

Billing and Coding Guidelines:

CHIRO-001 - Chiropractic Services

CMS National Coverage Policy

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Coverage Guidelines

AT modifier Effective for services rendered on or after 10/01/2004

For Medicare purposes, the AT modifier shall now be used only when chiropractors bill for active/corrective treatment. CR 3449 requires that 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.

The AT modifier must not be placed on the claim when maintenance therapy has been provided. Claims without the AT modifier will be considered as maintenance therapy and denied. Chiropractors who give or receive from beneficiaries an ABN shall follow the instructions in Pub. 100-04, Medicare Claims Processing Manual, Chapter 23, section 20.9.1.1 and include a GA (or in rare instances a GZ) modifier on the claim.

Manual Manipulation. --Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation, i.e., by use of hands. Additionally, manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. However, no additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself

No other diagnostic or therapeutic service furnished by a chiropractor or under his or her order is covered. This means that if a chiropractor orders, takes, or interprets an x-ray, or any other diagnostic test, the x-ray or other diagnostic test, can be used for claims processing purposes, but Medicare coverage and payment are not available for those services. (Of course, this prohibition does not affect the coverage of x-rays or other diagnostic tests furnished by other practitioners under the program. For example, an x-ray or any diagnostic test taken for the purpose of determining or demonstrating the existence of a subluxation of the spine, is a diagnostic test covered under the Social Security Act if ordered, taken, and interpreted by a physician who is a doctor of medicine or osteopathy.)

Some chiropractors have been identified as using an "intensive care" concept of treatment. Under this approach, multiple daily visits (as many as four or five in a day) are given in the office or clinic and so-called room or ward fees are charged since the patient is confined to bed usually for the day. The room or ward fees are not covered and reimbursement under Medicare will be limited to not more than one treatment per day unless documentation of the reasonableness and necessity for additional treatment is submitted with the claim.

Coding Guidelines

1. The precise level of subluxation must be specified on the claim and must be listed as the primary diagnosis. The neuromusculoskeletal condition necessitating the treatment must be listed as the secondary diagnosis.
2. All claims for chiropractic services must include the following information:
Date of the initiation of the course of treatment.

Symptom/condition/Secondary diagnosis code(s)
Subluxation(s)/Primary diagnosis code(s)
Date of Service
Place of Service
Procedure Code
Failure to report these items will result in claim denial or delay.

Note: Date of last x-ray is no longer required. Any date placed in item 19 is considered date of last x-ray. It is recommended that providers do not place any date in item 19 of the CMS-1500 claim form.

3. Limitation of Liability rules apply: The purpose of the Limitation of Liability provision is to protect the beneficiary from liability in denial cases under certain conditions when services rendered are found to be not reasonable and medically unnecessary.

If the provider uses the AT Modifier and believes a service is likely to be denied by Medicare as not being medically necessary, the beneficiary must sign an Advance Beneficiary Notification (ABN) and the GA modifier must be used.

4. *The following information must be recorded by the chiropractor and kept on file. The date of the initial treatment or the date of the exacerbation of the existing condition must be entered in Item 14 of Form CMS-1500 or the electronic equivalent. This serves as affirmation by the chiropractor that all documentation required as listed below and in the regulations is being maintained on file by the chiropractor. Specify the precise spinal location and level of subluxation giving rise to the diagnosis and symptoms.*
5. Physician signature for progress notes and reports (hand written, electronic). Initials if signed over a typed or printed name or accompanied by a signature log or attestation statement.

Non-Covered Services:

All services other than manual manipulation of the spine for treatment of subluxation of the spine are excluded when ordered or performed by a doctor of chiropractic. Chiropractors are not required to bill these to Medicare. Chiropractic offices may want to submit charges to Medicare to obtain a denial necessary for submitting to a secondary insurance carrier. The following are examples of (not an all inclusive list) of services that, when performed by a Chiropractor, are excluded from Medicare coverage.

- Laboratory tests
- X-rays
- Office Visits (history and physical)
- Physiotherapy
- Traction
- Supplies
- Injections
- Drugs
- Diagnostic studies including EKGs
- Acupuncture
- Orthopedic devices
- Nutritional supplements and counseling

Medicare does not cover chiropractic treatments to extraspinal regions (CPT 98943), which includes the head, upper and lower extremities, rib cage, and abdomen.

Request for Review

When requesting a review, submit documentation that supports the medical necessity of the denied service.

Revision History

12/01/2015 Updated information under CMS National Coverage Policy.

04/01/2015 Annual review, no change in coverage, removed underlining, updated CMS reference.

11/01/2014 Removed outdated information for placing diagnosis codes in position 1, 2, 3 and 4. Removed duplicative information regarding placement of primary and secondary diagnosis codes.

05/01/2014 Reformatted CMS references, removed the section under Non covered services “and for which the beneficiary is responsible for payment:” because some services could be denied as provider liable.