Medlearn Matters
Information for Medicare Providers

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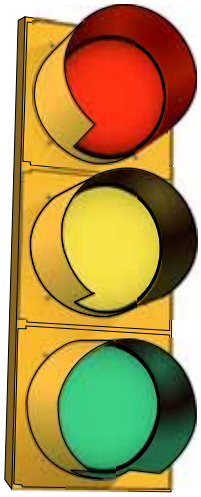
Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR 3063

Provider Types Affected

Chiropractors

Provider Action Needed



STOP – Impact to You

Chiropractors have been submitting a very high rate of incorrect claims to Medicare. Medicare only pays for chiropractic services for active/corrective treatment (those using HCPCS codes 98940, 98941, or 98942). Claims for medically necessary services rendered on or after October 1, 2004, must contain the Acute Treatment (AT) modifier to reflect such services provided, or the claim will be denied.

CAUTION – What You Need to Know

This article completely replaces MM3063 on the same subject. On or after October 1, 2004, when you provide acute or chronic active/corrective treatment to Medicare patients, you must add the AT modifier to every claim that uses HCPCS codes 98940, 98941, or 98942. If you don't add this modifier, your care will be considered maintenance therapy and will be denied because maintenance chiropractic therapy is not considered medically reasonable or necessary under Medicare.

In addition, carriers may develop local coverage determinations (LCDs) that indicate an appropriate frequency of service for a given clinical indication. You may submit claims for services that exceed the frequency limits that the LCDs established, with or without the AT modifier, depending on whether you believe that the care you have rendered is either active treatment or maintenance therapy. But, be aware that in either case your claims will continue to be autodenied if the services exceed the frequency limits of reasonable and necessary services specified in the LCD.

GO – What You Need to Do

Make sure that your billing staff is aware that they must apply the AT modifier to HCPCS codes 98940, 98941, or 98942 when your clinical documentation reflects that the care you provided to a Medicare patient consists of active/corrective treatment. Additionally, your billing staff should be aware of any LCDs for these services in your area that might limit the frequency or circumstances under which active/corrective chiropractic can be paid.

Background

The 2003 Improper Medicare FFS Payment report indicates that chiropractors have the highest provider Compliance Error Rate in Medicare, filing claims incorrectly almost one-third of the time. Chapter 15, Section 30.5 of the Benefits Policy Manual states the Medicare program does not consider chiropractic maintenance therapy as medically reasonable or necessary, and is not payable under the Medicare program. So, in order for you to bill Medicare correctly, you need to indicate which of your claims are for active/corrective therapy and which are for maintenance therapy. A modifier ("AT") already exists which can be used for this purpose.

Therefore, you must place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. For services rendered on or after October 1, 2004, all of your claims for active/corrective therapy (HCPCS codes 98940, 98941, 98942) that do not contain the AT modifier will be denied. This is because, as mentioned above, services without this modifier will be considered maintenance therapy (services that seek to prevent disease, promote health, and prolong and enhance the quality of life; or maintain or prevent deterioration of a chronic condition), and are not considered medically reasonable or necessary under Medicare.

However, the presence of the AT modifier may not, in all instances, indicate that the service is reasonable and necessary. Carriers may develop LCDs that indicate an appropriate frequency of service. You may submit claims for services that exceed the frequency limits established within the LCD, with or without the AT modifier, depending on whether you believe that you have rendered active treatment or maintenance therapy, respectively.

In either case, your claims will be autodenied if the services exceed the frequency limits of reasonable and necessary services specified in the LCD. And, if contractors' LCDs do not specify frequencies that define the limit of reasonable and necessary care, they may deny your claim, if appropriate, after medical review.

For those services that exceed the frequency limits established within the LCD, you may wish to obtain an Advance Beneficiary Notice (ABN) from the beneficiary and also apply the GA modifier (to be used when you want to indicate that you expect that Medicare will deny a service as not reasonable and necessary and that you do have on file an ABN signed by the beneficiary) or the GZ modifier (to be used when you want 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.

Important Dates to Know

Effective Date: October 1, 2004

Implementation Date: October 4, 2004

Related Instruction

The revisions to Chapter 15 of the Medicare Benefit Policy Manual are attached to the official instruction released to your carrier. That instruction may be found at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

Once at that Web page, scroll down the CR NUM column on the right to locate CR3449 and click on that file.

Also, you may check any LMRP/LCDs that may apply to you at:

http://www.cms.hhs.gov/mcd

For more information about the use of the ABN, consult the Internet-Only Manual (IOM), Pub. 100-04, Chapter 23, Section 20.9.1.1. You can access this information at:

http://www.cms.hhs.gov/manuals/104_claims/clm104c23.pdf

Additional Information

If you have any questions, please contact your carrier at their toll free number, which may be found at:

http://www.cms.hhs.gov/medlearn/tollnums.asp