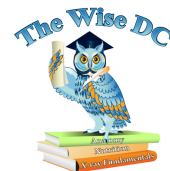
Outcome Measurements That Defend Your Medically Necessary Care

The following outcomes measurements help to demonstrate patient progress or lack of progress:

1. Visual Analog Scale
2. Roland-Morris, Oswestry or Neck Disability Index (NDI)
3. range-of-motion measurements
4. strength/endurance measurements

Introduction to S. O. A. P. Notes

- The Gold Standard for daily office notations is the S. O. A. P. note.
- S. O. A. P. is an acronym, with each letter representing a section of the patient note. S. stands for subjective complaints; O. stands for objective findings; A. stands for clinical assessment; and P. stands for treatment plan.



- The S. O. A. P. note was introduced by Dr. Lawrence Weed as a method of organizing medical records.
- The S. O. A. P. note records what the physician does to manage the patient's condition on a daily basis and is a standardized form of communication. Third party payers make decisions about reimbursement based on the quality, legibility, and completeness of daily office notations.
- The method of writing S. O. A. P. notes helps the physician to organize the thought processes involved in patient care and offers a structured way of thinking for problem solving. They are also used for quality assurance and improvement purposes and chronicle subjective and objective improvement, patient response to treatment, and the efficacy of care.

S - Writing Subjective Complaints

- ☐ Document the patient's subjective complaints in the words of the patient. The subjective complaint will include information regarding the patient's area/areas of pain, level of function, response to treatment, emotions, goals of care, lifestyle or home situation, emotions and attitudes.
- ☐ It is acceptable to use "Pt." the first time, but do not repeat it with every sentence, as it is implied that the information in this section came from the patient.
- ☐ Quoting the patient verbatim is the most appropriate method of conveying subjective information. Some reasons for using direct quotes from the patient might be to illustrate confusion or loss of memory, denial, attitude toward therapy or the use of abusive language.
- ☐ The subjective portion of the note includes pertinent information that will assist the physician with setting treatment goals for the patient, planning the patients treatment, and deciding when to discontinue treatment.

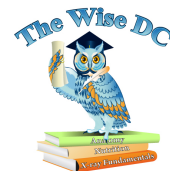
A guide you in the taking of a pain history for a new patient/complaint:

Location- Where the patient describes the complaint is, and where the patient points to the complaint .

Mechanism of Injury – How the symptoms started (insidious, or trauma).

Onset – Date of injury recorded as day/ month/year – If the patient cannot give a specific then "insidious onset" should be recorded with an approximate time of initiation of symptoms such as days, weeks, months, years, ago.

Palliative/Provocative - What makes it better (palliative)? What makes it worse



(provocative)?

Quality – Patient’s description of pain “ache” “toothache” “crampy” “ouchy” “nagging” etc.

Radiation or referral– Radiating, if not “patient denies radiation or referral of symptoms” or “symptoms remain local”

Severity – severity of sx’s “0-4” scale “0-10” scale – Pain diagram – Visual

AnalogueScale.

Temporal factors – Is chief complaint worse in the morning or evening? Is it constant or intermittent? Worse before or after specific activities?

Unrelated symptoms – Associated symptoms e.g. Headaches any other “unrelated” symptoms.

Various other health care providers– Seen any other healthcare providers for this condition?

Progression of symptoms: Is the condition getting worse, better, or remain the same. If better or worse, describe.

O - Writing Objective Findings

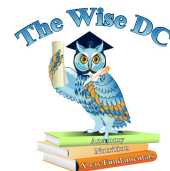
□ The objective part of the note is the section in which the results of tests and measurements performed and the physician’s objective observations of the patient are recorded. Objective data are the measurable or observable information used to plan patient treatment. Objective information reported in one note can be compared with measurements taken and recorded in the past to monitor patient progress.

□ Objective findings which may be found in S. O. A. P. notes may include orthopedic, neurologic, and chiropractic findings. A testing procedure that illicit a positive finding should be noted and re-tested on the next date of treatment.

□ Information derived from objective testing should be organized under headings, should be written in a clear and concise manner and should list the results of objective measurement procedures performed by the physician.

A - Writing Assessment

□ The assessment section of the daily office note provides a summary of the patients major problems as written in the Subjective and Objective parts of the note. Assessment includes diagnostic impressions, patient response to treatment, short term goals, long term goals and expected functional outcomes.



