Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST

1154

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
4114 - 4120 (Cont.)	4-31.2 - 4-34 (6 pp.)	4-31.2 - 4-34 (6 pp.)

CLARIFICATION/MANUALIZATION--EFFECTIVE/IMPLEMENTATION DATE: Not Applicable

Section 4118, Chiropractic Services, manualizes Program Memorandum B-99-20, which was effective July 1, 1999 and allowed chiropractors to act as suppliers of DMEPOS upon receipt of a valid supplier number from the National Supplier Clearinghouse.

NEW/REVISED MATERIAL--EFFECTIVE DATE: ***October 1, 2000***
IMPLEMENTATION DATE: ***October 1, 2000***

Section 4118, Chiropractic Services, mandates x-ray date and review requirements for x-rays when the chiropractor chooses to use an x-ray to show subluxation for claims with dates of services on or after October 1, 2000.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

4113. BILLING FOR SNF AND NF VISITS

Special modifiers are required for billing for visits to patients in SNFs and NFs. These modifiers enable you to:

- Administer the appropriate prepayment parameters for SNF and NF visits (see §§5210 and 5301); and

- Identify visits made by PAs, NPs, and CNSs for application of the appropriate payment limitations. (See §§5259 and 5301.)

Your system must be capable of accepting and employing two modifiers for each line item in order to administer these requirements.

Instruct billers to use the following modifiers for reporting visits to SNF and NF patients by physicians, PAs, NPs, and CNSs:

A. Physician Services, Team Member.--Modifier AM.

B. Physician Assistant Services, Non-Team Member.--Modifier AN.

C. Physician Assistant Services, Team Member.--Modifier AU.

D. Nurse Practitioner Services, Team Member, Non-Rural Area.--Modifier AL.

E. Nurse Practitioner Services, Team Member, Rural Area.--Modifier AK.

F. Nurse Practitioner Services, Non-Team Member, Rural Area.--Modifier AV.

G. Clinical Nurse Specialist Services, Team Member.--Modifier AY.

H. Clinical Nurse Specialist Services, Non-Team Member.--Modifier AW.

4114. BILLING PROCEDURES FOR MAXILLOFACIAL SERVICES

For dates of services January 1, 1996 and after, when the physician makes the prosthetic impression and constructs the prosthesis, the physician bills using CPT codes 21076 through 21089. In these instances, the cost of the prosthesis is included in the practice expense relative value units assigned to that specific CPT code. When a prosthetist or outside lab makes the prosthetic impression and constructs the prosthesis, the prosthetist/outside lab should bill the DMERC using the appropriate Level II HCPCS codes.

If the physician makes the prosthetic impression and a prosthetist or outside lab constructs the prosthesis, the physician bills using CPT code 21299 (unlisted craniofacial and maxillofacial procedure). Medical documentation must accompany the claim because of the use of an unlisted procedure code. The prosthetist or outside lab bills the DMERC using the Level II HCPCS codes.

Do not pay for both the CPT surgical code (other than 21299 for impression) and the Level II HCPCS code for these claims. The physician and the prosthetist/outside lab must bill separately for the procedures they have furnished.

4115. AMBULANCE SERVICES

You are responsible for processing ambulance service claims for non-hospital patients. The supplier uses Form HCFA-1491, Request for Medicare Payment - Ambulance.

Some items on Form HCFA-1491 may not be pertinent in some areas of the country. Instruct ambulance suppliers in your service area which items are essential for complete claims information. For example, in some areas an ambulance supplier only charges a base rate for specified services. In these instances, items 14, 15, and 16 are not completed.

Form HCFA-1491 contains the information necessary for you to perform the review described in §2125. Carefully review round trip ambulance services to outpatient dialysis facilities on a per visit basis for medical necessity. Deny claims for transportation to freestanding dialysis facilities for routine maintenance dialysis treatments.

When a beneficiary files a claim for ambulance services on Form HCFA-1491, the data required must accompany the claim. (See §3002.D about requesting ambulance suppliers to include this information on their office statements.) Corroborating evidence may be received in the form of a physician's bill for inpatient hospital or SNF visits.

(See §§3102B and 4105.5 regarding jurisdiction of suppliers with sales or rental outlets in multiple carrier service areas.)

