



1



2



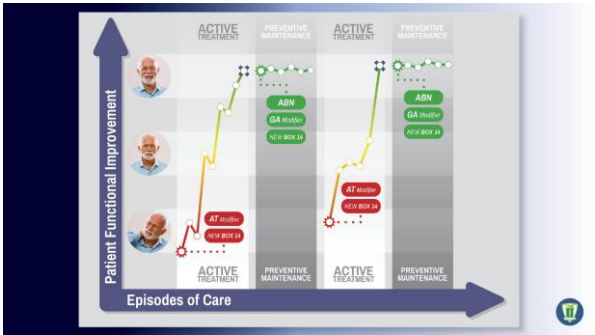
3



4



5



6



10

11

12

Understand and Implement Medical Necessity Definitions

The definition of Medical Necessity, per Medicare, is:

- 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.**

13

AT = Active Treatment

- By definition meets medical necessity
- Billed and expected to be paid
- Follows MAC screens
- Should not be automatic

14

The Opposite of Active Treatment

Maintenance therapy is defined (per Chapter 15, Section 30.5.B, of the Medicare Benefits Policy Manual) as a **treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition.**

15

The KMC University's Guide to MEDICARE MODIFIERS

Code	Description/Effect	Effect on Medicare Payment
AT	Chiropractic treatment for a neuromusculoskeletal condition	Medicare will consider for payment.
GA	For Medicare use: Medicare reimbursement rate is 80% of the non-Medicare rate.	Medicare will deny or not medically necessary. Patient will be financially responsible.
GZ	Medicare use: Medicare reimbursement rate is 80% of the non-Medicare rate.	Claims will be denied. Patient will be financially responsible for payment.

Code	Description/Effect	Effect on Medicare Payment
GY	Indicates statutorily non-covered services are covered by a plan.	Billing of these services is not required unless the patient requests. Patient is financially liable.
GX	Not for the Medicare use.	Claims will be denied. Medicare will deny or not medically necessary. Patient will be financially responsible.
GP	Used for certain therapy services as well as certain treatment plans.	Claims will be denied. Medicare will deny or not medically necessary. Patient will be financially responsible.

MANDATORY SUBMISSION

VOLUNTARY SUBMISSION

MEDICARE PART B

16

Chiropractic Services – Medical Policy Article

NOT AN LCD REFERENCE ARTICLE

This article is not a direct support of an LCD. (Last updated: 10/1/2024)

Article Guidance

Article Text

Chiropractic manipulation treatment (CMT) is a form of manual treatment to influence joint and neuromusculoskeletal function. This treatment may be accomplished using a variety of techniques. Medicare covers chiropractic manipulation services when performed by a chiropractor, as defined in the Medicare Manual, Chapter 15, Section 30.5.B. A chiropractor must also meet certain requirements to not be a Medicare provider. Medicare Manual, Chapter 15, Section 30.5.B. This article provides guidance on the requirements for the diagnosis, treatment, documentation and billing of chiropractic services.

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. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam. (CMS Publication 100-02, Medicare Benefit Policy Manual Chapter 15, Section 30.5.B.)

Most spinal care problems fall into the following categories:

- Acute/trauma:** A patient's condition is considered acute when the patient is being treated for a new injury, identified by a x-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.
- Therapeutic:** A patient's condition is considered chronic when a patient is expected to significantly improve or be relieved with further treatment for a chronic condition, but where the continued therapy can be expected to result in some functional improvement. Once the chronic status has improved, the patient is no longer eligible for Medicare coverage of chiropractic services. Further manipulation treatment is considered maintenance therapy and is not covered. (CMS Publication 100-02, Medicare Benefit Policy Manual Chapter 15, Section 30.5.B.)
- Maintenance:** A patient's condition is considered chronic when a patient is expected to significantly improve or be relieved with further treatment for a chronic condition, but where the continued therapy can be expected to result in some functional improvement. Once the chronic status has improved, the patient is no longer eligible for Medicare coverage of chiropractic services. Further manipulation treatment is considered maintenance therapy and is not covered. (CMS Publication 100-02, Medicare Benefit Policy Manual Chapter 15, Section 30.5.B.)

An acute representation is a temporary but marked deterioration of the patient's condition that is causing significant interference with activities of daily living due to an acute flare-up of the previously treated condition. The patient's clinical record must specify the date of occurrence, nature of the event, or other pertinent factors that would support the medical necessity of treatment. As with all acute injury, treatment should be initiated as soon as possible and the duration of treatment should be as short as possible.

Maintenance Therapy:

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 continued therapy, and the chiropractic treatment services are supportive rather than corrective in nature, the treatment is then considered maintenance therapy. (CMS Publication 100-02, Medicare Benefit Policy Manual Chapter 15, Section 30.5.B.)

MEDICARE PART B

17

DCs Must Answer with Certainty!

Is there a subluxation present, capable of causing a significant neuromusculoskeletal (NMS) condition, and does the patient have a documented loss of function that can be improved?

If No...

In this circumstance, per Medicare coverage requirements, medical necessity cannot be established and therefore the condition is likely maintenance care.

18

855-832-6562

3

What Medicare and Other Payers Want to See

<https://www.cms.gov/medicare/coverage/coverage-guidance>

- Prove Medical Necessity
- Cause and start date
- End date of care
- Diagnosis match patient complaints, does that match billing and coding
- Is patient on/following a treatment plan?

