Coding and Payment Guide
for Chiropractic Services
A comprehensive coding, billing, and reimbursement resource for chiropractic services
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Modifier Use

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, and others do not recognize the use of modifiers by chiropractors for coding or billing. Communication with the payer group ensures accurate coding. Following are several guidelines.

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.

Medicare requires chiropractors to indicate on a claim whether the treatment is for an acute condition or for maintenance therapy. The AT modifier is used to describe an acute treatment. Claims submitted without modifier AT will be denied since Medicare does not cover maintenance therapy. The AT modifier is used to describe whether the treatment is for an acute condition or for maintenance therapy. Maintenance therapy is provided only if the patient falls into either an acute or chronic category. Acute or chronic should be documented in the patient’s medical record into which the patient falls (acute or chronic). Acute or chronic must be clear in the patient’s medical record. The AT modifier is used to describe whether the treatment is for an acute condition or for maintenance therapy. The AT modifier is used to describe whether the treatment is for an acute condition or for maintenance therapy. The AT modifier is used to describe whether the treatment is for an acute condition or for maintenance therapy. Maintenance therapy.

All treatments must be categorized as either acute subluxation, chronic subluxation, or maintenance therapy and be reported on the claim form as follows:

1. When the patient is being treated for an acute subluxation, procedure code 98940, 98941, or 98942 is reported with modifier AT (acute treatment).
2. When the patient is being treated for a chronic subluxation, procedure code 98940, 98941, or 98942 is reported without a modifier.
3. When the patient is being treated with maintenance therapy, procedure code 98940, 98941, or 98942 is reported with modifier GY (statutorily excluded).

Note: When using modifier GY, the medical record must clearly document the service that is not covered (i.e., maintenance therapy) and be available to the carrier upon request.

In addition to reporting the modifiers on the claim, it must be clear in the patient’s medical record into which category the patient falls (acute or chronic). Acute or chronic treatment may be documented in the patient’s medical record for each date of service. No abbreviations should be used.

Note: An exacerbation of a previous injury should be categorized into either “acute” or “chronic” (e.g., an identifiable re-injury would fall under acute).

According to Medicare policy, room or ward fees are not covered. Reimbursement under Medicare is limited to one treatment per day even if multiple daily treatments are provided to a patient in the office or clinic.

Other Factors Influencing Payment

In addition to the above-stated payment methodologies, other issues affect the manner in which a practice codes and bills for services.

Medicare Vulnerability Analysis of Chiropractic Services

In June 2005, the Office of the Inspector General (OIG) released a report on a vulnerability inspection study performed on chiropractic services. The objective of the inspection was to determine if chiropractic services provided to Medicare beneficiaries met Medicare coverage criteria and documentation requirements. The OIG found that approximately 67 percent of the chiropractic services allowed by Medicare in 2001 did not meet Medicare’s coverage criteria. In addition, many of these services were miscoded or undocumented. Later Medicare CERT data indicates that chiropractors filed claims incorrectly 30.6 percent of the time and had one of the highest compliance error rates among the professions whose services are covered.

These findings mean that carriers will probably begin to scrutinize claims for chiropractic services more closely in the future. Providers should review their claims processing systems to determine that:

- Modifiers are used correctly
- Patients are notified that maintenance therapy is noncovered under the Medicare program
- Modifier AT is appended to the service code ONLY when acute treatment is provided
- Modifier GY is appended to the service code when maintenance therapy is provided
- Random comparisons of medical record information supports the codes assigned to the claim

Stark Self-Referral Regulations

In 1989, Congress enacted the Stark I law because of concern about potential kickbacks to physicians. The law, named after sponsor Rep. Fortney “Pete” Stark, (D., Calif.), is designed to prevent physicians from referring Medicare patients to clinical laboratories or other entities in which the physicians hold a financial stake, unless a particular exception applies.

The bill’s passage came in the wake of increased business activities in the health care industry. Studies showed that physicians who had ownership in labs ordered tests more frequently than physicians who referred to independent laboratories.

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72010  Radiologic examination, spine, entire, survey study, anteroposterior and lateral

Explanation
The entire spine is surveyed in a radiologic exam that includes anteroposterior views, with the patient supine, knees flexed, and feet flat on the table, and lateral views, either recumbent or erect. Right and left posterior obliques may be performed with the patient in the semi-supine position with the spine at a 45 degree angle to the table.

Coding Tips
This procedure has 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 (AP). Front to back.

Oblique (OBL) x-ray view. Slanted view of the object being x-rayed.

Radiograph. Image made by an x-ray.

Supine. Lying on the back; also known as dorsal decubitus position.