- ☐ Goals: 1) Written to help plan treatment that meets the needs and problems of the patient, 2) Prioritize treatment and measure effectiveness, 3) Communicate to a third party the duration, frequency and types of treatment needed to resolve the patient's problem.
- ☐ Short term goals are written as steps along the way to achieving long term goals.
- ☐ Long term goals are written to describe how each of the patient's problems will be finally resolved.
- ☐ Expected functional outcomes list the functional level that the patient is expected to reach by the time he or she is discharged from therapy.

P - Writing Plan

- ☐ The Plan part of the note is the final step in the planning process for patient care.
- ☐ Information that must be included in the plan section of a note: 1) Frequency that the patient will be seen.
2) Treatment provided and proposed.
- ☐ Information that may be included in the plan section of a note: 1) Location of the treatment (in office, at home, in a pool, gym). 2) Plans for further assessment, reassessment, or discharge 3) Equipment needs and equipment ordered. 4) Referral for cross discipline examination/treatment or ancillary diagnostic testing.

S.O.A.P. Note Example:

Date: ___1/01/2016_____

Patient's Name: _____

Patient's Signature: _____

Doctor's Signature: _____

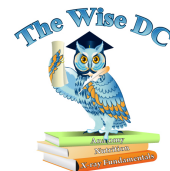
S - "I have a pain in my neck which travels down into my right arm and numbness in my right hand and fingers.

I feel about the same as I did yesterday."

O - Decreased, painful cervical flexion 35/50o; extension 28/60; right rotation 54/80; right lateral flexion 37/45; (+) positive Cervical Distraction, and Foraminal Compression on the right; all upper extremity reflexes are normal (biceps, C5; brachioradialis C6; triceps C7; finger flexors C8; hand intrinsic C8); (+) positive Tinel's and Phalen's Tests.

A - Cervical nerve root compression; carpal tunnel syndrome right wrist. Patient's response to treatment has been slow, complicated by work duties as a secretary. Short term goal is pain relief.

P - A change in treatment was discussed with the patient and implemented. Patient consent was given (see consent form). Diversified cervical adjustments to C5 PL



and C6 PL remain unchanged. The use of heat therapy to the cervical spine was discontinued, replaced by manual cervical traction. Treatment is to continue at 3x per week for 1 week followed by re-examination. Referral for neurological evaluation was advised. Drs. Johnson and Smith were recommended. The patient wants to consider this option and we will discuss further in one week.

Summary of Do's and Don'ts of Record Keeping

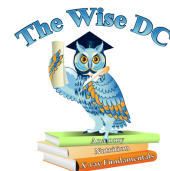
Do:

- ☐ Maintain records in ink.
- ☐ Make additions and changes appropriately.
- ☐ Identify patient name, date and year of service. Document unusual events.
- ☐ Identify the record keeper.
- ☐ Record all patient contacts.
- ☐ Maintain legibility.
- ☐ Maintain a legend for any codes used.
- ☐ Maintain records forever.
- ☐ Fill in all blanks or make a line through blank spaces.
- ☐ Initial all documents rather than scratching out the entire record.
- ☐ Customize the forms used.
- ☐ Document patient non-compliance.
- ☐ Proof-read correspondence and reports.

Don't:

- ☐ Erase, skip lines, leave spaces, “squeeze in” notes, use correction fluid, or back date or alter.
- ☐ Say anything disparaging about the patient.
- ☐ Avoid judgmental words.
- ☐ Ever enter data prematurely.
- ☐ Avoid ambiguous words.
- ☐ Criticize other providers.
- ☐ Use two different pens on the same day's entry.
- ☐ Alter records.
- ☐ Use computer generated notes unless individualized.

Other Types of Protective Documentation



Patient Sign - In Sheets

Daily patient sign-in sheets provide a handwritten record of a patient's presentation for care on a particular date. This protects against allegations of insurance fraud. Only the patient should sign the sheet with no substitutions. Some practice management companies tell their students to list 5, 10 or 15 fictitious names on their daily sign-in sheet before their first patient of the day arrives to produce an illusion of a successful office. This practice should be avoided. If uncovered, this dishonest act could destroy the credibility of the doctor in his community and could be a valuable tool for a plaintiff's attorney in a malpractice suit.

