Medicare Diagnosis

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Diagnosis

- The diagnosis is one of two codes that you place on the CMS 1500 form when you submit a claim.
- The diagnosis communicates the patient's condition to the computer that reads the claim.
- The computer is programmed to read the diagnosis and make certain decisions, including whether or not you get paid.
- The more accurately that you diagnose the patient, the better you can manage the case and the better you will get paid and the less likely you are to be reviewed.
- There is nothing magical about a diagnosis.
- You are simply taking what you find as you conduct you examination and combining it with the patient's subjective complaints and your training and experience to report the patient's condition and probable cause of their problem.
- The Medicare Benefits Policy Manual, Chapter 15, Section 24.1.2(2)(A)(4) states: "The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term 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."

Areas of the Spine

Area of Spine	Names of Vertebrae	Number of Vertebrae	Short Form or Other Name	Subluxation ICD-9 code
Neck	Occiput Cervical Atlas Axis	7	Occ, CO C1-C7 C1 C2	M99.00 M99.01
Back	Dorsal or Thoracic Costovertebral Costotransverse	12	D1-D12 T1-T12 R1-R12 R1-R12	M99.02
Low Back	Lumbar	5	L1-L5	M99.03
Pelvis	Ilii r and l		I, Si	M99.05
Sacral	Sacrum, Coccyx		S, SC	M99.04

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Which Diagnosis Code to Use

- There are currently three groups of codes that are used by chiropractors to identify the subluxation:
- The ICD-10 code M99.0X
- The ICD-10 code M99.1X
- And the HCPCS code S8990
- HCPCS Code S8990
    - There are three reasons for not using S8990 for Medicare billing.
    - The Health Care Procedure Coding System (HCPCS) is developed and maintained by CMS and consist of a letter followed by a series of numbers.
    - The codes are categorized by the letter prefixes.
    - The "S" codes are Private Payer Codes.
    - Quoting from the HCPCS Manual: "HCPCS "S" codes are temporary national codes established by the private payers for private payer use. Prior to using "S" codes on insurance claims to private payers, you should consult with the payer to confirm that the "S" codes are acceptable. **"S" codes are not valid for Medicare use."**
    - S8990 is defined as "physical or manipulative therapy performed for maintenance rather than restoration".
    - Maintenance care is not a covered service for Medicare beneficiaries.
    - As such, we are not required to bill Medicare for maintenance care and would not require a specific code for that purpose.
    - Not a single Medicare Administrative Contractor lists code S8990 in a Local Coverage determination.
    - If this code is not listed in the LCD then it is not acceptable to use when billing chiropractic services.
    - Reason 1 is sufficient to explain why code S8990 is not to be used to bill maintenance CMT to Medicare.
    - However, if this code were allowed to be used for Medicare billing, then reasons 2 and 3 would come into play.
- The M99.0X series of codes.
    - These are defined as: Segmental and somatic dysfunction of (specific) region.
    - This is the code that we should use for diagnosis of the subluxation.
    - This code is listed in every state's Local Coverage Determination and thus is required by every carrier or MAC.
- The M99.1X series of codes.
    - These are defined as: Subluxation complex (vertebral) of (specific) region.
    - This code is listed in Noridian's Local Coverage Determination and is an option for this MAC.
    - Noridian covers the states of California, Hawaii, Nevada, Alaska, Idaho, Oregon, Washington, Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming.
    - Also the territories of American Samoa, Guam, and the Northern Mariana Islands.

Areas of the Spine

Area of the Spine	Name of Vertebra	ICD-10 Codes
Neck	Cervical	M99.01, M99.11
Back	Thoracic	M99.02, M99.12
Low Back	Lumbar	M99.03, M99.13
Pelvis	ILLII R & L	M99.05, M99.15
Sacral	Sacrum, Coccyx	M99.04, M99.14

- When you file a claim for procedure code 98940 you must have primary and secondary diagnoses listed for one to two spinal regions on the claim form.
- When you file a claim for procedure code 98941 you must have primary and secondary diagnoses for three to four spinal regions listed on the claim form.
- When you file a claim for procedure code 98942 you must have primary and secondary diagnoses for all five spinal regions listed on the claim form.

ICD-10

- The ICD-10 coding system is completely different from the old ICD-9 system.
- The ICD-10 codes consist of letter and number combinations up to 7 characters.
- The ICD-10 codes are much more specific than the ICD-9 codes.
- The ICD-10 codes can also serve as both diagnosis codes and procedure codes however the procedure codes are not currently in widespread use.
- The ICD-10-CM code set contains approximately 68,000 codes as opposed to the ICD-9-CM code set which contained about 17,000 codes.
- ICD-10 has both an alphabetic index and a tabular list.
- Using a code from the alphabetical index only will cause you to misdiagnose a condition a significant part of the time.
- Find the code in the alphabetical index then look it up in the tabular index for additional information.
- The ICD-10-CM Tabular List contains categories, subcategories and codes.

