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2



MEDICARE PART B RULES AND REGULATIONS

- **INTERNET-ONLY MANUALS (IOMS)**
 - <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs>
 - OR, at www.cms.gov, in search function type “Medicare Internet-Only Manual”
 - The Chiropractic Section is Chapter 15, section 240.

3



MEDICARE WILL ONLY COVER

- THE MANUAL MANIPULATION OF THE SPINE FOR THE PURPOSE OF CORRECTING A SUBLUXATION.
- NO OTHER DIAGNOSTIC OR THERAPEUTIC SERVICE FURNISHED BY A CHIROPRACTOR OR UNDER THE CHIROPRACTOR’S ORDER IS COVERED.

4



MEDICARE CLAIM SUBMISSION

- A CHARGE MAY NOT BE IMPOSED FOR PREPARING AND FILING THE CLAIM.
- PHYSICIANS MAY NOT GIVE THE COMPLETED CLAIM FORM TO THE BENEFICIARY TO MAIL TO WPS
- MEDICARE TIMELY FILING LIMITATIONS MUST BE FOLLOWED.

5



MEDICARE PAYABLE CPT CODES

- 98940 (CMT); SPINAL, ONE OR TWO REGIONS
- 98941 (CMT); SPINAL, THREE OR FOUR REGIONS
- 98942 (CMT); SPINAL, FIVE REGIONS
- MUST USE "AT" MODIFIER FOR PAYABLE CMT CODES TO BE CONSIDERED "MEDICALLY NECESSARY"

6



INDICATIONS AND LIMITATIONS OF COVERAGE

- ...SIGNIFICANT HEALTH PROBLEMS...
- ...NEUROMUSCULOSKELETAL CONDITION NECESSITATING TREATMENTS...
- ...SERVICES RENDERED MUST HAVE A DIRECT THERAPEUTIC RELATIONSHIP TO THE PATIENT'S CONDITION.
- REASONABLE EXPECTATION OF **RECOVERY** OR **IMPROVEMENT** OF FUNCTION NEEDED.

7



INDICATIONS AND LIMITATIONS OF COVERAGE

- SPINAL AXIS ACHES, STRAINS, SPRAINS, NERVE PAINS AND FUNCTIONAL MECHANICAL DISABILITIES OF THE SPINE ARE CONSIDERED TO BE MEDICALLY NECESSARY, THERAPEUTIC GROUNDS FOR CMT.
- THE LEVEL OF SPINAL SUBLUXATION **MUST** BEAR A DIRECT CAUSAL RELATIONSHIP TO THE PATIENT'S SYMPTOMS.

8



INDICATIONS AND LIMITATIONS OF COVERAGE

- THE SYMPTOMS MUST BE DIRECTLY RELATED TO THE LEVEL OF THE SUBLUXATION THAT HAS BEEN DIAGNOSED.
- THE SUBLUXATION MUST BE DEMONSTRATED BY X-RAY OR PHYSICAL EXAM USING P.A.R.T. ASSESSMENT AND RECORDED IN PATIENT NOTES.
- THE STATEMENT OR DIAGNOSIS OF "PAIN" IS NOT SUFFICIENT TO SUPPORT MEDICAL NECESSITY FOR THE TREATMENTS.

9



INDICATIONS AND LIMITATIONS OF COVERAGE

- THE PROBLEM/COMPLAINT AND THE PRECISE LEVEL OF THE SUBLUXATION MUST BE SPECIFIED AND CLEARLY DOCUMENTED IN THE CHART.
- THE NEED FOR AN EXTENSIVE, PROLONGED COURSE OF TREATMENT MUST BE CLEARLY DOCUMENTED IN THE MEDICAL RECORD.

10



INDICATIONS AND LIMITATIONS OF COVERAGE

- COVERAGE ... DENIED IF THERE IS **NOT** A REASONABLE EXPECTATION THAT THE TREATMENT WOULD RESULT IN **SIGNIFICANT IMPROVEMENT** OF THE PATIENT'S CONDITION.
- MAINTENANCE THERAPY IS NOT COVERED.
- CONTINUED REPETITIVE TREATMENT WITHOUT AN ACHIEVABLE AND CLEARLY DEFINED TREATMENT GOAL IS CONSIDERED MAINTENANCE THERAPY.