Patient Symptoms List

Create a symptoms list form and have the patient handwrite their symptoms and complaints. These lists can be used periodically, such as at the time of a re-examination, as their daily use would be too time consuming.

Example Symptoms List

Today I have neck, back and right leg pain with numbness in my right foot.

Date: _____

Patient: _____

Patient Signature: _____

Patient Progress Report

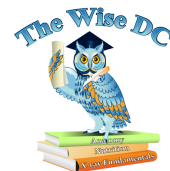
A patient progress report, written in their own words or checked off in a list format, done periodically, can offer a record of the patient's perception of clinical progress. For ultimate malpractice protection, the form must be completed, dated and signed by the patient only.

Example:

Patient Progress Report

Since my last exam:

1. Improved _____
2. Unchanged _____
3. Worse _____
4. Resolved _____
5. Other _____



Date: _____ Patient Name: _____ Patient
Signature: _____

Document Patient Non Compliance

A patient's failure to follow through with a doctor's recommendations should be documented. Every doctor will have a different tolerance level for non compliant patients. Examples of patient non compliance include:

- ☐ Failure of the patient to show for scheduled appointments.
- ☐ Failure of the patient to perform prescribed at home therapy such as the use of ice/heat or exercise.
- ☐ Failure of the patient to refrain from working, lifting, bending, sports activities, school, driving and housework.
- ☐ Failure of the patient to heed recommendations for life style modifications.

Non-Compliance Notifications

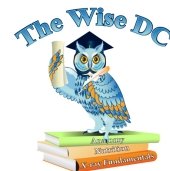
Non-compliant patients should be discharged from care, notified of their non-compliance specifying discussed and agreed to treatment plans, dates and types of non-compliance and referred to another provider of care when appropriate to prevent a claim of abandonment.

How Long Should You Keep Records?

As a general rule of thumb, maintain patient records forever. Also, be knowledgeable of the statute of limitations for your particular state. Most states have statutes of limitation of 3 - 7 years. This means that a malpractice claim must be made within 3-7 years after the date of the negligent act. There is an exception which applies to a negligent act against a child. A person that claims to have been a victim of a negligent act while they were a child must bring suit within one year after their 18th birthday.

Discharge Notations

Discharge notes summarize the treatment the patient received, the total number treatments received, patient response to treatment, any patient education performed, instructions or equipment given or sold to the patient, and recommendations for future treatment or follow up care.



Documentation Forms

Documentation forms decrease the amount of writing by the physician, increase the efficiency of documenting patient care, increase the consistency of documentation, provide consistent data gathering and present organized, clinical information that is more easily read by all of the parties who use the information.

Computerized Documentation

Advantages of Computerization Documentation

- ☐ Computers can have all of the orthopedic, neurologic and chiropractic tests and measurements readily available to the physician.
- ☐ Limitless space to place the information gathered.
- ☐ Documentation tailored to the specific needs of the physician.
- ☐ Information is presented in a clear, concise and legible manner.
- ☐ Quick data entry by simply touching a stylus to the computer screen.

Disadvantages of computerized documentation

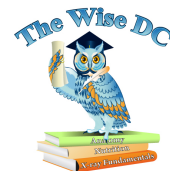
- ☐ Repetitive, unaltered reporting of daily subjective complaints, objective findings, assessment and plan will raise a red flag. Static clinical information implies unresponsiveness to the treatment rendered.
- ☐ Limitations of the computer program may limit reporting capabilities.

Patient Authorization

Before releasing a patients records to a third party, have the patient sign an authorization consenting to the release of their medical records. Never release original records and make sure that the authorizations are current (not more than approximately 60-90 days old).

(Example) Patient Authorization to Release Information and Medical Records

I authorize Dr. Smith and his employees to provide to the person(s) listed below, all medical information, and records requested, pertaining to any examination, treatment, or condition that I have had in the past, presently have, or may have in the future.



