CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 137 **Date: APRIL 9, 2004**

CHANGE REQUEST 3234

I. SUMMARY OF CHANGES: This change will add to the Internet Only Manual (IOM) the information from Part 3, Section 4118 of the Medicare Carriers Manual that was erroneously omitted during the transition to the IOM.

CLARIFICATION/MANUALIZATION - EFFECTIVE DATE: N/A
***IMPLEMENTATION DATE: N/A**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	12/220/Chiropractic Services

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Medicare Claims Processing Manual

Chapter 12 - Physicians/Nonphysician Practitioners

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(Rev. 137, 04-09-04)

220 – Chiropractic Services

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B3-4118

A - Verification of Chiropractor's Qualifications

Establish a reference file of chiropractors eligible for payment as physicians under the criteria in Pub. 100-02, Benefits Policy Manual, Chapter 15, Sections 30.5 & 240A. 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 CMS-1500. This serves as affirmation by the chiropractor that all documentation required as listed below and in Pub. 100-02, Benefits Policy Manual, Chapter 15, Section 240.1.2 is being maintained on file by the chiropractor.

1. Specification of the precise spinal location and level of subluxation (see Pub. 100-02, Benefits Policy Manual, Chapter 15, Section 240.1.4) 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 Form CMS-1500 and the date must be within the parameters specified in Pub. 100-02, Benefits Policy Manual, Chapter 15, Section 240.1.2.

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) message must be generated:

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

The following remittance advice (RA) message must be generated:

Claims adjustment reason code 96, - "noncovered charge (s)," and

Line level remark code M111, " We do not pay for chiropractic manipulative treatment when the patient 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 and RA messages.

1. Do not pay for manual manipulation of the spine in treating conditions other than those indicated in Pub. 100-02, Benefits Policy Manual, Chapter 15, Section 240.1.3 and deny claims for treatment of any condition not reasonably related to a subluxation involving vertebrae at the spinal level specified. Use the MSN 15.4, "The information provided does not support the need for this service or item." 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. Use the MSN 15.4, "The information provided does not support the need for this service or item." For the RA, use the Claims Adjustment Reason Code B22, "This payment is adjusted 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 CMS-1500. Use the MSN 9.2, "This item or service was denied because information required to make payment was missing." For the RA, use the Claims Adjustment Reason Code 16, "Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate."

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 to 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 Pub. 100-02, Benefits Policy Manual, Chapter 15, Section 240.1.2.)

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 hone 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.