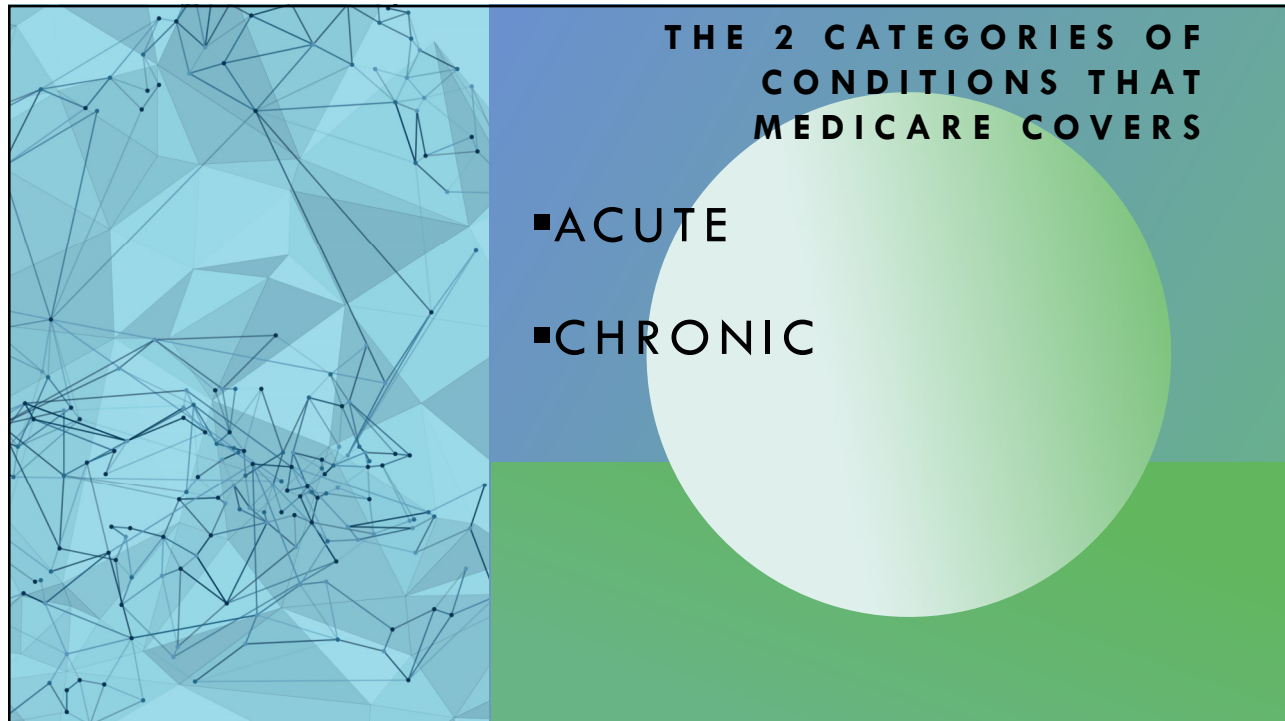
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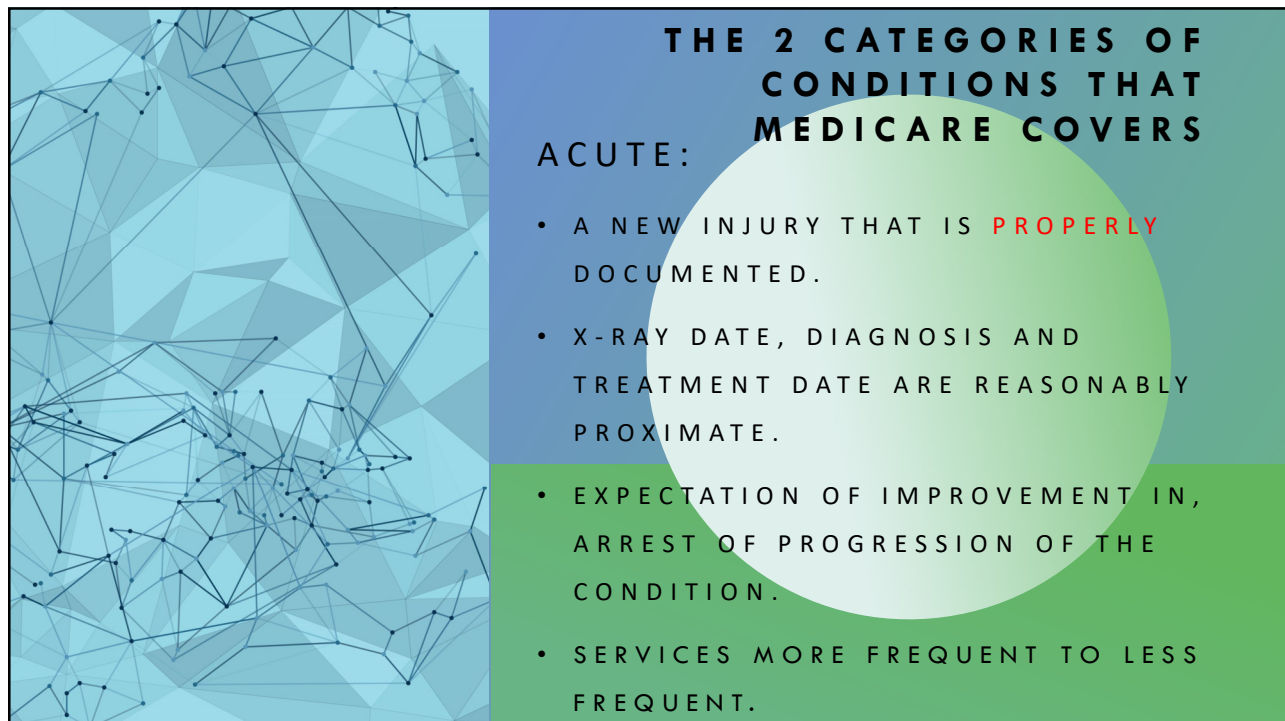
INDICATIONS AND LIMITATIONS OF COVERAGE