Party Requesting Records

Name: ____ Dr. Jones ____

Address: _____

Patient Name: _____

Patient's Signature: _____

Patient Address: _____

Date: _____

Treatment Withdrawal Letter

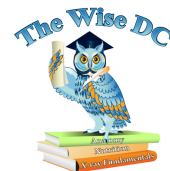
A treatment withdrawal letter, where a doctor unilaterally withdraws from providing services to a patient, is a letter of last resort. Prior to sending this letter, the doctor should send the patient a non-compliance notification specifying the patient's non-compliant actions (ex. Failure to perform prescribed at-home therapy, failure to lose weight, failure to follow work restrictions, and failure to make scheduled appointments etc.). If the patient's non-compliance can not be remedied, then it is advisable for the doctor to withdraw from treating the patient.

In the withdrawal letter the doctor must; offer the patient sufficient notice of withdrawal allowing the patient to find another doctor; send the letter certified, return receipt requested; maintain record of the letter in the patient's file. It is not imperative that the doctor specify the reasons for his withdrawal of treatment as the reasons were clearly specified in the prior non-compliance notification.

Recording History and Examination

Initial Case History

- ☐ Date and mechanism of the onset
- ☐ Nature and location of the injuries sustained
- ☐ Presenting subjective complaints (note the intensity, character, duration and frequency of the complaint)
- ☐ Past medical history
- ☐ Prior treatment for the presenting complaint
- ☐ Social/work/family history
- ☐ Physical, Orthopedic, Neurologic, Chiropractic Examination.
- ☐ Diagnostic x-rays and or other studies indicated by examination.



- ☐ Formulation of a Diagnostic Impression / Treatment Goals / Treatment Plan.
- ☐ Chiropractic treatment - manipulation, passive physiotherapy and active rehabilitation.
- ☐ Periodic re-examination performed approximately every 8-10 visits, every 30 days or as clinically necessary in the judgment of the attending physician.

Narrative Report Writing

All narrative reports should contain the following;

- ☐ The Beginning - which paints a picture for the reader explaining the onset of an injury or illness;
- ☐ The Middle - which contains the patient's current condition and the physical examination
- ☐ The End - This contains the bottom line of the report specifying the author's conclusions.

Report Format

Introduction (Beginning)

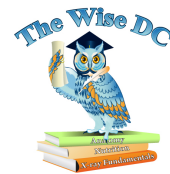
This portion of the report identifies the author, and date of the report, who requested the report, who the report is about, why the report was done, the date of accident and the type of examination performed.

Dear Mr. Thompson:

Tom Jones is a 27 year old male whom I examined at your request on January 2, 2016 for evaluation of injuries sustained in an automobile accident on December 20, 2015. I performed chiropractic evaluation of his head, spine, torso, and upper and lower extremities. The results of my evaluation are contained in the body of this report.

History of the Injury/Cause

This portion of the report should describe the date of injury, the mechanism of injury and the nature and location of the injuries sustained. Identify what transpired after the accident including any type of emergency room treatment or



hospitalization. Avoid embellishing the history with graphic terms that may infer bias. For example, "The patient experienced a bone-jarring impact that severely injured his spine".

Effect on Work or ADL's

Identify the patient's ability or inability to perform his normal and customary job requirements.

Past History

This section is used to reveal injuries, illnesses or accidents which may have a bearing on this particular accident. Identify prior accidents, treating providers, type of care rendered, the length of treatment, permanent restrictions or impairments and how long it has been since the patient was treated for that particular injury.

Surgical History

Record all surgical procedures.

Middle of the Report

Current Condition

This portion of the report should describe the patient's condition from head to toe. Each area of the body should be reported on, whether the patient complains of problems or not.

Physical Examination

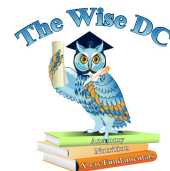
Reproduce your examination form findings in this portion of the narrative report to include vital signs, chiropractic analysis, range of motion, orthopedic and neurologic findings.

Roentgenological Analysis

Identify the date of examination, number and position of the views taken, assessment of bone alignment and quality, assessment of soft tissue structures, culminating with your clinical impression and diagnosis.

Diagnosis

This portion of the report states the condition detected. It is important to remember that the diagnosis should be a condition, such as subluxation and not a symptom,



such as cervicalgia. Avoid embellishing the diagnosis and using vague terms. For example; using the term multiple spinopelvic disrelationships, instead of pelvic subluxation. The diagnosis must be compatible with other portions of the report, understandable to others and summarize the patient's condition.

