# Local Coverage Article: Chiropractic Services (A52987)

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# Contractor Information

| Contractor Name | Contract Number | Contract Type | Jurisdiction |
|---|---|---|---|
| Novitas Solutions, Inc. | 04411 | A and B MAC | J - H |

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# Article Information

## General Information

**Article ID**
A52987

Original ICD-9 Article ID
A47798

**Article Title**
Chiropractic Services

**AMA CPT / ADA CDT / AHA NUBC Copyright Statement**


**Jurisdiction**
Texas

**Original Effective Date**
10/01/2015

**Revision Effective Date**
10/01/2015

**Revision Ending Date**
N/A

**Retirement Date**
N/A

# Article Guidance

**Article Text:**

**Coding Guidelines**

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

**When billing for Chiropractic services:**

- Report the initial treatment phase.
- Report the date of X-ray if an X-ray is used to demonstrate subluxation. The X-ray film must be available for review upon request.
- A physical examination may be used to document subluxation if an X-ray is not used. The physical examination must be documented in the medical record and must support the subluxation as described in LCD L35424.
- Report the level of subluxation using the appropriate ICD-10-CM code.
- In addition to reporting the ICD-10-CM code for the level of subluxation, report any other pertinent ICD-10-CM codes.
- As per the definitions supplied in LCD L35424, all treatments must be categorized as either acute subluxation, chronic subluxation or maintenance therapy. An exacerbation of a previous injury should be categorized into either "acute" or "chronic" (e.g., an identifiable re-injury would fall under acute).

The following modifiers should be reported with procedure code 98940, 98941, or 98942 as is appropriate to each patient's situation:

- **AT** – acute treatment
- **GA** – authorization has been provided to notify the beneficiary of the likelihood that services will be denied as not reasonable and necessary under Medicare guidelines.
- **GZ** – item or service expected to be denied as not reasonable and necessary

For Medicare purposes, the AT modifier shall now be used only when chiropractors bill for active/corrective treatment.

1. Every chiropractic claim (those containing HCPCS code 98940, 98941, 98942) with a date of service on or after October 1, 2004, to include the Acute Treatment (AT) modifier if active/corrective treatment is being performed; or
2. No modifier if maintenance therapy is being performed. Contractors shall deny a chiropractic claim (containing HCPCS code 98940, 98941, 98942) with a date of service on or after October 1, 2004, that does not contain the AT modifier.

**Reasons for Denial**

Excluded from Medicare coverage is any service other than manual manipulation for the treatment of subluxation of the spine. The chiropractor is not required to bill excluded services. However, if the beneficiary requests Medicare be billed, the provider must bill services to Medicare in order to obtain a denial for secondary insurance purposes. The following are examples (not an all-inclusive list) of services excluded from Medicare coverage when performed by a chiropractor; the beneficiary is responsible for payment.

- Laboratory tests
- X-rays
- Office visits (history and physicals)
- Physiotherapy
- Traction
- Supplies
- Injections
- Drugs

- EKGs or any diagnostic study
- Acupuncture
- Orthopedic devices
- Nutritional supplements/counseling
- Any service ordered by the chiropractor

In addition, services will be denied, prospectively as well as retrospectively, when:

- the contractor determines that the service is not medically reasonable and necessary; and/or
- the guidelines of LCD L35424 are not followed; and/or
- the medical record does not verify that the service described by the HCPCS code was provided; and/or
- there exists one of the absolute contraindications; and/or
- the mechanical or electric equipment, that is used for manipulation does not meet the definition of "manual device" as specified in the "Description" section of LCD L35424; and/or
- an X-ray or physical exam does not support one of the primary diagnoses listed in the "ICD-10 Codes That Support Medical Necessity" section of LCD L35424; and/or
- the service was performed as maintenance therapy; and/or
- the documentation, in the medical record is lacking the information required under the "Documentation Requirements" section of LCD L35424.

**Other Information**

**Other Comments**

The diagnosis code reported must be representative of the patient's condition.

**Additional Information**

Please refer to LCD L35424, Chiropractic Services, for additional information.

LCD L35424 is not intended to be interpreted as reflecting chiropractic scope of practice, but rather reflecting chiropractic coverage under the Medicare program. Back to Top

# Coding Information

**Bill Type Codes:**

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

| Bill Type Code | Bill Type Description |
|---|---|
| 999x | Not Applicable |

**Revenue Codes:**

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the article services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

| Revenue Code | Revenue Code Description |
|---|---|
| 99999 | Not Applicable |

**CPT/HCPCS Codes** N/A
**ICD-10 Codes that are Covered** N/A
**ICD-10 Codes that are Not Covered** N/A
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# Revision History Information

Please note: The Revision History information included in this Article prior to 06/20/2013 will now display with a Revision History Number of "R1" at the bottom of this table. All new Revision History information entries completed on or after 06/20/2013 will display as a row in the Revision History section of the Article and numbering will begin with "R2".

| Revision History Date | Revision History Number | Revision History Explanation |
|---|---|---|
| 10/01/2015 | R2 | Article revised effective for dates of service on and after 10/01/2014 to update the LCD reference from L34831 to L35424 and to create a uniform article with other MAC jurisdiction. Article published 07/24/2014. |
| 10/01/2015 | R1 | Article revised to remove the requirement to report P.A.R.T. on the claim effective for dates of service on or after 03/25/2014. (Article revised on 06/06/2014) |

Back to Top **Related Local Coverage Document(s)** N/A

**Related National Coverage Document(s)** N/A

**Statutory Requirements URL(s)** N/A

**Rules and Regulations URL(s)** N/A

**CMS Manual Explanations URL(s)** N/A

**Other URL(s)** N/A

**Public Version(s)** Updated on 07/17/2014 with effective dates 10/01/2015 - N/A Back to Top

# Keywords

N/A Read the **Article Disclaimer** Back to Top