- MAINTENANCE THERAPY INCLUDES 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.** WHEN FURTHER CLINICAL IMPROVEMENT CANNOT REASONABLY BE EXPECTED FROM CONTINUOUS ONGOING CARE, AND THE CHIROPRACTIC TREATMENT BECOMES SUPPORTIVE RATHER THAN CORRECTIVE IN NATURE, THE TREATMENT IS THEN CONSIDERED MAINTENANCE THERAPY.

12



13



14



THE 2 CATEGORIES OF CONDITIONS THAT MEDICARE COVERS

CHRONIC:

- NOT EXPECTED TO COMPLETELY RESOLVE.
- EXPECTED TO RESULT IN SOME FUNCTIONAL IMPROVEMENT.
- ONCE FUNCTIONAL STATUS HAS REMAINED STABLE TREATMENT BECOMES MAINTENANCE THERAPY AND IS NOT COVERED.

15



CONTRAINDICATIONS TO TREATMENT

- A RELATIVE CONTRAINDICATION IS A CONDITION THAT ADDS SIGNIFICANT RISK OF INJURY TO THE PATIENT FROM DYNAMIC THRUST BUT DOES NOT RULE OUT THE USE OF DYNAMIC THRUST.
- THE DOCTOR SHOULD DISCUSS THIS RISK WITH THE PATIENT AND RECORD THIS IN THE CHART.