End of the Report

Comments and Conclusions

This portion of the report is often read first by third parties. Consequently, this section is often started with a summary of the facts of the case followed by your response to questions posed by the referral source regarding reasonableness and necessity of care, causal relation, apportionment permanent impairment and maximum chiropractic improvement.

Prognosis

In this section the author is asked to predict the future for the patient. Rely on your past experience in treating similar cases and support your opinions with available, current literature.

Future Medical Care

Opine whether future care will be curative or palliative in nature. Curative care provides improvement in the condition and infers the patient has yet to reach maximum chiropractic improvement. Palliative care provides relief for the patient but does not cure the effects of the injury.

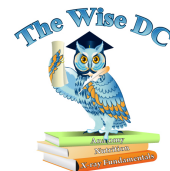
Documenting Maximum Chiropractic Improvement

☐ When the upper and lower limits of subjective pain have been established after a trial period of treatment.

For example, if after two months of regular chiropractic treatment, the patient reports feeling great for 24 hours following the adjustment only to return to the same intensity as before the adjustment. This signifies the patient will only attain palliative relief from the treatment and maximum improvement has been achieved.

☐ When the patient fails to progress clinically between treatments.

☐ When the patients symptoms worsen during the treatment program.(23)



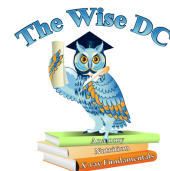
Documenting the Reasonableness and Necessity of Supportive Care

The following criteria must be documented to substantiate the reasonableness and necessity of supportive care;

- ☐ The patient must be deemed to have reached a point of maximum chiropractic improvement.
- ☐ There must be documented, objective evidence of a permanent injury.
- ☐ There must be documented, clinical trials of withdrawal from treatment which resulted in exacerbation.
- ☐ Supportive treatment should never be prescheduled and should be provided solely in response to a documented exacerbation.
- ☐ Supportive treatment should provide relief of symptoms/increased activities of daily living.
- ☐ Record attempts at alternate care and the patient's response
- ☐ Exhaust other forms of possible treatment
- ☐ Generally, this care will average approximately 2 visits per month.

Documenting the Reasonableness and Necessity of Ancillary Diagnostic Testing

The purpose of ancillary diagnostic testing (i.e. advanced imagery, electrodiagnostics, labs, etc.) is to aid in the development of a differential diagnosis. In general, to justify the referral for, or the provision of an ancillary diagnostic testing procedure, there must first have been a trial course of treatment which did not result in resolution of the patient's condition. Secondly, the attending chiropractor must document positive objective findings consistent with the type of testing procedure ordered or performed. Thirdly, the timing of the testing procedure is essential. For example, an E. M. G. test would not be clinically indicated on the date of injury. Lastly, the attending chiropractor must correlate the information derived from the testing procedure to the patient's condition and treatment plan.



Blue Cross Blue Shield Documentation Guidelines

Daily Treatment Documentation

Chiropractic claims require proper documentation and appropriate billing of codes to receive accurate reimbursement. Documentation should be legible and intelligible and clearly identify medical necessity. Failure to meet these requirements may result in claim denial or claims returned for more information. BCBS accepts chiropractic documentation in the following formats:

- Dictated and transcribed
- Legibly handwritten
- Templates – must be filled out completely

Documentation for all patient services must be dated and signed. Whiteout and excessive pen marks should not be used to modify or delete documentation. Use of standardized abbreviations can facilitate the documentation process. Non-standard abbreviations should be translated prior to submitting records to BCBS.

The most utilized and widely accepted method of record keeping is the SOAP format.

Documentation for Initial/New Patient

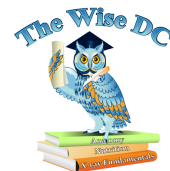
The complexity of the problem ascertained in the history may help determine the type of examination provided and how many elements of the examination will be included. The elements of the objective portion in a new patient record may include:

Vital signs

- Height
- Weight
- Blood pressure (which can be age and/or condition dependent)
- Pulse
- Respiration (if indicated by symptoms)
- Temperature (if indicated by febrile symptoms)

Observation

Observations can be measured with an inclinometer, a goniometer, or visually.



