Medicare Diagnosis
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Value Based Payment Modifiers

- Value Based Payment Modifier, or VM as it is referred to by CMS, is mandated by the Patient Protection and Affordable Care Act (PPACA).
- The VM will be phased in starting in 2015 for groups of over 100 physicians that are billing under a single Tax ID Number (TIN) based on their 2013 PQRS Participation.
- The VM will apply to all physicians participating in Medicare Fee for Service by 2017.
- It is important to note that the VM is directly tied to the PQRS.
- The quality portion of the VM measure is based on the PQRS.
- For 2015, those groups that did not participate in PQRS will receive a VM of -1%.
- In other words, their payments will be cut by 1%.
- This is in addition to the 1.5% pay cut for not participating in the PQRS program.
- The following chart shows the current fee adjustments.

	Low Cost	Average Cost	High Cost
High quality	+2.0x*	+1.0x*	+0.0%
Average quality	+1.0x*	+0.0%	-0.5%
Low quality	+0.0%	-0.5%	-1.0%

- Note that this is the earliest release of this information.
- Medicare has a tendency to "adjust as they go" on programs like this.
- The single most important piece of information for you now is to know that if you do not report PQRS measures you will receive a negative payment adjustment.
- Start reporting PQRS now!

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.
- "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."

Which Diagnosis Code to Use

- There are currently three groups of codes that are used by chiropractors to identify the subluxation:
- The ICD-9 code 739.x
- The ICD-9 code 839.x
- 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.
- ICD-9 code 839.X
    - Defined as "other, multiple, and ill defined dislocations."
    - The 830-839 series of diagnoses are for dislocations and subluxations.
    - The subluxations referenced here are medical subluxations.
    - Taber's Cylopedic Medical Dictionary defines subluxation as: A partial or incomplete dislocation.
    - This section provides individual codes for open dislocations and closed dislocations.
    - Open dislocations include:
        - Compound,
        - Infected, or
        - With foreign body
    - Closed dislocations include:
        - Complete,
        - Dislocation NOS,
        - Partial,
        - Simple, or
        - Uncomplicated
    - Clearly, the 839.X series of codes is not for use by chiropractors.
- The 739.X series of codes.

- These are defined as: Nonallopathic lesions not elsewhere classified.
- They include:
    - Segmental Dysfunction
    - Somatic Dysfunction
- This is the code that was designed for use by chiropractors.
- 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.

Areas of the Spine

Area of the Spine	Name of Vertebra	ICD-9 Code
Neck	Occiput	739.0
	Cervical	739.1
Back	Thoracic	739.2
Low Back	Lumbar	739.3
Pelvis	ILLII R & L	739.5
Sacral	Sacrum, Coccyx	739.4

Local Coverage Determination

- The following is taken from the LCD for Illinois. There is similar language in almost every other LCD.
- The neuromusculoskeletal condition necessitating the treatment must be listed as the secondary diagnosis.
- Local Coverage Determinations are issued by Medicare Administrative Contractors to clarify policy regarding specific services.
- All but six states and Railroad Medicare have LCDs specific for chiropractic.
- Connecticut, New York, North Carolina, South Carolina, Virginia, and West Virginia do not have LCDs specific for chiropractic.
- 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.
- You can find the chiropractic LCD on the Mac's website.
- Or you can find them in the "resources" section of my website.
- 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.
- The following is an example from the WPS LCD:

- Once the maximum therapeutic benefit has been achieved for a given condition, ongoing maintenance therapy is not considered to be medically necessary under the Medicare program.
- Other information, such as this on documentation requirements, will be present:
- Documentation supporting the medical necessity of this item, such as ICD-9 codes, must be submitted with each claim. Claims submitted without ICD-9 codes will be denied as being not medically necessary. Documentation in the form of progress notes need not be submitted with each claim but be available upon request.
- Remember that these are samples from the WPS LCD.
- Yours may be different.
- This is why you should have a printed copy on hand for your office.
- Most LCDs contain a list of diagnoses that are to be used for secondary diagnoses.
- These are the only diagnoses to be used for this MAC.
- Some LCDs break them into sections like this and some do not.
- Those states with articles and a few states with LCDs do not have a list of secondary diagnoses to use.
- I have prepared a "Universal Medicare Diagnosis List" that you can download for free in the forms section of my website.

Hierarchy of Diagnosis

- Neurological Diagnosis
    - 724.3 Sciatica
- Structural Descriptor Diagnosis
    - 722.52 Degeneration of Lumbosacral Intervertebral Disc
- Functional Diagnosis
    - 719.7 Difficulty Walking
- Soft Tissue, Extremity, Complicating Factors
    - 847.0 Sprains and Strains of the Neck
- The condition must be coded to the highest level of specificity.
- If the highest level of specificity is "soft tissue" then that is what you code.

Diagnosis

- 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.
- The diagnosis is part 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.

ICD-10

- The implementation deadline for ICD-10 is now October 1, 2014.
- The ICD-10 coding system is completely different from the ICD-9 system.
- The ICD-10 codes consist of letter and number combinations up to 10 places.
- The ICD-10 codes are much more specific than the ICD-9 codes.
- The ICD-10 codes will also serve as both diagnosis codes and procedure codes.
- You need to start familiarizing yourself with the ICD-10 codes now.
- The following are some links to ICD-10 resources.
- FAQs on ICD-10 Transition
- Medscape Modules on ICD-10
- An Introduction to ICD-10 Transition
- Small and Medium Practice Transition Checklist
- ICD-10 Implementation guide
- ChiroCode ICD-10 book, 2nd Ed.

Summary

- 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.