16



DEMONSTRATING A SUBLUXATION

- X-RAY THAT IS REASONABLY PROXIMATE TO TREATMENT OR,
- PHYSICAL EXAM

17

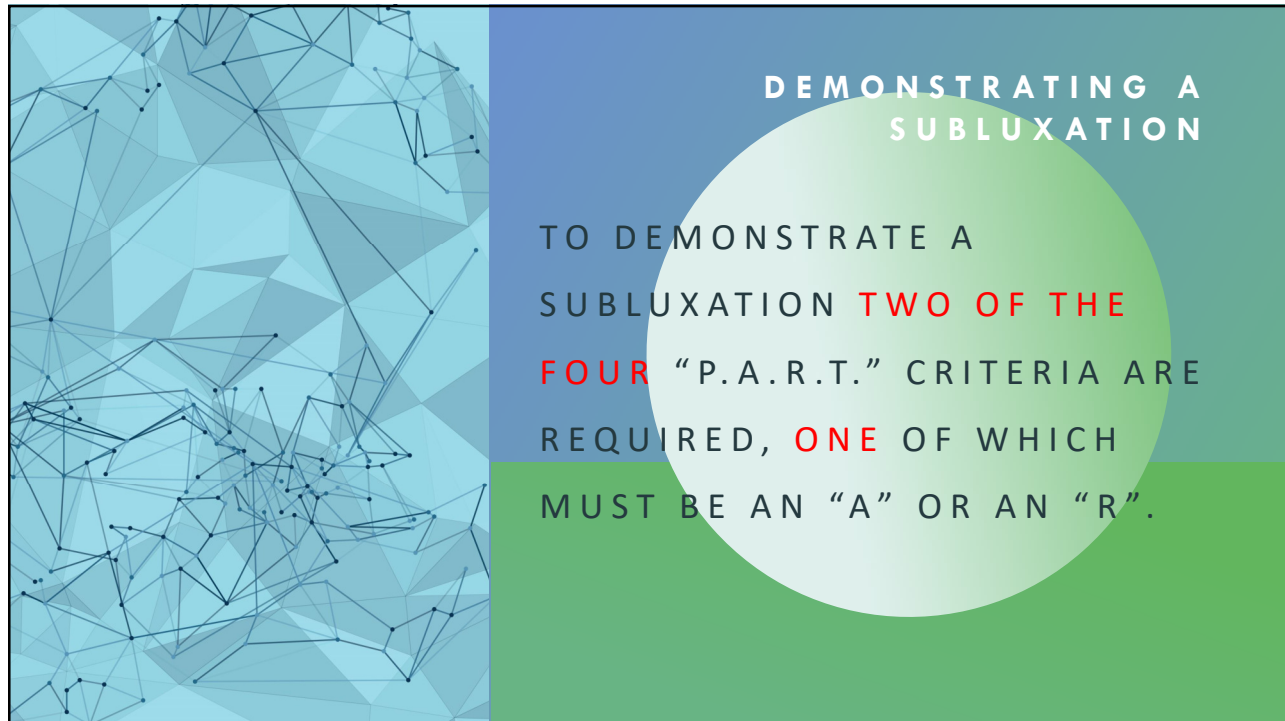


DEMONSTRATING A SUBLUXATION

PHYSICAL EXAMINATION USING
P.A.R.T.:

- P - PAIN/TENDERNESS
- A - ASYMMETRY/MISALIGNMENT
- R - RANGE OF MOTION
ABNORMALITY
- T - TISSUE, TONE ABNORMALITY

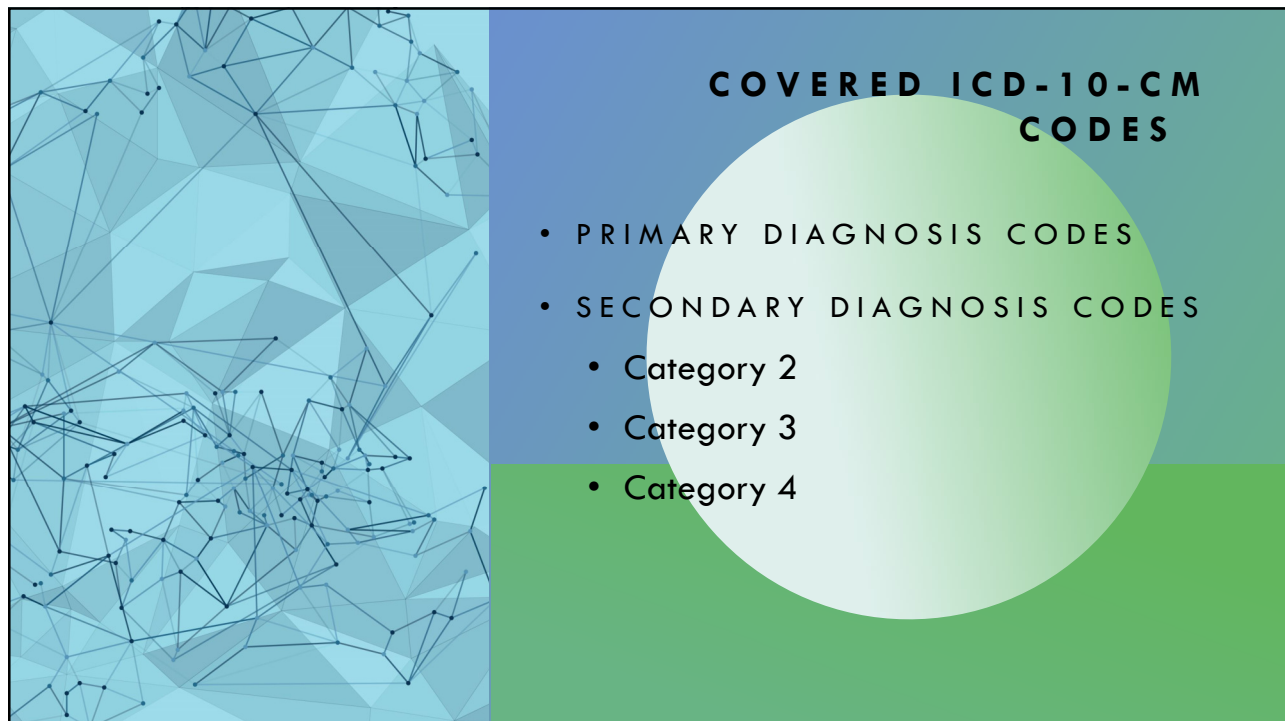
18



**DEMONSTRATING A
SUBLUXATION**

TO DEMONSTRATE A
SUBLUXATION **TWO OF THE**
FOUR "P.A.R.T." CRITERIA ARE
REQUIRED, **ONE** OF WHICH
MUST BE AN "A" OR AN "R".

19



**COVERED ICD-10-CM
CODES**

- PRIMARY DIAGNOSIS CODES
- SECONDARY DIAGNOSIS CODES
 - Category 2
 - Category 3
 - Category 4

20



**COVERED ICD-10-CM
CODES-PRIMARY**

- M99.00 OCCIPUT, ATLAS
- M99.01 CERVICAL REGION
- M99.02 THORACIC REGION
- M99.03 LUMBAR REGION
- M99.04 SACRAL REGION
- M99.05 PELVIC REGION

21



**COVERED ICD-10-CM
CODES-SECONDARY**

- GROUP 2, DIAGNOSES THAT GENERALLY REQUIRE SHORT TERM TREATMENT.
- GROUP 3, DIAGNOSES THAT GENERALLY REQUIRE MODERATE TERM TREATMENT.
- GROUP 4, DIAGNOSES THAT MAY REQUIRE LONGER TERM TREATMENT.
- LISTED IN [LOCAL COVERAGE LETTER FOR CHIROPRACTIC SERVICES-A56273](#).

22

23

BILLING: CMS 1500 FORM

Patient name: Identification number: (optional)	Notifier name: Notifier address Notifier phone (including TTY)
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Advance Beneficiary Notice of Non-coverage (ABN)

Medicare doesn't pay for everything, even some care you or your health care provider think you need. **We expect Medicare may not pay for the item, test, service or care listed below.** If Medicare doesn't pay, you may have to pay.