- Auscultation (if indicated by symptoms)
- Percussion (if indicated by symptoms)
- Palpation
- Range of Motion (this can relate to active ROM, passive ROM, and active assisted ROM)

Examination

This may include deep tendon and pathological reflexes if indicated by symptoms.

- Vascular examination (if indicated by symptoms)
- Provocative orthopedic tests
- Neurological testing, which may include cranial nerves
- Station, gait, and balance
- Sensory examination
- Muscle testing using Grade 0 thru 5
- Use of various other types of instrumentation and objective measurement

Assessment

The initial new patient assessment is based on the subjective and objective data and the physician's interpretation of this data. An assessment of any risk factors inconsistent with the data should be included.(24)

Billing Rules Article

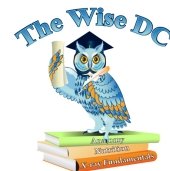
For Chiropractors: Know 97140 Billing Rules

Author : Heather M. Garcia, CBCS, CMAA, CMB

Healthcare Business Monthly Archive

July 1, 2014

“Aetna has made a nationwide policy decision for chiropractic reimbursement, which states that when manual therapy (97140 *Manual therapy techniques, one or more regions, each 15 minutes*) is performed on the same date of service (DOS) as a chiropractic manipulative treatment (98940-98943), the manual therapy will be denied, automatically. There are two options to overcome this:

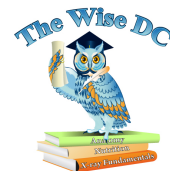


1. Perform the manual therapy service on a different DOS than the adjustment (if your state scope of services permits it); or
2. Submit the services together, anticipate the denial, and submit an appeal with your treatment records.

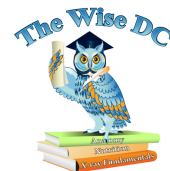
Keep in mind: Appeals will work if you are an out-of-network provider and will be less effective if you are an in-network provider. If you are in network, you have agreed to Aetna's policies (through your contracts), and you'll most likely need to write off reimbursement for 97140. In-network providers cannot bill the patient. Out-of-network providers can bill the patient, if necessary".(25)

Footnotes Documenting the Medical Necessity of Chiropractic Services

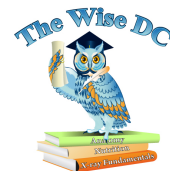
- 1) http://www.chiro.org/Medicare/ABSTRACTS/Medicare_Documentation_ACA.pdf
- 2) http://www.chiro.org/Medicare/ABSTRACTS/Medicare_Documentation_ACA.pdf
- 3) <https://medicare.com/resources/what-medically-necessary-means-and-how-it-affects-your-medicare-coverage/>
- 4) <https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912.html>
- 5) <https://www.ama-assn.org/ssl3/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/resources/html/PolicyFinder/policyfiles/HnE/H-320.953.HTM>
- 6) <http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>
- 7) <http://www.aetna.com/cpb/medical/data/100-199/0107.html>
- 8) <http://www.aafp.org/fpm/2006/0600/p45.html>
- 9) <http://www.law.uh.edu/faculty/jmantel/health-law/WicklinevState239CalRptr810.pdf>
- 10) (www.hcqualitycommission.gov).
- 11) (www.ncqa.org).
- 12) <http://www.athenahealth.com/knowledge-hub/icd-10/codes>
- 13) <http://www.wichiro.org/newicd10codes/>
- 14) <http://www.bcbsm.com/content/dam/public/Providers/Documents/help/faqs/icd10-payers-collaboration-chiropractic.pdf>



