Coding and Payment Guide for Chiropractic Services

A comprehensive coding, billing, and reimbursement resource for chiropractic services
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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 health. Medicare Part B coverage provides payment for medical supplies and physician and outpatient services.

Not all services rendering 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
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 after this introduction: “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 “v” symbol). Please note that the CCI edits will be updated quarterly and posted on Optum’s website at http://www.optumcoding.com/cci_edits.

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 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. The full text of all of the internet-only manuals (IOM) may be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.

How to Use This Guide
The 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 the coder 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. Peruse 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 the ICD-9-CM manual to locate the appropriate code. At this time, coders 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.
Radiologic examination, sacroiliac joints; less than 3 views

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>72200</td>
<td>Radiologic examination, sacroiliac joints; less than 3 views</td>
</tr>
<tr>
<td>72202</td>
<td>3 or more views</td>
</tr>
</tbody>
</table>

**Explanation**

Films are taken of the articulation between the sacrum, the triangular bone beneath the lumbar vertebrae, and the ilium, or upper portion of the hip bone. The exam may be performed in both anteroposterior and right and left posterior oblique views. Code 72200 reports one or two views and 72202 reports three or more views.

**Coding Tips**

These procedures have both a technical and professional component. To claim only the professional component, append modifier 26. To claim only the technical component, append modifier TC. To claim the complete procedure (i.e., both the professional and technical components), submit without a modifier.

**Terms To Know**

- **anteroposterior.** Front to back.
- **closed dislocation.** Simple displacement of a body part without an open wound.
- **oblique x-ray view.** Slanted view of the object being x-rayed.
- **professional component.** Portion of a charge for health care services that represents the physician’s (or other practitioner’s) work in providing the service, including interpretation and report of the procedure. This component of the service usually is charged for and billed separately from the inpatient hospital charges.
- **radiograph.** Image made by an x-ray.
- **sprain and strain.** Injuries to a joint, in which the fibers of supporting ligaments or muscles are overstretched or slightly ruptured, with the ligaments and muscles maintaining continuity.
- **technical component.** Portion of a health care service that identifies the provision of the equipment, supplies, technical personnel, and costs attendant to the performance of the procedure other than the professional services.

**ICD-9-CM Diagnostic Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>714.0</td>
<td>Rheumatoid arthritis — (Use additional code to identify manifestation: 357.1, 359.6)</td>
</tr>
<tr>
<td>715.15</td>
<td>Primary localized osteoarthrosis, pelvic region and thigh</td>
</tr>
<tr>
<td>715.25</td>
<td>Secondary localized osteoarthrosis, pelvic region and thigh</td>
</tr>
<tr>
<td>715.33</td>
<td>Localized osteoarthrosis not specified whether primary or secondary, pelvic region and thigh</td>
</tr>
<tr>
<td>716.15</td>
<td>Traumatic arthropathy, pelvic region and thigh</td>
</tr>
<tr>
<td>719.45</td>
<td>Pain in joint, pelvic region and thigh</td>
</tr>
<tr>
<td>719.55</td>
<td>Stiffness of joint, not elsewhere classified, pelvic region and thigh</td>
</tr>
<tr>
<td>720.2</td>
<td>Sacroiliitis, not elsewhere classified</td>
</tr>
<tr>
<td>724.6</td>
<td>Disorders of sacrum</td>
</tr>
</tbody>
</table>

<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>72200</td>
<td>0.17</td>
<td>0.71</td>
<td>0.02</td>
<td>0.90</td>
<td>0.90</td>
</tr>
<tr>
<td>72202</td>
<td>0.19</td>
<td>0.84</td>
<td>0.02</td>
<td>1.05</td>
<td>1.05</td>
</tr>
</tbody>
</table>

**CCI Version 18.3**

Also not with 72202: 72200

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
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.

Additionally, 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