Item, test, service or care	Reason Medicare may not pay	Estimated cost

What to do now

- Read this notice to make an informed decision about your care.
- Ask any questions you have.
- Choose one option below to let us know if you still want to get the item, test, service or care.

Choose ONE option below. We can't choose for you.
If you choose Option 1 or 2, we may help you use any other insurance you might have, but Medicare can't require us to do this.

☐ **Option 1: I want the item, test, service or care listed above, and I want Medicare to be billed for an official decision on payment.** (I'll get on a Medicare Summary Notice (MSN). You can ask to be paid now. I understand that if Medicare doesn't pay, I'm responsible to pay, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you'll refund any payments I made to you, minus co-pays or deductibles.)

☐ **Option 2: I want the item, test, service or care listed above, but don't bill Medicare.** You can ask to be paid now and I'm responsible to pay. I understand that I can't appeal, since Medicare isn't billed.

☐ **Option 3: I don't want the item, test, service or care listed above.** I understand I'm not responsible for payment and I can't appeal to see if Medicare would pay.

Additional information:

This notice gives our opinion, not an official Medicare decision. For other questions about this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Signing below means you received and understand this notice. You can ask to get a copy.

Signature _____	Date (mm/dd/yyyy) _____
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You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit www.Medicare.gov/aboutus/accessibility/complaints/index.cfm.

AMA Disclaimer Statement: According to the Physician Reduction Act of 1995, no person is required to respond to a collection of information unless it displays a valid OMB control number. This notice has OMB control number 0938-0046. The time required to complete this information collection is estimated to average 30 minutes per response, including the time for reviewing instructions, gathering existing data resources, gathering the needed information, reviewing the information collection, estimating the burden of the collection of information, sending comments regarding the collection of information, and completing and reviewing the collection of information. Send comments regarding this information collection to Washington Headquarters Service, Paperwork Project Director, U.S. Department of Health & Human Services, 1215 Jefferson Avenue, NE, Atlanta, GA 30334-3981. You may also contact the Office of Management and Budget, Paperwork Project Director, 1215 Jefferson Avenue, NE, Atlanta, GA 30334-3981. If you have comments regarding the accuracy of the information or suggestions for improving this form, please write to GSA, TSD Security Framework, 401 M Street, SW, Washington, DC 20503.

Form CMS-R-131 (Sup. 03/1/2020)

Form Approved CMS No. 0039-0005

24



REASONS FOR NON-COVERAGE

- EXCLUDED SERVICES
- NON-COVERED ICD-10-CM CODE(S)
- CODING GUIDELINES

25



DOCUMENTATION REQUIREMENTS

- INITIAL VISITS
 1. History
 2. Present Illness
 3. Physical Examination
 4. Diagnosis
 5. Treatment Plan
 6. Initial Treatment Date

26



DOCUMENTATION REQUIREMENTS-INITIAL VISIT

1. HISTORY:

- Symptoms causing patient to seek treatment
- Family history if relevant
- Past health history
- Mechanism of trauma
- Quality and character of symptoms/problem
- Onset, duration, intensity, frequency, location and radiation of symptoms
- Aggravating or relieving factors and
- Prior interventions, treatments, medications, secondary complaints.

27



DOCUMENTATION REQUIREMENTS-INITIAL VISIT

3. Evaluation of musculoskeletal/nervous system through physical examination.



28



**DOCUMENTATION
REQUIREMENTS-INITIAL
VISIT**

4. Diagnosis: The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term or descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named.

29



**DOCUMENTATION
REQUIREMENTS-INITIAL
VISIT**

5. Treatment plan, which should include:

- Recommended level of care (duration and frequency of visits)
- Specific treatment goals and
- Objective measures to evaluate treatment effectiveness.

