DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®

Official Information Health Care Professionals Can Trust

Chiropractic Services

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

No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's order is covered. For instance, if a chiropractor orders, takes, or interprets an x-ray, or any other diagnostic test, the x-ray or other diagnostic test, can be used for claims processing purposes, but Medicare coverage and payment are not available for those services. This prohibition does not affect the coverage of x-rays or other diagnostic tests furnished by other practitioners under the program. For example, an x-ray or any diagnostic test taken for the purpose of determining or demonstrating the existence of a subluxation of the spine is a diagnostic x-ray test covered under Section 1861(s)(3) of the Social Security Act if ordered, taken, and interpreted by a physician who is a doctor of medicine or osteopathy. (Effective July 1, 1999, chiropractors can bill for durable medical equipment (DME), prosthetics, orthotics and supplies if, as the supplier, they have a valid supplier number assigned by the National Supplier Clearinghouse. However, a chiropractor will not be reimbursed if they order the DME.)

Effective for claims with dates of service on or after January 1, 2000, an x-ray is not required to demonstrate the subluxation. However, an x-ray may be used for this purpose if the chiropractor so chooses. The x-ray must have been taken reasonably close to (within 12 months prior or 3 months following) the beginning of treatment. In certain cases of chronic subluxation (for example, scoliosis), an older x-ray may be accepted if the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent. A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated.

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: pain/tenderness evaluated in terms of location, quality, and intensity; asymmetry/misalignment identified on a sectional or segmental level; range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or decrease of sectional or segmental mobility); and tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

Qualifications for Chiropractor

Prior to July 1, 1974

Chiropractors licensed or authorized to practice prior to July 1, 1974, and those individuals who commenced their studies in a chiropractic college before that date must meet all of the following three minimum standards to render payable services under the program:

- Preliminary education equal to the requirements for graduation from an accredited high school or other secondary school;

- Graduation from a college of chiropractic approved by the State's chiropractic examiners that included the completion of a course of study covering a period of not less than 3 school years of 6 months each year in actual continuous attendance covering adequate course of study in the subjects of anatomy, physiology, symptomatology and diagnosis, hygiene and

sanitation, chemistry, histology, pathology, and principles and practice of chiropractic, including clinical instruction in vertebral palpation, nerve tracing, and adjusting; and

- Passage of an examination prescribed by the State's chiropractic examiners covering the subjects listed above.

After June 30, 1974

- Individuals commencing their studies in a chiropractic college after June 30, 1974, must meet all of the above three standards and all of the following additional requirements:
- Satisfactory completion of 2 years of pre-chiropractic study at the college level;
- Satisfactory completion of a 4-year course of 8 months each year (instead of a 3-year course of 6 months each year) at a college or school of chiropractic that includes not less than 4,000 hours in the scientific and chiropractic courses specified in the second bullet under "Prior to July 1, 1974" above, plus courses in the use and effect of x-ray and chiropractic analysis; and
- The practitioner must be over 21 years of age.

Eligibility – All Medicare beneficiaries enrolled in Part B.

Scenario/Situations

Scenario (If this happens)	Action to be Taken (Then)	References
A non-participating (non-par) provider of chiropractic services chooses to accept assignment on a particular claim.	The Medicare reimbursement is five percent less than a participating provider, as reflected in the annual Medicare Physician Fee Schedule. The amount paid by the beneficiary must be reported in Item 29	Addressing Misinformation Regarding Chiropractic Services and Medicare http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Chiropractors_fact_sheet.pdf
A non-par provider of services chooses not to accept assignment on a particular claim.	The Medicare reimbursement is five percent less than a participating provider, as reflected in the annual Medicare Physician Fee Schedule and Medicare's payment is made to the beneficiary.	Medicare Claims Processing Manual, Chapter 1, Section 30.3 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
A chiropractor provides a service which is supportive rather than corrective.	The treatment is considered maintenance therapy and is not payable.	Addressing Misinformation Regarding Chiropractic Services and Medicare http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Chiropractors_fact_sheet.pdf
The term(s) used to describe the service performed suggests that it may not have been treatment by means of manual manipulation.	The Medicare carrier (or Medicare Administrative Contractor (MAC)) analyst refers the claim for professional review and interpretation.	Medicare Benefit Policy Manual; Chapter 15; Section 240 –Chiropractic Services http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

