Coding and Payment Guide for Chiropractic Services

A comprehensive coding, billing, and reimbursement resource for chiropractic services
Contents

Introduction ................................................................. 1
Coding Systems ............................................................ 1
Claim Forms ............................................................... 2
Contents and Format of This Guide ......................... 2

The Reimbursement Process ......................................... 5
Payer Types .................................................................. 5
Coverage Issues ......................................................... 9
Payment Methodologies ............................................. 9
Modifier Use .................................................................. 12
Other Factors Influencing Payment ......................... 12
Participation in Medicare Plans ................................. 25
Supplemental Medicare Coverage ......................... 26

Documentation—An Overview ......................................... 33
Methods of Documentation ........................................ 33
General Guidelines for Documentation .................. 34
Principles of Documentation ...................................... 34
Fraud and Abuse ....................................................... 36

Claims Processing ........................................................ 41
The CMS-1500 Claim Form ........................................... 53
The UB-04 Claim Form .............................................. 66

Procedure Codes ........................................................... 73
Structure of the CPT Coding System ....................... 73
CPT Coding Conventions ........................................... 73
Unlisted Procedures and Modifiers ....................... 74
Payment for Surgical Services and Procedures .......... 75
Evaluation and Management Services .................. 75

HCPCS Level II Definitions and Guidelines .............. 221
Symbols ..................................................................... 221
Modifiers .................................................................... 221
HCPCS Level II Codes ............................................... 222

ICD-9-CM Index .......................................................... 231
ICD-9-CM Coding Conventions .............................. 231
Coding Neoplasms ................................................... 231
Manifestation Codes ................................................ 232
Official ICD-9-CM Guidelines for Coding and Reporting .............................................................. 232
ICD-9-CM Codes ........................................................ 234

Alphabetic Index to External Causes of Injury and Poisoning (E Code) ............................................. 273

Medicare Official Regulatory Information ................. 287
### Coding and Payment Guide for Chiropractic Services

**Introduction**

Billing language that providers and payers can use for payment purposes. The codes are required for billing by both private and public insurance carriers, managed care companies, and workers' compensation programs. A requirement of HIPAA is that CPT codes are used for the reporting of physician and other health care services.

The AMAV CPT Editorial Panel reviews the coding system and adds, revises, and deletes codes and descriptions. The panel accepts information and feedback from providers about new codes and revisions to existing codes that could better reflect the services.

The majority of codes are found in category I of the CPT coding system. These five-digit numeric codes describe procedures and services that are customarily performed in clinical practices.

CPT category II codes are supplemental tracking codes that are primarily used when participating in the Physician Quality Reporting Initiative (PQRI) established by Medicare and are intended to aid in the collection of data about quality of care. At the present time, participation in this program is optional and physicians should not report these codes if they elect not to participate. Category II codes are alphanumeric, consisting of four digits followed by an "H" and should never be used in lieu of a category I CPT code. This series of codes is updated on a biannual basis (January 1 and July 1), with codes that are released becoming effective six months later (e.g., codes released on January 1 become effective July 1). Refer to the AMA CPT website at [http://www.ama-assn.org/go/cpt](http://www.ama-assn.org/go/cpt) for the most recent list.

Category III of the CPT coding system contains temporary tracking codes for new and emerging technologies that are meant to aid in the collection of data on these new services and procedures. Indicated by four numeric digits followed by a "T." Like category II codes, Category III CPT codes are released twice a year (January 1 and July 1) and can be found on the AMA CPT website. RVUs are not assigned for these codes, and payment is made at the discretion of the local payer. Once implemented, a service described by a category III CPT code may eventually become a category I code.

**HCPCS Level II Codes**

HCPCS Level II codes are commonly referred to as national codes or by the acronym HCPCS (Healthcare Common Procedure Coding System—pronounced "H piks"). HCPCS codes are used for billing Medicare and Medicaid patients and have also been adopted by some third-party payers.

HCPCS Level II codes, updated periodically and published annually by CMS, are intended to supplement the CPT coding system by including codes for nonphysician services, durable medical equipment (DME), and office supplies. These Level II codes consist of one alphabetic character (A through Z) followed by four numbers. Non-Medicare acceptance of HCPCS Level II codes is inconsistent. Providers should check with the payer before billing these codes.