4118. CHIROPRACTIC SERVICES

A. Verification of Chiropractor's Qualifications.--Establish a reference file of chiropractors eligible for payment as physicians under the criteria in §2020.26. Pay only chiropractors on file. Information needed to establish such files is furnished by the RO.

The RO is notified by the appropriate State agency which chiropractors are licensed and whether each meets the national uniform standards.

B. Durable Medical Equipment Regional Carriers Processing Claims When a Chiropractor is the Supplier.--Effective July 1, 1999, except for restrictions to chiropractor services as stipulated in §§1861(s)(2)(A) of the Social Security Act, chiropractors (specialty 35) can bill for durable medical equipment, prosthetics, orthotics and supplies if, as the supplier, they have a valid supplier number assigned by the National Supplier Clearinghouse. In order to process claims, the Common Working File has been changed to allow specialty 35 to bill for services furnished as a supplier.

C. Documentation.--The following information must be recorded by the chiropractor and kept on file. The date of the initial treatment or date of exacerbation of the existing condition must be entered in Item 14 of Form HCFA-1500. (See §2010.2.) This serves as affirmation by the chiropractor that all documentation required as listed below and in §2251.2B is being maintained on file by the chiropractor.

1. Specification of the precise spinal location and level of subluxation (see §2251.4) giving rise to the diagnosis and symptoms.

2. Effective for claims with dates of service on and after January 1, 2000, the x-ray is no longer required. However, the x-ray may still be used to demonstrate subluxation for claims processing purposes. Effective for claims with dates of service on or after October 1, 2000, when the x-ray is used to demonstrate subluxation, the date of the x-ray must be entered in Item 19 of the HCFA-1500 and the date must be within the parameters specified in §2251.2.

For claims with dates of service prior to January 1, 2000 and for claims with dates of service on or after October 1, 2000 for which an x-ray is still used to show subluxation, the following instructions on documentation apply:

An x-ray film (including the date of the film) is available for your review demonstrating the existence of a subluxation at the specified level of the spine. If the beneficiary refuses to have the x-ray, the chiropractor must submit one of the appropriate HCPCS codes for chiropractic manipulation in addition to modifier GX (service not covered by Medicare), and the claim will be denied as a technical denial.

The following Medicare Summary Notice (MSN)/Explanation of Medicare Benefits (EOMB) message should be generated.

"This service is covered only when recent x-rays support the need for the service." (MSN message 3.1.)

"Medicare pays for the services of a chiropractor only when "recent" x-rays support the need for the services. Recent means the x-rays were taken within the last 12 months." (EOMB message 3.1.)

On the provider remittance, use existing American National Standard Institute (ANSI) X12-835 claims adjustment reason code 96, noncovered charges. In addition, install and include the following new line level remark code M111, " We do not pay for chiropractic manipulative treatment when the beneficiary refuses to have an x-ray taken."

NOTE: The refusal of the beneficiary to have an x-ray taken will no longer need to be coded for claims with dates of service on or after January 1, 2000.

D. Claims Processing.--Edits and suggested MSN, EOMB, and remittance advice (RA) messages.

1. Do not pay for manual manipulation of the spine in treating conditions other than those indicated in §2251.3 and deny claims for treatment of any condition not reasonably related to a subluxation involving vertebrae at the spinal level specified. As appropriate, use the MSN 15.4, "The information provided does not support the need for this service or item." or the EOMB 15.9, "The information we have in your case does not support the need for this service." For the RA, use the Claims Adjustment Reason Code 50, "These are non-covered services because this is not deemed a 'medical necessity' by the payer."

2. Edit to verify that the claim has the primary diagnosis of subluxation. As appropriate, use the MSN 15.4, "The information provided does not support the need for this service or item." or the EOMB 15.9, "The information we have in your case does not support the need for this service." For the RA, use the Claims Adjustment Reason Code B22, "This claim/service is denied/reduced based on the diagnosis."

3. Edit to verify that the date of the initial visit or the date of exacerbation of the existing condition is entered in Item 14 of Form HCFA-1500 (see §2010.2). As appropriate, use the MSN, "This item or service was denied because information required to make payment was missing." or the EOMB 9.8, "Medicare cannot pay for this service because the claims is missing information/documentation." For the RA, use the Claims Adjustment Reason Code 16, "Claim/service lacks information which is needed for adjudication."