- All categories are 3 characters.
- A three-character category that has no further subdivision is equivalent to a code.
- Subcategories are either 4 or 5 characters.
- Codes may be 3, 4, 5, 6 or 7 characters.
- A code that has an applicable 7th character is considered invalid without the 7th character.
- The ICD-10-CM utilizes a placeholder character "X".
- The "X" is used as a placeholder at certain codes to allow for future expansion.
- Where a placeholder exists, the X must be used in order for the code to be considered a valid code.
- Certain ICD-10-CM categories have applicable 7th characters.
- The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct.
- If a code that requires a 7th character is not 6 characters, a placeholder X must be used to fill in the empty characters.
- Diagnosis codes are to be used and reported at their highest number of characters available.
- A three-character code is to be used only if it is not further subdivided.
- A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.
- Alphabetic Index abbreviations
    - NEC "Not elsewhere classifiable"
        - This abbreviation in the Alphabetic Index represents "other specified." When a specific code is not available for a condition, the Alphabetic Index directs the coder to the "other specified" code in the Tabular List.
    - NOS "Not otherwise specified"
        - This abbreviation is the equivalent of unspecified.
- Tabular List abbreviations
    - NEC "Not elsewhere classifiable"
        - This abbreviation in the Tabular List represents "other specified". When a specific code is not available for a condition, the Tabular List includes an NEC entry under a code to identify the code as the "other specified" code.
- NOS "Not otherwise specified"
    - This abbreviation is the equivalent of unspecified.
- Punctuation
    - [ ] Brackets are used in the Tabular List to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the Alphabetic Index to identify manifestation codes.
    - ( ) Parentheses are used in both the Alphabetic Index and Tabular List to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers.

  - The nonessential modifiers in the Alphabetic Index to Diseases apply to subterms following a main term except when a nonessential modifier and a subentry are mutually exclusive, the subentry takes precedence.
  - : Colons are used in the Tabular List after an incomplete term which needs one or more of the modifiers following the colon to make it assignable to a given category.
- "Other" codes
  - Codes titled "other" or "other specified" are for use when the information in the medical record provides detail for which a specific code does not exist. Alphabetic Index entries with NEC in the line designate "other" codes in the Tabular List. These Alphabetic Index entries represent specific disease entities for which no specific code exists so the term is included within an "other" code.
- "Unspecified" codes
  - Codes titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code. For those categories for which an unspecified code is not provided, the "other specified" code may represent both other and unspecified.
- Includes Notes
  - This note appears immediately under a three character code title to further define, or give examples of, the content of the category.
- Inclusion terms
  - List of terms is included under some codes. These terms are the conditions for which that code is to be used. The terms may be synonyms of the code title, or, in the case of "other specified" codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the Alphabetic Index may also be assigned to a code.
- Excludes Notes
  - The ICD-10-CM has two types of excludes notes. Each type of note has a different definition for use but they are all similar in that they indicate that codes excluded from each other are independent of each other.
- Excludes1
  - A type 1 Excludes note is a pure excludes note. It means "NOT CODED HERE!" An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.
  - An exception to the Excludes1 definition is the circumstance when the two conditions are unrelated to each other. If it is not clear whether the two conditions involving an Excludes1 note are related or not, query the provider.
- Excludes2
  - A type 2 Excludes note represents "Not included here." An excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have

both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.

- "And"
  - The word "and" should be interpreted to mean either "and" or "or" when it appears in a title. For example, cases of "tuberculosis of bones", "tuberculosis of joints" and "tuberculosis of bones and joints" are classified to subcategory A18.0, Tuberculosis of bones and joints.
- "With"
  - The word "with" or "in" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated or when another guideline exists that specifically requires a documented linkage between two conditions.
  - For conditions not specifically linked by these relational terms in the classification or when a guideline requires that a linkage between two conditions be explicitly documented, provider documentation must link the conditions in order to code them as related.
  - The word "with" in the Alphabetic Index is sequenced immediately following the main term, not in alphabetical order.
- "See" and "See Also"
  - The "see" instruction following a main term in the Alphabetic Index indicates that another term should be referenced. It is necessary to go to the main term referenced with the "see" note to locate the correct code.
  - A "see also" instruction following a main term in the Alphabetic Index instructs that there is another main term that may also be referenced that may provide additional Alphabetic Index entries that may be useful. It is not necessary to follow the "see also" note when the original main term provides the necessary code.
- "Code also" note
  - A "code also" note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction. The sequencing depends on the circumstances of the encounter.
- "code first" and "use additional code"
  - Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, if applicable, followed by the manifestation. Wherever such a combination exists, there is a "use additional code" note at the etiology code, and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.

