Coding and Payment Guide for Chiropractic Services

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

2013
Contents

Introduction ......................................................... 1
Coding Systems ..................................................... 1
Claim Forms .......................................................... 2
Contents and Format of This Guide ......................... 3

The Reimbursement Process ................................. 5
Payer Types .......................................................... 5
Coverage Issues ..................................................... 9
Payment Methodologies ......................................... 10
Participation in Medicare Plans ......................... 23
Supplemental Medicare Coverage .......................... 24
Workers’ Compensation .......................................... 29

Documentation—An Overview ......................... 33
Methods of Documentation ................................... 33
General Guidelines for Documentation ................. 34
Principles of Documentation .................................. 34
Waste, Fraud and Abuse ........................................ 37

Claims Processing ................................................. 45
What to Include on Claims ..................................... 45
Medicare Benefit Notices ....................................... 52
The CMS-1500 Claim Form ..................................... 57

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 ............ 225
Introduction ......................................................... 225
HCPCS Level II—National Codes ......................... 225
The Conventions: Symbols and Modifiers ............... 225
HCPCS Level II Codes ........................................... 226

ICD-9-CM Index ................................................... 235
ICD-9-CM Coding Conventions ......................... 235
Coding Neoplasms ................................................. 235
Manifestation Codes ............................................. 236
Official ICD-9-CM Guidelines for Coding and Reporting ................................................... 236
Diagnostic Coding and Reporting Guidelines for Outpatient Services (Hospital-Based and Physician Office) ................................................... 236
ICD-9-CM Codes .................................................. 238

Alphabetic Index to External Causes of Injury and Poisoning (E Code) .............................................. 278

Medicare Official Regulatory Information ............... 293

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Introduction

Coding and Payment Guide for Chiropractic Services

Contents and Format of This Guide

Coding and Payment Guide for Chiropractic Services has three sections: reimbursement, definitions and guidelines, and Medicare official regulatory information.

Reimbursement


Definitions and Guidelines

This section begins with the standard coding definitions and guidelines for CPT, HCPCS Level II, and ICD-9-CM codes. Our experts have crosswalked the reference, wherever possible, to the applicable procedure or supply code listed in the definitions and guidelines section.

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 claims filing process is in the claims processing section.

ICD-9-CM Definitions and Guidelines

An overview of the ICD-9-CM coding conventions and guidelines are presented in this section. A comprehensive alphabetic index of ICD-9-CM diagnosis codes specific to chiropractic services is in the index at the end of this section.

Medicare Official Regulatory Information

The full excerpts from Medicare manuals pertaining to chiropractic services are provided in this section. These excerpts often do not identify the guideline with corresponding CPT or HCPCS Level II codes. Our experts have crosswalked the reference, wherever possible, to the applicable procedure or supply code listed in the definitions and guidelines section.

How to Use This Guide

The first three chapters: "The Reimbursement Process," "Documentation—An Overview," and "Claims Processing" may be read in their entirety and/or used as references. When using this Coding and Payment Guide for code assignment, follow these important steps to improve accuracy and experience fewer overlooked diagnoses and services:

Step 1. Carefully read the medical record documentation that describes the patient's diagnosis and the service provided. Remember, more than one diagnosis or service may be documented.

Step 2. Locate the main term for the procedure or service documented in the CPT index. This will identify the procedure code that may be used to report this service.

Step 3. Locate the procedure code in the "Procedure Codes" chapter. Read the explanation and determine if that is the procedure performed and supported by the medical record documentation. The Terms to Know section may be used to ensure appropriate code assignment.

Step 4. At this time you can review the additional information pertinent to the specific code found in the coding tips, IOM reference, and CCI sections or the Medicare physician fee schedule references.

Step 5. Puruse the list of ICD-9-CM codes to determine if the condition documented in the medical record is listed and the code identified. If the condition is not listed refer to the ICD-9-CM index or your ICD-9-CM manual to locate the appropriate code. At this time, you may also determine what, if any, CCI edits are applicable.