6. INITIAL TREATMENT DATE

30



**DOCUMENTATION REQUIREMENTS-
SUBSEQUENT VISITS**

1. HISTORY – INCLUDE REVIEW OF CHIEF COMPLAINT, CHANGES SINCE LAST VISIT AND SYSTEM REVIEW IF RELEVANT.
2. PHYSICAL EXAM – EXAM OF AREA OF SPINE INVOLVED IN DIAGNOSIS, ASSESSMENT OF CHANGE IN PATIENT CONDITION SINCE LAST VISIT.
3. DOCUMENTATION OF TREATMENT GIVEN ON DAY OF VISIT.

31



DOCUMENTATION REQUIREMENTS

- FAILURE TO DOCUMENT THE MEDICAL NECESSITY OF THE CHIROPRACTIC MANUAL SPINAL MANIPULATION(S) MAY RESULT IN DENIAL OF CLAIM(S). DOCUMENTATION MUST BE LEGIBLE AND MADE AVAILABLE TO MEDICARE UPON REQUEST. FAILURE TO DO SO MAY RESULT IN DENIAL OF CLAIMS.

32



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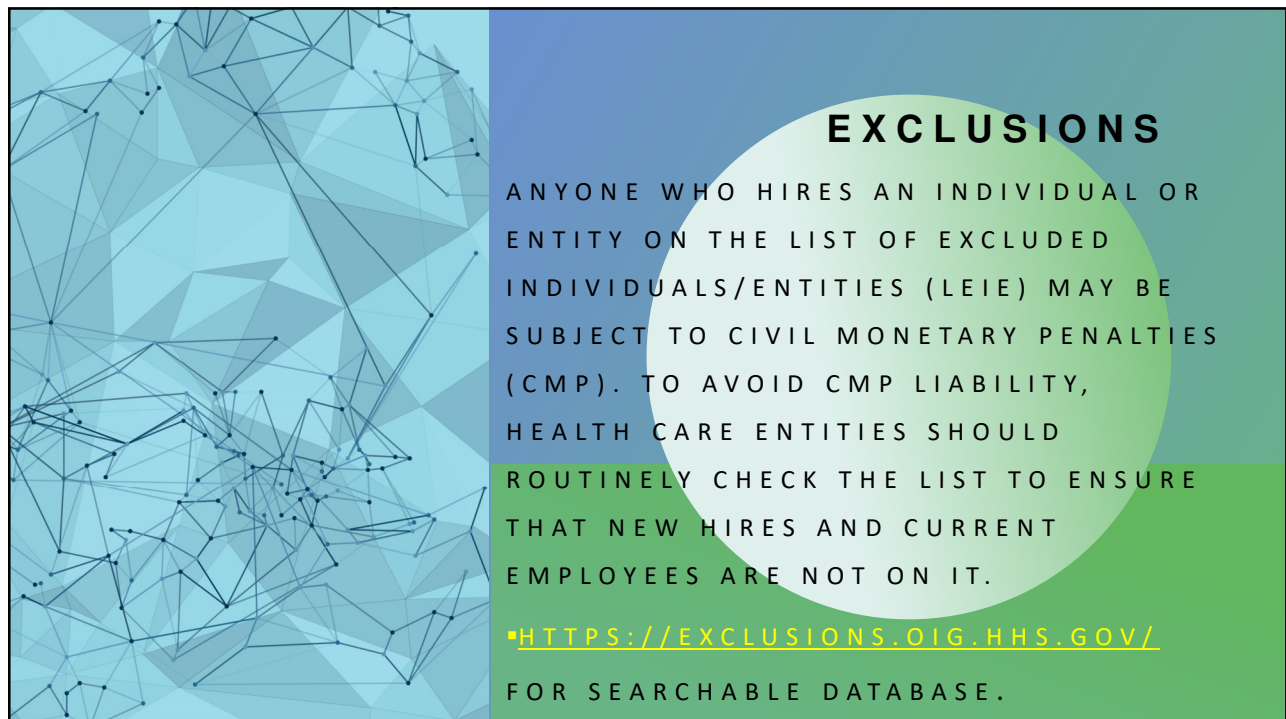
APPEALS