Exceptions / Error Messages ons

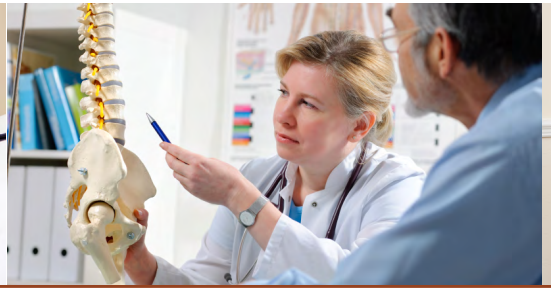
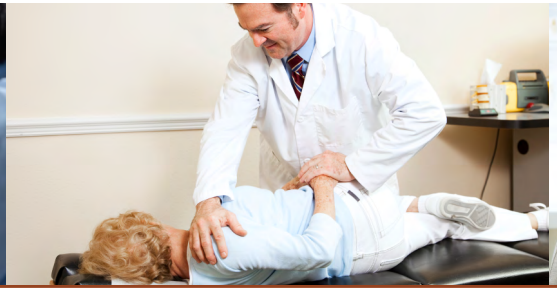
Scenario (If this happens)	Action to be Taken (Then)	References
Further clinical improvement cannot reasonably be expected from continuous ongoing care making the chiropractic treatment supportive rather than corrective in nature.	The treatment is then considered maintenance therapy, which is defined by Medicare as "not reasonable and necessary" and therefore not reimbursable by Medicare.	Medicare Benefit Policy Manual; Chapter 15; Section 240 – Chiropractic Services http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
A chiropractor provided manual manipulation of the spine in treating conditions other than those indicated in the Medicare Benefits Policy Manual, Chapter 15, Section 240.1.3 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html on the CMS website.	Payment will not be made and the following messages will be issued: Medicare Summary Notice (MSN) 15.4, "The information provided does not support the need for this service or item." Claims Adjustment Reason Code 50, "These are non-covered services because this is not deemed a "medical necessity" by the payer."	Medicare Claims Processing Manual, Chapter 12 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
The claim does not have a primary diagnosis of subluxation.	MSN 15.4, "The information provided does not support the need for this service or item." Claims Adjustment Reason Code B22, "This payment is adjusted based on the diagnosis."	Medicare Claims Processing Manual, Chapter 12 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
The date of the initiation of the course of treatment is not entered in Item 14 of Form CMS-1500.	MSN 9.2, "This item or service was denied because information required to make payment was missing." 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."	Medicare Claims Processing Manual, Chapter 12 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

Payment Requirements

CMS-1500 Form Field	Information to Enter	ANSI 4010A1 Format
Item 14	The treatment is then considered maintenance therapy, which is defined by Medicare as "not reasonable and necessary" and therefore not reimbursable by Medicare.	Medicare Benefit Policy Manual; Chapter 15; Section 240 – Chiropractic Services http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Item 17	Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data. When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 will be used for each ordering/referring physician. **Note: The only time that Item 17 needs to be completed for chiropractic services is when an xray service is billed on the claim form for denial purposes, since it is an ordered service.**	2310A NM103
Item 17b	Enter the NPI of the referring/ordering physician listed in Item 17b. All physicians who order services or refer Medicare beneficiaries must report this data.	Loop 2310A NM109
Item 19	Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date if an x-ray, rather than a physical examination, was the method used to demonstrate the subluxation. By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, is on file, along with the appropriate x-ray and all are available for carrier review.	Loop 2300 PWK01,02,05,06
Item 21	**Note: For chiropractic claims use an ICD-9-CM in the 739 series specifying subluxationfor the primary diagnosis and a secondary ICD-9-CM for the symptoms associated with the diagnosis of subluxation, which can be found in the local coverage determination (LCD) of your Medicare contractor.** Up to four ICD-9-CM codes can be used. Although Item 21 can only contain the diagnoses for two regions treated and its corresponding symptoms, the clinical record MUST document the additional primary and secondary diagnoses justifying treatment of the additional regions billed.	Loop 2300 HI01-2 HI02-2 HI03-2 HI04-2