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HCPCS Codes
N/A

ICD•9 Diagnostic Codes
338.21 Chronic pain due to trauma
338.4 Chronic pain syndrome
723.4 Brachial neuritis or radiculitis nos
724.2 Lumbago
724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified
739.1 Nonallopathic lesion of cervical region, not elsewhere classified
739.2 Nonallopathic lesion of thoracic region, not elsewhere classified
739.3 Nonallopathic lesion of lumbar region, not elsewhere classified
839.20 Closed dislocation, lumbar vertebra
839.21 Closed dislocation, thoracic vertebra
847.0 Neck sprain and strain
847.2 Lumbar sprain and strain

IOM References
100-2, 15, 80; 100-4, 13, 10; 100-4, 13, 100

CCI
72020-72120

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ICD-9-CM Index

The ICD-9-CM index contains comprehensive information about the most frequently diagnosed chiropractic medicine conditions. This book is based on official Centers for Medicare and Medicaid Services (CMS) material and uses the most up-to-date diagnosis coding information available.

This chapter is meant only as a quick reference for chiropractic medicine diagnoses. It does not replace the Ingenix ICD-9-CM code books.

Physicians and hospitals are required by law to submit diagnosis codes for Medicare reimbursement. A passage in the Medicare Catastrophic Coverage Act of 1988 requires health care offices to include appropriate diagnosis codes when billing for services provided to Medicare beneficiaries. The repeal of the Act has not changed this requirement. CMS designated ICD-9-CM as the coding system physicians must use.

This chapter concentrates on the most common diagnoses that utilize chiropractic medicine services. Easy to use, it contains an alphabetic list of diagnoses, and has symbols (see the symbol key) to identify common coding principles. Understanding these principles will increase the efficiency and promptness of claim submission for Medicare and other third-party payers.

Codes effective October 1, 2009 to September 30, 2010

ICD-9-CM Coding Conventions
The ICD-9-CM coding conventions, or rules, used in this book are outlined below. All ICD-9-CM coding rules can be found in the front of any ICD-9-CM code book.

The symbol \( \text{\#} \) is used to indicate when a fifth-digit subclassification is required to complete a code. This symbol refers the coder to corresponding boxed information that defines the appropriate fifth digit.

Modifiers
The provider’s diagnostic statement usually contains several medical terms. To translate the terms into diagnosis codes, choose only the condition as the main term. The other terms may be considered modifiers.

There are two types of modifiers, nonessential and essential:

- Nonessential modifiers are shown in parentheses after the term that they modify. Nonessential modifiers may be either present or absent in the diagnostic or procedure statement without affecting the code selection. These modifiers do not affect the code selection.
- Essential modifiers are indented under the main term. When there is only one essential modifier, it is listed next to the main term after a comma. Essential modifiers affect code assignment; therefore, they should be used in the coding process only if they are specified in the physician’s diagnosis.

In the following example, “anterior,” “meatal,” “organic,” “posterior,” and “spasmodic” are nonessential modifiers, and “urethra” is an essential modifier.

Stricture (see also Stenosis) 799.89
urethra (anterior) (meatal) (organic) (posterior) (spasmodic) 598.9

Cross-References
Cross-references make locating a code easier. Two types of cross-references are used in this book: see and see also.

The “see” cross-reference directs the coder to look for another term elsewhere in the book. For example:

Tumor demoid (W808410)—see Neoplasm, by site, benign

The “see also” cross-reference provides the coder with an alternative main term if the appropriate description is not found under the initial main term, such as:

Stricture (see also Stenosis) 799.89
urethra (anterior) (meatal) (organic) (posterior) (spasmodic) 598.9

Abbreviations
NEC: “Not elsewhere classifiable.” Not every condition has its own ICD-9-CM code. The NEC abbreviation is used with those categories of codes for which a more specific code is not available. The NEC code describes all other specified forms of a condition. For example:

Disorder (see also Disease)
bone NEC 733.90

NOS: “Not otherwise specified.” Coders should use an NOS code only when they lack the information necessary for assigning a more specific code.

Coding Neoplasms
The index contains a neoplasm table in which the codes for each particular type of neoplasm are listed for the body part, system, or tissue type affected. The columns divide the codes into neoplasm type: malignant, benign, uncertain behavior, and unspecified with three distinct columns appearing under the malignant heading for primary, secondary, and carcinoma in situ.

Malignant neoplasms are uncontrolled new tissue growths or tumors that can progressively invade tissue in other parts of the body by spreading or metastasizing the disease producing cells from the initial site of malignancy. Primary defines the body site or tissue where the malignancy first began to grow and spread from there to other areas.