Medlearn Matters
Information for Medicare Providers

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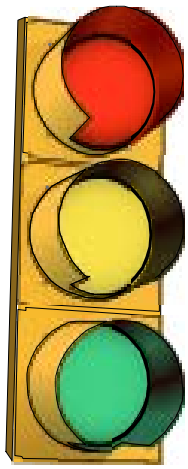
New Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy

Provider Types Affected

Chiropractic care providers.

Provider Action Needed



STOP – Impact to You

Chiropractors have been submitting a very high rate of incorrect claims to Medicare. 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.

CAUTION – What You Need to Know

On or after October 1, 2004, when you provide acute or chronic active/corrective treatment to Medicare patients, you must add the AT modifier to every one of your claims that use HCPCS codes 98940, 98941, or 98942. If you don't add this modifier, your care will be considered maintenance therapy and will be denied because maintenance chiropractic therapy is not medically reasonable or necessary under Medicare. Additionally, your billing staff should be aware of any local policy (LMRP/LCD) for these services in your area that might limit the frequency or circumstances under which active/corrective chiropractic can be paid. If you exceed that limit, you shall not use the AT modifier.

GO – What You Need to Do

Make sure that your billing staff are 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.

Background

Chapter 15, Section 30.5 of the Benefits Policy Manual states that chiropractic maintenance therapy is not medically reasonable or necessary, and is not payable under the Medicare program.

Further, Medicare data indicates that chiropractors filed claims incorrectly almost a third of the time, ranking chiropractor claims among the highest Provider Compliance Error Rates in Medicare. To bill Medicare correctly, use the AT modifier for each claim you submit that is for active/corrective therapy.

For services rendered on or after October 1, 2004, all of your claims for active/corrective therapy (HCPCS codes 98940, 98941, 98942) that do not contain the AT modifier will be denied. Claims above your contractors' frequency limits must be billed without the AT modifier (you may still add the GA or GZ modifier as appropriate), and will be denied.

Important Dates to Know

Effective Date: October 1, 2004

Implementation Date: October 4, 2004

Related Instructions

For more information about using the AT modifier, consult Chapter 15, Section 30.5 and 240.1.3 of the Benefits Policy Manual. In early October, you can access Chapter 15 at:

http://www.cms.hhs.gov/manuals/102_policy/bp102c15.pdf.

You can view this instruction before then at:

http://www.cms.hhs.gov/manuals/future.asp

Also, you may check any LMRP/LCDs that may apply to you at:

http://www.cms.hhs.gov/mcd.