Payment Requirements

CMS-1500 Form Field	Information to Enter	ANSI 4010A1 Format
Item 24D	Enter the appropriate CPT code that best describes the service: **98940:** Chiropractic manipulative treatment (CMT); spinal, one or two regions **98941:** spinal, three to four regions **98942:** spinal, five regions **98943:** CMT, extraspinal, one or more regions is not covered by Medicare. **AT modifier** must be used on a claim for covered services (98940, 98941, and/or 98942) when providing active/corrective treatment to treat acute or chronic subluxation **GA modifier** to indicate that you expect Medicare will deny a service as not reasonable and necessary and that you do have on file an Advance Beneficiary Notice (ABN) signed by the beneficiary **GZ modifier** to indicate that you expect that Medicare will deny an item or service as not reasonable and necessary and that you have not had an ABN signed by the beneficiary), as appropriate on covered services **GY modifier** must be used when suppliers want to indicate that the item or supply is statutorily noncovered or is not a Medicare benefit (all chiropractic codes other than 98940, 98941, and 98942)	Loop 2300 HI01-2 HI02-2 HI03-2 HI04-2
Item 29	If a non-par provider chooses to accept assignment, the amount paid by the beneficiary must be reported.	Loop 2300 AMT02

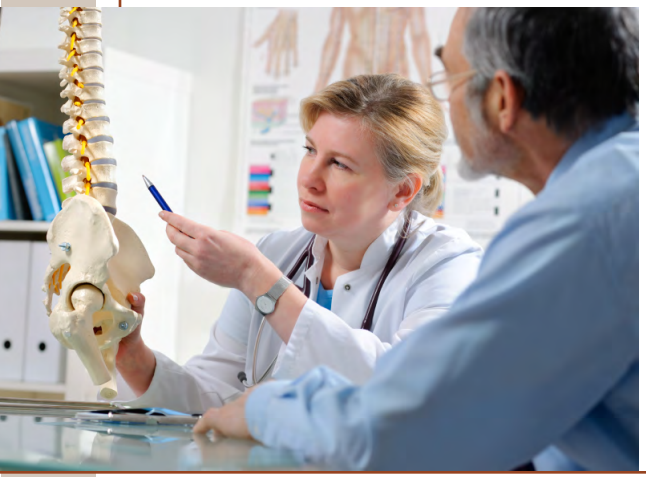

Frequently Asked Questions

Are there any visit caps or limits for chiropractic services?

No. There are no caps/limits in Medicare for covered chiropractic care rendered by chiropractors who meet Medicare's licensure and other requirements as specified in the Medicare Benefit Policy Manual, Chapter 15, Section 30.5 (available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html** on the CMS website). There may be review screens (numbers of visits at which the Medicare Carrier or A/B MAC may require a review of documentation), but caps/limits are not allowed.

Do non-participating (non-par) providers of chiropractic services have to bill Medicare for services to Medicare beneficiaries?

Yes. Being non-par does not mean the provider doesn't have to bill Medicare. All Medicare covered services must be billed to Medicare, or the provider could face penalties. For more details on participating and non-par providers, see the fact sheet entitled "Medicare Enrollment for Physicians, Non-Physician Practitioners, and Other Health Care Suppliers" at **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/suppliers.pdf** on the CMS website.



Is it true that non-par providers are not subject to Medicare audits/ reviews?

No. The non-par or participating (par) status of the physicians does not affect the possibility of any of their Medicare claims being audited/reviewed. CMS audits/reviews are intended to protect Medicare trust funds and to identify billing errors so providers and their billing staff can be alerted to errors and educated on how to avoid future errors.

Can chiropractors opt out of Medicare?

No. Opting out of Medicare is not an option for Doctors of Chiropractic. Being non-participating and opting out are not the same things. Chiropractors may decide to be participating or non-participating with regard to Medicare, but they may not opt out. For further discussions of the Medicare "opt out" provision, see the Medicare Benefit Policy Manual (Chapter 15, Section 40; Definition of Physician/ Practitioner) at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf** on the CMS website.