E. X-ray Review.-- Effective for claims with dates of service on and after January 1, 2000, the x-ray is no longer required. However, effective for claims with dates of service on or after October 1, 2000, should the chiropractor choose the use the x-ray to show subluxation, the x-ray review process is still required as outlined below minus the requirement in the last sentence of number 2. For claims with dates of service prior to January 1, 2000, all aspects of the following instructions still apply.

1. Carriers should conduct post-payment reviews of x-rays on a sample basis. Prepayment review should be undertaken in all questionable cases.

2. It is the responsibility of the treating chiropractor to make the documenting x-ray(s) available to the carrier's review staff. If x-rays are not made available, or suggest a pattern in failing to demonstrate subluxation for any reason, including unacceptable technical quality, the carrier should conduct prepayment review of x-rays in 100 percent of the subsequent claims for treatments by the practitioner involved until satisfied that the deficiency will no longer occur. Where there is no x-ray documentation of subluxation on prepayment review, the claims, of course, should be denied. (The last sentence of this paragraph only refers to claims with dates of service prior to January 1, 2000.)

3. The x-ray film(s) must have been taken at a time reasonably proximate to the initiation of the course of treatment and must demonstrate a subluxation at the level of the spine specified by the treating chiropractor on the claim. (See §2251.2B.)

4. An x-ray obtained by the chiropractor for his own diagnostic purposes before commencing treatment should suffice for claims documentation purposes. However, when subluxation was for treatment purposes diagnosed by some other means and x-rays are taken to satisfy Medicare's documentation requirement, carriers should ask chiropractors to cone in on the site of the subluxation in producing x-rays. Such a practice would not only minimize the exposure of the patient but also should result in a film more clearly portraying the subluxation.

5. An x-ray will be considered of acceptable technical quality if any individual trained in the reading of x-rays could recognize a subluxation if present.

6. When claims have been denied because the x-ray(s) initially offered failed to document the existence of a subluxation requiring treatment, no review of these decisions should be undertaken on the basis of x-ray(s) subsequently taken. Permitting such reviews could be an inducement to excessive exposure of patients to radiation in cases where the decision to treat was made despite x-rays that did not show a subluxation.

4120. FOOT CARE

4120.1 Application of Foot Care Exclusions to Physicians' Services.--The exclusion of foot care is determined by the nature of the service (§2323). Thus, reimbursement for an excluded service should be denied whether performed by a podiatrist, osteopath, or a doctor of medicine, and without regard to the difficulty or complexity of the procedure.

When an itemized bill shows both covered services and noncovered services not integrally related to the covered service, the portion of charges attributable to the noncovered services should be denied. (For example, if an itemized bill shows surgery for an ingrown toenail and also removal of calluses not necessary for the performance of toe surgery, any additional charge attributable to removal of the calluses should be denied.)

In reviewing claims involving foot care, the carrier should be alert to the following exceptional situations:

1. Payment may be made for incidental noncovered services performed as a necessary and integral part of, and secondary to, a covered procedure. For example, if trimming of toenails is required for application of a cast to a fractured foot, the carrier need not allocate and deny a portion of the charge for the trimming of the nails. However, a separately itemized charge for such excluded service should be disallowed. When the primary procedure is covered the administration of anesthesia necessary for the performance of such procedure is also covered.

2. Payment may be made for initial diagnostic services performed in connection with a specific symptom or complaint if it seems likely that its treatment would be covered even though the resulting diagnosis may be one requiring only noncovered care.

3. Payment may be made for routine-type foot care such as cutting or removal of corns, calluses, or nails when the patient has a systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous (§2323C).

a. Claims for such routine services would show in item 7D of the SSA-1490 the complicating systemic disease. Where these services were rendered by a podiatrist this item should also include the name of the M.D. or D.O. who diagnosed the complicating condition. In those cases where active care is required, the approximate date the beneficiary was last seen by such physician must also be indicated.

NOTE: Section 939 of P.L. 96-499 removed "warts" from the routine foot care exclusion effective July 1, 1981.