**Claim Forms**

Institutional (facility) providers use the UB-04 claim form, also known as the CMS-1450, or the electronic format using the 837I to file a Medicare Part A claim. Noninstitutional providers and suppliers (private practice or other health care providers' offices) use the CMS-1500 form or the 837P electronic format to submit claims for Medicare Part B covered services. Medicare Part A coverage includes inpatient hospital, skilled nursing facilities, hospice, and home healthcare. Medicare Part B coverage provides payment for medical supplies and physician and outpatient services.

Not all services rendered by a facility are inpatient services. Providers working in facilities routinely render services on an outpatient basis. Outpatient services are provided in settings that include rehabilitation centers, certified outpatient rehabilitation facilities, skilled nursing facilities, and hospitals. Outpatient and partial hospitalization facility claims might be submitted on a CMS-1500, UB-04, or their electronic equivalents, depending on the payer. For professional component billing, most claims are filed using ICD-9-CM diagnosis codes, CPT procedure codes, and HCPCS Level II codes to report supplies on the CMS-1500 paper claim or the 837P electronic format.

A step-by-step guide for completing the CMS-1500 and UB-04 claim forms and an explanation of the claims filing process is in the claims processing section.

**Contents and Format of This Guide**

CPT coding and payment guide for Chiropractic Services has three sections: reimbursement, definitions and guidelines, and Medicare official regulatory information.

**Reimbursement**

The first section of the guide provides comprehensive information about the coding and reimbursement process. It has three chapters: "Documentation—An Overview," "The Reimbursement Process," and "Claims Processing." CMS relative value units for CPT codes are identified in the definitions and guidelines section.

**Definitions and Guidelines**

The second section provides definitions and guidelines for CPT, HCPCS Level II, and ICD-9-CM codes.

**CPT and HCPCS Level II Definitions and Guidelines**

This section begins with the standard coding definitions and guidelines for CPT codes. Following the CPT definitions and guidelines is a listing of the most common CPT codes applicable to chiropractic services. At the top of each page you will find a CPT code or CPT code range with its official description, followed by an explanation of the procedure or supply, and coding tips. The listed CPT codes are crosswalked to HCPCS Level II codes, common ICD-9-CM codes, relative value units, and, when applicable, coding tips, terms to know, Medicare manual section reference numbers, and Correct Coding Initiative (CCI) edits (mutually exclusive edits are indicated by the "x" symbol). A numeric listing of CPT laboratory codes completes this section. The HCPCS Level II definitions and guidelines, with an alphanumeric listing of the common HCPCS Level II codes, follows. All this information is designed to allow the user to appropriately code and bill for services.
ICD-9-CM Diagnostic Codes

707.15 Ulcer of other part of foot — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)
707.8 Chronic ulcer of other specified site
707.9 Chronic ulcer of unspecified site

Explanation
Selective techniques are those in which the physician has complete control over which tissue is removed and which is left behind, including high-pressure waterjet, and sharp debridement techniques. Another newer method is autolysis. Autolytic debridement is accomplished using occlusive or semi-occlusive dressings that keep wound fluid in contact with the necrotic tissue. Wound assessment, topical applications, instructions regarding ongoing care of the wound, and the possible use of a whirlpool for treatment are included in these codes. Report 97597 for a total wound surface area less than or equal to 20.0 sq. cm and 97598 for a total wound surface area greater than 20.0 sq. cm. Report the appropriate code per session.

Coding Tips
These codes are reported only once per treatment session, regardless of the number of wounds treated. Do not report these codes in addition to 11042-11047.

ICD-9-CM Diagnostic Codes

454.0 Varicose veins of lower extremities with ulcer
454.2 Varicose veins of lower extremities with ulcer and inflammation

707.01 Pressure ulcer, elbow — (Use additional code to identify pressure ulcer stage: 707.20-707.25)
707.02 Pressure ulcer, upper back — (Use additional code to identify pressure ulcer stage: 707.20-707.25)
707.10 Ulcer of lower limb, unspecified — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)
707.13 Ulcer of ankle — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)
707.14 Ulcer of heel and midfoot — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)