Step 6. Determine if any Medicare regulatory information is associated with this code and if so, an excerpt of this information may be found in the appendix titled, "Medicare Official Regulatory Information."

Step 7. Finally, review the HCPCS Level II section to determine if there are applicable HCPCS Level II codes that may be reported. This section also includes HCPCS Level II modifiers as well as coding tips.
Application of a modality to 1 or more areas; diathermy (eg, microwave)

97024

infrared

97026

ultraviolet

97028

Explanation

In 97024, the clinician uses diathermy or microwave as a form of superficial heat for one or more body areas. After application and safety instructions have been provided, the clinician supervises the treatment. Once applied and safety instructions have been provided, the treatment is supervised. This code can only be billed one unit per day. In 97026, the clinician uses infrared light as a form of superficial heat that will increase circulation to one or more localized areas. Once applied and safety instructions have been provided, the treatment is supervised. This code can only be billed one unit per day. In 97028, the clinician applies ultraviolet light to treat dermatological problems. Once applied and safety instructions have been provided, the treatment is supervised. This code can only be billed one unit per day.

Coding Tips

Modality is defined as any group of agents that may include thermal, acoustic, radiant, mechanical, or electrical energy to produce physiologic changes in tissues for therapeutic purposes. Codes included in this section do not include specific time increments as a requirement. The modalities identified by codes 97010–97028 require supervision by the provider but do not require direct patient contact (one-to-one). This is a service-based code and is reported only once per date of service. If the service is performed more than once on any given day, the appropriate modifier should be reported and documentation should support its use. According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

Terms To Know

diathermy. Applying heat to body tissues by various methods for therapeutic treatment or surgical purposes to coagulate and seal tissue.

physical therapy modality. Therapeutic agent or regimen applied or used to provide appropriate treatment of the musculoskeletal system.

ultraviolet light. Light source consisting of light rays with a higher frequency than those at the violet end of the visual spectrum.

ICD-9-CM Diagnostic Codes

722.10 Displacement of lumbar intervertebral disc without myelopathy

723.1 Cervicalgia

723.3 Cervicobrachial syndrome (diffuse)

739.1 Nonallopathic lesion of cervical region, not elsewhere classified

739.3 Nonallopathic lesion of lumbar region, not elsewhere classified

839.00 Closed dislocation, unspecified cervical vertebra

839.01 Closed dislocation, first cervical vertebra

839.02 Closed dislocation, second cervical vertebra

839.03 Closed dislocation, third cervical vertebra

839.04 Closed dislocation, fourth cervical vertebra

839.05 Closed dislocation, fifth cervical vertebra

839.06 Closed dislocation, sixth cervical vertebra

839.07 Closed dislocation, seventh cervical vertebra

839.08 Closed dislocation, multiple cervical vertebrae

839.20 Closed dislocation, lumbar vertebra

839.21 Closed dislocation, thoracic vertebra

846.0 Sprain and strain of lumbosacral (joint) (ligament)

847.2 Lumbar sprain and strain

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References

100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.4; 100-3,10.3; 100-3,150.5; 100-3,240.3; 100-4,5,10; 100-4,5,20.4

CCI Version 17.3

0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64493, 64505-64530, 97002, 97004 Also not with 97024: 97018, 97026 Also not with 97026: 97018, 97022 Also not with 97028: 97018, 97022, 97026 Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
HCPCS Level II Definitions and Guidelines

Introduction
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—National Codes
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”). These codes, updated and published annually by the Centers for Medicare and Medicaid Services (CMS), are intended to supplement the CPT coding system by including codes for nonphysician services, administration of injectable drugs, durable medical equipment (DME), and office supplies.

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 contractor 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.

The Conventions: Symbols and Modifiers
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)
AT Acute treatment (this modifier should be used when reporting service 98940, 98941, 98942)
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