- "in diseases classified elsewhere"
    - In most cases the manifestation codes will have in the code title, "in diseases classified elsewhere." Codes with this title are a component of the etiology/ manifestation convention. The code title indicates that it is a manifestation code. "In diseases classified elsewhere" codes are never permitted to be used as first-listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the underlying condition. See category F02, Dementia in other diseases classified elsewhere, for an example of this convention.

Hierarchy of Diagnosis

- Nerve related Disorders (e.g. radiculopathy)
- Acute Injuries (e.g. sprains and strains)
- Structural Diagnoses (e.g. degenerative disc disease)
- Functional Diagnoses (e.g. difficulty with walking)
- Symptoms (e.g. neck pain)
- Complicating Factors/Comorbidities (e.g. diabetes)
- External Causes (e.g. place and activity)
- The condition must be coded to the highest level of specificity.
- If the highest level of specificity is "symptoms" then that is what you code.

Local Coverage Determination

- There are currently 12 Medicare Part B Jurisdictions plus Railroad Medicare in the country.
- Each one has a Local Coverage Determination covering chiropractic.
- Local Coverage Determinations are issued by Medicare Administrative Contractors to clarify policy regarding specific services.
- At the top of each LCD is a section marked "Document Information".
- In that section will be a "Revision Effective Date".
- This date will tell you how current the information is that is in this document.
- You should have a copy of your state's LCD for reference for your doctor and for your biller.
- You can find the chiropractic LCD on your Mac's website.
- Or you can find them in the "resources" section of my website www.chiromedicare.net.
- Most LCDs contain the information provided in the Medicare Benefits Policy Manual, Chapter 15, section 240 that is specific to the documentation requirements for chiropractors.
- Some will also contain utilization guidelines for chiropractic.
- Some will contain a list of secondary diagnoses that they accept.

Diagnosis

- The Medicare Benefits Policy Manual, Chapter 15, Section 240.1.3 states: "The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function."
- In other words, the area(s) of chief complaint must be consistent with the area(s) of examination.
- Which must be consistent with the area(s) of adjustment.
- Which must be consistent with the area(s) billed.
- The diagnosis must reflect this.
- The diagnosis must be consistent with the orthopedic and neurological test findings.
    - For example: If you have a diagnosis of Sciatica then you should have a compliant of low back pain with radiation down the leg and positive Laseque's and Braggard's tests.
- You must have imaging reports to confirm certain diagnoses.
    - For example: If you have a diagnosis of Degenerative Disk Disease you should have an x-ray report on file that lists disk thinning and spurring on the vertebral margins.
- Your diagnosis can be changed as new information becomes available.
    - For example: A patient has both low back and cervical diagnoses. At the first re-exam the cervical problem has resolved. It is appropriate to remove the cervical diagnosis from the claim form for services after the re-exam.
- Your diagnosis can be changed as new information becomes available.
    - For example: A patient has both low back and cervical diagnoses. At the first re-exam the cervical problem has resolved. It is appropriate to remove the cervical diagnosis from the claim form for services after the re-exam.
- The diagnosis is part, but not all, of the Assessment portion of the SOAP notes.
- It is your opinion of what is wrong with the patient.
- The better that you communicate this information to third party payers, the better you will be paid.

Non-Medicare Diagnosis

- Medicare diagnoses usually require that each spinal region have a primary subluxation diagnosis and a secondary neuromusculoskeletal diagnosis.
- All other third party payers do not want the subluxation diagnosis as the primary diagnosis.
- List the appropriate diagnoses in the order of the hierarchy of diagnosis.
- For most third-party payers you are not restricted to a list of diagnoses.
- You can use the appropriate diagnosis from the ICD-10 book.
- Just like with Medicare, you are communicating the patient's condition to the insurance companies computer.
- The more accurately and thoroughly that you diagnose the better that you will be paid and the fewer problems that you will have.

Summary

- The purpose of the diagnosis is to report what you have found to be wrong with the patient.
- You report what is there and what the subjective and objective information lead you to believe in your opinion based on your training and experience is the patient's underlying condition.
- These diagnoses are used by third party payers to determine the expected time frame of care.
- Medicare is very clear that the doctor is responsible for communicating the patient's condition to them.
- Understanding the diagnosis process and choosing the most accurate and specific diagnoses for that patient will convey the most accurate information to Medicare.
- Medicare is legally obligated to pay for care that is medically necessary.
- Clear and accurate diagnoses are an important part of proving medical necessity.