<table>
<thead>
<tr>
<th>Work Value</th>
<th>Non-Fac PE</th>
<th>Fac PE</th>
<th>Malpractice</th>
<th>Non-Fac Total</th>
<th>Fac Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>97597</td>
<td>0.58</td>
<td>0.88</td>
<td>0.05</td>
<td>1.51</td>
<td>1.02</td>
</tr>
<tr>
<td>97598</td>
<td>0.80</td>
<td>1.03</td>
<td>0.05</td>
<td>1.88</td>
<td>1.33</td>
</tr>
<tr>
<td>97602</td>
<td>0.32</td>
<td>0.60</td>
<td>0.04</td>
<td>0.96</td>
<td>0.96</td>
</tr>
</tbody>
</table>

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
HCPCS Level II Definitions and Guidelines

One of the keys to gaining accurate reimbursement lies in understanding the multiple coding systems that are used to identify services. To be well-versed in reimbursement practices, coders should be familiar with the ICD-9-CM, CPT, and HCPCS Level II coding systems. The last of these, the HCPCS Level II system, is increasingly important to reimbursement, as it has been extended to a wider array of medical services.

HCPCS Level II codes commonly are referred to as national codes or by the acronym HCPCS, which stands for the Healthcare Common Procedure Coding System (pronounced “hik-piks”). When using HCPCS Level II codes, keep the following in mind:

• CMS does not use consistent terminology for unlisted services or procedures. The code descriptions may include any one of the following terms: unlisted, not otherwise classified (NOC), unspecified, unclassified, other, and miscellaneous.

• When billing for specific supplies and materials, avoid CPT code 99070 (general supplies) and be as specific as possible unless the local carrier directs otherwise.

• Coding and billing should be based on the service and supplies provided. Documentation should describe the patient’s problems and the service provided to enable the payer to determine reasonableness and necessity of care.

• Refer to Medicare coverage reference to determine whether the care provided is a covered service.

• When both a CPT and HCPCS Level II code share nearly identical narratives, apply the CPT code. If the narratives are not identical, select the code with the narrative that better describes the service. Generally, the HCPCS Level II code is more specific and takes precedence over the CPT code.

Symbols
Symbols used in the HCPCS Level II system may be presented in various ways, depending on the vendor. In this publication, the pattern established by the AMA in the CPT code books is followed. For example, bullets and triangles signify new and revised codes, respectively.

When a code is new to the HCPCS Level II system, a bullet (●) appears to the left of the code. This symbol is consistent with the CPT system’s symbol for new codes. The bullet represents a code never before seen in the HCPCS coding system.

A triangle (▲) is used (as in the CPT system) to indicate that a change in the narrative of a code has been made from the previous year’s edition. The change made may be slight or significant, but it usually changes the application of the code.

Modifiers
A system of two-digit modifiers has been developed to allow the provider to indicate that the service or procedure has been altered by certain circumstances. Fee schedules have been developed based on these modifiers. Some third-party payers, such as Medicare, require chiropractors to use modifiers in some circumstances. Communication with the payer group ensures accurate coding.

Addition of the modifier does not alter the basic description for the service; it merely qualifies the circumstances under which the service was provided. Circumstances that modify a service include the following:

• Procedures that have both a technical and professional component were performed.
• More than one individual or setting was involved in the service.
• Only part of a service was performed.
• The service was delivered to more than one patient.

The following list of HCPCS modifiers is used most often by chiropractors:

A1 Dressing for one wound
A2 Dressing for two wounds
A3 Dressing for three wounds
A4 Dressing for four wounds
A5 Dressing for five wounds
A6 Dressing for six wounds
A7 Dressing for seven wounds
A8 Dressing for eight wounds
A9 Dressing for nine or more wounds
AQ Physician providing a service in an unlisted health professional shortage area (HPSA)
BP The beneficiary has been informed of the purchase and rental options and has elected to purchase the item
BR The beneficiary has been informed of the purchase and rental options and has elected to rent the item
BU The beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision
CC Procedure code change (use CC when the procedure code submitted was changed either for administrative reasons or because an incorrect code was filed)
ET Lower left, eyelid
F1 Left hand, second digit
F2 Left hand, third digit
F3 Left hand, fourth digit
F4 Left hand, fifth digit
F5 Right hand, thumb
F6 Right hand, second digit
F7 Right hand, third digit