A circular diagram with eight segments, each containing a medical record component. The segments are arranged in a circle around a central black circle. The segments are: HISTORY TAKEN (top), ACTIVITIES OF DAILY LIVING (top-right), EXAM REFLECTS DIAGNOSIS (right), TREATMENT PLAN (bottom-right), FUNCTIONAL DAILY NOTES (bottom), RE-EXAM UPDATE DX/PLAN (bottom-left), FUNCTIONAL DAILY NOTES (left), and DISCHARGE SUMMARY (top-left). Arrows connect the segments in a clockwise direction.

19

Reimbursement and claims processing information

You should collect the member's copayment, coinsurance and/or deductible for covered services and submit all clean claims for covered services to us for payment. Remember to include the patient-paid amount on claims and encounters submitted to us. Claims will be processed in accordance with:

- Original Medicare billing rules
- Medicare fee schedule
- All prospective payment system requirements
- Local coverage determinations
- The member's plan documents, including his or her Evidence of Coverage

Medicare limiting charges apply. With respect to bundling/unbundling logic, we use the Correct Coding Initiative (NCCI). The link to NCCI on the Centers for Medicare & Medicaid Services (CMS) website is www.cms.gov/nationalcorrectcoding/.

MEDICARE PART C

20

Humana. Claims Payment Policy

Subject: Chiropractic Services for Acute Treatment

Application: Medicare Advantage Products Published date: 12/2024

Policy number: C000000004

Related policies: N/A

Disclaimer: The intended audience of this medical claims payment policy is healthcare providers who treat Humana members. This policy is made available to provide information on certain Humana Medicare Advantage products. This policy is a guideline only and does not constitute medical advice, payment of premiums, plan and contribution, or representation of benefits, or a contract. This policy does not guarantee whether a provider is covered under a specific Medicare plan or policy, nor is it intended to replace any other document. There may be other factors, such as, state and federal law and regulations, provider contract terms, and plan provisions that apply. This policy is subject to change or termination by Humana. Humana has not and does not have the authority to interpret and apply this policy. No part of this policy may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise without express written permission. For more information, please contact your Humana agent. For more information, please contact your Humana agent. For more information, please contact your Humana agent.

Overview

This policy establishes Humana's billing requirements and reimbursement guidelines for chiropractic services covered under the Medicare Part B benefit.

Under some Humana Medicare Advantage (MA) plans there is supplemental benefits that covers chiropractic services that Original Medicare would not cover. This policy does not apply to services provided under one of these benefits.

Medicare Advantage Payment Policy

Definitions of Related Terms

References

General Humana Resources

MEDICARE PART C

21

Medicare Advantage Payment Policy

In addition to the policy, claims payments are subject to other plan requirements for the processing and payment of claims, including, but not limited to, requirements of medical necessity and reasonable and applicable referral or authorization requirements.

Humana MA plans allow chiropractic services consistent with the applicable Centers for Medicare & Medicaid Services (CMS) guidance. Humana plans cover chiropractic services under the Medicare Part B benefit for the same diagnoses as Original Medicare. In addition, the chiropractic service must be rendered for acute treatment purposes to be covered under the Medicare Part B benefit. Providers must report chiropractic services covered under the Medicare Part B benefit consistent with guidance in applicable CMS published transmittals and Internet-only Manuals. That includes, but is not limited to, the criteria outlined in this policy.

Humana requires providers to report modifier AT when billing for chiropractic services Current Procedural Terminology (CPT®) codes 98940 – 98942 when the service meets all qualifications for coverage under the Medicare Part B benefit.

Humana uses the reporting of modifier AT to determine whether to apply a charge for CPT code 98940 – 98942 to the Medicare Part B benefit. Only claims reported with modifier AT will be applied to the Medicare Part B benefit.

Definitions of Related Terms

- **Modifier AT:** Acute treatment
- **CPT code 98940:** Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
- **CPT code 98941:** Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
- **CPT code 98942:** Chiropractic manipulative treatment (CMT); spinal, 5 regions

MEDICARE PART C

22

Active Episodes of Care

Expect Payment from Payer

A circular diagram with eight segments, each containing a medical record component. The segments are arranged in a circle around a central black circle. The segments are: HISTORY TAKEN (top), ACTIVITIES OF DAILY LIVING (top-right), EXAM REFLECTS DIAGNOSIS (right), TREATMENT PLAN (bottom-right), FUNCTIONAL DAILY NOTES (bottom), RE-EXAM UPDATE DX/PLAN (bottom-left), FUNCTIONAL DAILY NOTES (left), and DISCHARGE SUMMARY (top-left). Arrows connect the segments in a clockwise direction.

23

Maintenance

- Wellness
- Preventive care
- Promote health
- Prolong/enhance the quality of life
- Supportive
- Maintain or prevent deterioration of a chronic condition

Expect Payment from Your Patient!

MEDICARE PART B

24



25

**CRAZY OFFERS
JUST FOR YOU!**

FOR NON-MEMBERS...

Library Annual Membership
FIRST MONTH FREE!

One-on-One with a Specialist
**FULL VHOL CREDIT
TOWARD YOUR
PURCHASE!**

**NEXT-GEN
MEDICARE**
Practical and Updated Training For Billing & Risk Management

FOR MEMBERS...

Proactive Chart Review (PCR)
Regular Price: \$349
**SPECIAL
VHOL OFFER:
JUST**
\$59

**MEMBERSHIP
HAS ITS
PRIVILEGES!**

KMCUniversity.com | (855) 832-6562

26



27