Level	Time Limit for Filing Request	Monetary Threshold to be Met
1. Redetermination	120 days from date of receipt of the notice of initial determination	None
2. Reconsideration	180 days from the date of receipt of the redetermination*	None
3. Administrative Law Judge (ALJ) Hearing	60 days from the date of receipt of the reconsideration	2026 = \$200
4. Departmental Appeals Board (DAB) Review/Appeals Council	60 days from the date of receipt of the ALJ hearing decision	None
5. Federal Court Review	60 days from date of receipt of the Appeals Council decision	2026 = \$1,960

34



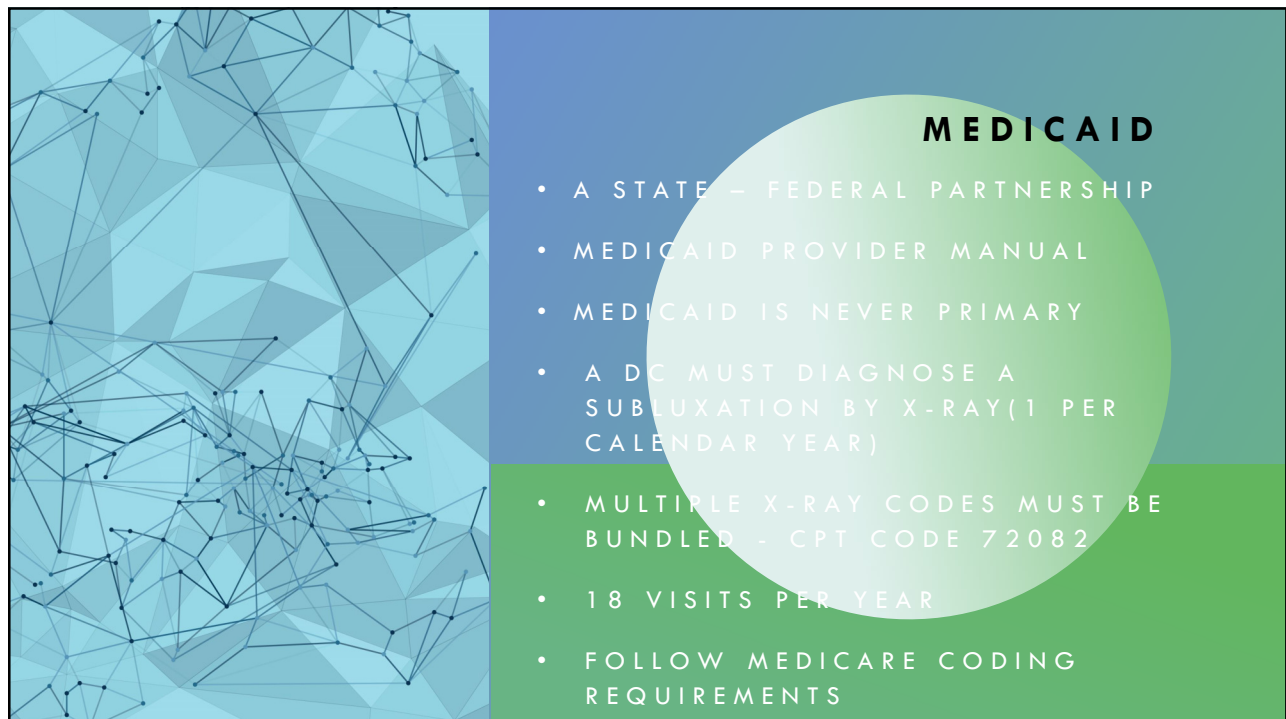
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36



37



38



MEDICAID

- 18 visits per Year
- Follow Medicare coding requirements
- DCs can choose to not treat, or to limit, Medicaid patients
- Dual Enrollees (Oh no!)

39

RESOURCES

- [Medicare Documentation Checklist & Guidelines for Chiropractic Doctor](#)
- [Medicare Revalidation List](#)
- [Medicare Coverage for Treating Relatives](#)
- [Beneficiaries Dually Eligible for Medicare & Medicaid](#)

40