Can chiropractors (specialty 35) ever bill for durable medical equipment, prosthetics, orthotics, and supplies?

Yes. If as the supplier, they have a valid supplier number assigned by the National Supplier Clearinghouse and Medicare's rules for ordering the supplies are followed. However, a chiropractor who is a supplier cannot both order and furnish the DME. If a chiropractor orders DME, it will not be reimbursed.

Under what circumstances should the chiropractor get an ABN signed by the patient?

The decision to deliver an ABN must be based on a genuine reason to expect that Medicare will not pay for a particular service on a specific occasion for that beneficiary due to lack of medical necessity for that service. The beneficiary can then make a reasonable and informed decision about receiving and paying for the service. If the beneficiary decides to receive the service, the chiropractor must submit a claim to Medicare even though it is expected that Medicare will deny the claim and that the beneficiary will pay, unless the beneficiary selects option 2 on the ABN.

What are the covered chiropractic services under Medicare?

Spinal manipulation is a covered service under Medicare. Acute, chronic, and maintenance adjustments are all "covered" services, but only acute and chronic services are considered active care and therefore, may be reimbursable. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment moves from corrective to supportive in nature, the treatment is then considered maintenance therapy.

Do non-par providers have the same documentation requirements as par providers?

Yes. Chiropractic care has documentation requirements to show medical necessity. The participating status of the provider is not relevant to the documentation requirements.

How does Medicare define subluxation?

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 services remains intact. A subluxation may be demonstrated by an x-ray or by a physical examination.

Are maintenance therapy services covered by Medicare?

Chiropractic maintenance therapy is not considered to be medically reasonable or necessary under the Medicare program, and is therefore not payable.

How does Medicare define maintenance therapy services?

Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition.

How should a chiropractor bill for maintenance services?

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.

How can a subluxation be demonstrated?

A subluxation may be demonstrated by an x-ray or by physical examination.

Are Chiropractors eligible for bonus incentive programs?

Doctors of Chiropractic are eligible for the eRx Incentive Program and the Physician Quality Reporting Initiative (PQRI) additional payments. Chiropractors are not eligible for incentive payments for Physician Scarcity Area payments.

What expenses for chiropractic services is the beneficiary responsible for in 2013?

In 2013, for approved Part B services, the beneficiary will pay the Part B deductible and then 20% of the Medicare-approved amount. The beneficiary will also pay all costs for any non-covered services. Beneficiary cost-sharing for Part C (Medicare Advantage) services will vary according to plan benefits.

What needs to be done to have a claim considered for Medicare Secondary Payer benefits?

For a paper claim to be considered for Medicare Secondary Payer benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form. (See Medicare Secondary Payer Manual, Chapter 3).

Do I have to submit a claim to Medicare if the beneficiary agrees to pay for the service?

Remember that, no matter what the beneficiary is willing to agree to, you have fee restrictions in place and Mandatory Claim Submission still applies. The only exception to this would be if the beneficiary specifically requests that you NOT bill Medicare. In that instance, you would NOT submit a claim, but the fee restrictions would still apply.

Do I have to submit a claim to Medicare, even though I know the service will be denied and the beneficiary has agreed to pay?

This is one of the purposes of the Advance Beneficiary Notice (ABN). If you have a covered service you feel will be denied, you would present an ABN to the beneficiary. If they choose Option #1, yes, you would still be required to submit a claim. If the beneficiary chooses Option #2, then you would not be able to submit a claim.

CMS Manual References

Medicare Benefit Policy Manual; Chapter 15 Section 240 – Chiropractic Services **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf**

Medicare Claims Processing Manual Chapter 12; Section 220 – Chiropractic Services **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf**

Other References

Addressing Misinformation Regarding Chiropractic Services and Medicare **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Chiropractors_fact_sheet.pdf**

MLN Matters® article: Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR3063. **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm3449.pdf**

What Doctors Need to Know about the Advance Beneficiary Notice (ABN) **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf**

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