- 15) https://www.bluecrossma.com/staticcontent/review_guidelines/Revised_BCBS_MA_Chiropractic_Billing_Guidelines.pdf
- 16) <https://www.bcbsnd.com/documents/10476/35335/Chiropractic+Reference+Manual/be5f4f8c-98b2-459f-8dab-c300df94dae8>
- 17) The “Medicare Benefit Policy Manual,” Chapter 15, Section 30.5 – Chiropractor’s Services and Section 240 – Chiropractic Services, can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf> on the CMS website.
- 18) The “Medicare Claims Processing Manual,” Chapter 12, Section 220 – Chiropractic Services, can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf> on the CMS website.
- 19) Office of Inspector General, May 2009, “Inappropriate Medicare Payments for Chiropractic Services,” can be found at <http://oig.hhs.gov/oei/reports/oei-07-07-00390.pdf> on the Internet.
- 20) <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>
- 21) <http://docplus.net/training/PART.pdf>
- 22) <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CERTMedRecDoc-FactSheet-ICN909160.pdf>
- 23) Medical--Legal Issues In Chiropractic, Volume 1, 1990, Stephen M. Forman
- 24) <http://www.bcbsm.com/content/dam/public/Providers/Documents/help/faqs/bcc-provider-manual.pdf>
- 25) <https://www.aapc.com/blog/27688-for-chiropractors-know-97140-billing-rules/>
- 26) New York State Workers’ Compensation Board. New York mid and low back injury medical treatment guidelines. Second edition, January 14, 2013. Available at: <http://www.wcb.ny.gov/content/main/hcpp/MedicalTreatmentGuidelines/MidandLowBackInjuryMTG2012.pdf>. Accessed April 6, 2016.
- 27) New York State Workers’ Compensation Board. New York neck injury medical treatment guidelines. Second edition, January 14, 2013. Available at: <http://www.wcb.ny.gov/content/main/hcpp/MedicalTreatmentGuidelines/NeckInjuryMTG2012.pdf>. Accessed April 6, 2016.



- 28) New York State Chiropractic Association. Cervical spine injury chiropractic practice parameters and guidelines. Available at: http://www.nysca.com/w/files/NYSCA_proposed_WC_C-spine_guideline.pdf. Accessed April 6, 2016.
- 29) http://www.chiro.org/Medicare/ABSTRACTS/Medicare_Documentation_ACA.pdf
- 30) http://www.chiro.org/Medicare/ABSTRACTS/Medicare_Documentation_ACA.pdf
- 31) <https://medicare.com/resources/what-medically-necessary-means-and-how-it-affects-your-medicare-coverage/>
- 32) <https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912.html>
- 33) <https://www.ama-assn.org/ssl3/ecommerce/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/resources/html/PolicyFinder/policyfiles/HnE/H-320.953.HTM>
- 34) <http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>
- 35) <http://www.aetna.com/cpb/medical/data/100-199/0107.html>
- 36) <http://www.aafp.org/fpm/2006/0600/p45.html>
- 37) <http://www.law.uh.edu/faculty/jmantel/health-law/WicklinevState239CalRptr810.pdf>
- 38) www.hcqualitycommission.gov
- 39) www.ncqa.org
- 40) <http://www.athenahealth.com/knowledge-hub/icd-10/codes>
- 41) <http://www.wichiro.org/newicd10codes/>
- 42) <http://www.bcbsm.com/content/dam/public/Providers/Documents/help/faqs/icd10-payers-collaboration-chiropractic.pdf>
- 43) https://www.bluecrossma.com/staticcontent/review_guidelines/Revised_BCBS_MA_Chiropractic_Billing_Guidelines.pdf
- 44) <https://www.bcbsnd.com/documents/10476/35335/Chiropractic+Reference+Manual/be5f4f8c-98b2-459f-8dab-c300df94dae8>
- 45) The “Medicare Benefit Policy Manual,” Chapter 15, Section 30.5 – Chiropractor’s Services and Section 240 – Chiropractic Services, can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf> on the CMS website.



- 46) The “Medicare Claims Processing Manual,” Chapter 12, Section 220 – Chiropractic Services, can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf> on the CMS website.
- 47) Office of Inspector General, May 2009, “Inappropriate Medicare Payments for Chiropractic Services,” can be found at <http://oig.hhs.gov/oei/reports/oei-07-07-00390.pdf> on the Internet.
- 48) <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>
- 49) <http://docplus.net/training/PART.pdf>
- 50) <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CERTMedRecDoc-FactSheet-ICN909160.pdf>
- 51) Medical--Legal Issues In Chiropractic, Volume 1, 1990, Stephen M. Forman
- 52) <http://www.bcbsm.com/content/dam/public/Providers/Documents/help/faqs/bcc-provider-manual.pdf>
- 53) <https://www.aapc.com/blog/27688-for-chiropractors-know-97140-billing-rules/>
- 54) <http://www.codingahead.com/2011/11/cpt-codes-for-chiropractic-services.html>
- 55) <http://www.medicalbillingcodings.org/2015/04/em-evaluationandmanagement-codes-changesandupdates.html>