L36617: Medicare Part A/B local coverage determination (LCD) comment summary

LCD Number

L36617

Contractor Name

First Coast Service Options, Inc.

Contractor Numbers

09101 – Florida
09201 – Puerto Rico/Virgin Islands
09102 – Florida
09202 – Puerto Rico
09302 – Virgin Islands

Contractor Type

MAC Part A/B

LCD Title

Chiropractic Services

AMA CPT Copyright Statement

Start Date of Comment Period:

02/12/2016

End Date of Comment Period:

03/28/2016

Comments received:

Comment #1: Comments received from the American Chiropractic Association (ACA) and the Florida Chiropractic Association (FCA) in support of the draft Local Coverage Determination (LCD) diagnostic requirement for utilization of the segmental and somatic dysfunction ICD-10 codes, M99.01 – M99.05, as the primary codes for reporting on the submitted claims forms. Based on experience gained from the release of previously modified chiropractic LCD language related to diagnostic changes, the ACA, concurred by the FCA, recommended the addition of the following language in the "Coding Information" section of the LCD to clarify that additional qualifying diagnostic codes are available and should be reported by doctors of chiropractic:

> "While it is mandatory to use the M99.01-M99.05 codes, it is appropriate and encouraged to utilize, in addition to the primary codes, additional clinical or qualifying diagnostic codes from the ICD-10 code base that best indicates the clinical condition of each individual patient. These qualifying codes would be beneficial to differentiate more complicated clinical conditions and subsequently aid in developing treatment plans and protocols."

Contractor response: Thank you for your comment and suggestion. A clarifying statement will be added to the final LCD indicating that the level of the subluxation must be specified on the claim and must be listed as the primary diagnosis. The neuromusculoskeletal condition necessitating treatment should be listed as the secondary diagnosis. All diagnosis codes must be coded to the highest level of specificity, and the primary diagnosis must be supported by x-ray or documented by physical examination.

Comment #2: A recommendation was received from the ACA and the FCA to modify the language in the "Utilization Guidelines" section of the proposed LCD by replacing the statement, "Chiropractic physicians submitting claims for beneficiaries receiving excessive services (CMTs) in a month (acute care) or over a year (chronic care) are likely to come under pre or post payment medical review. Outlier services (12 CMTs in a month, 30 CMTs in a year) should be extremely rare and could be subject to denials" with the following statement:

"Prolonged or repeated courses of treatment are more subject to medical review and may indicate maintenance therapy. Documentation to support the medical necessity of repeated courses of treatment must be present in the patient's plan of care."

The modified language addresses the reason for and the intent to perform medical review if submitted claims are suspected of being not medically reasonable or necessary. By using the modified language, there remains a consistency of standardizing, among the nations MAC's, interpretation of regulatory requirements and adjudication of submitted claims.

Contractor response: Thank you for your comment and recommendation. We agree that since the LCD addresses the same benefit and manual language it should be consistent in its interpretation. We added the recommended statement but will keep the utilization guideline. The utilization guideline language is consistent with another MAC that also administers claims in a high volume environment.

Comment #3: In regard to the information related to cervicogenic headaches, the ACA and FCA respectfully requests the deletion of the statements, "Chiropractic manipulative therapy to treat the cervical abnormality responsible for acute episodes of episodes of cervicogenic headaches meeting HIS or Syaastad's criteria will be allowed. Maintenance therapy for cervicogenic headaches will not be allowed." To identify one specific clinical condition and apply specific criteria, different from the criteria for all other conditions, to meet the standard of medical necessity is confusing and illogical. As stated in the Medicare Benefit Policy Manual, "Implementation of the chiropractic benefit requires an appreciation of the differences between chiropractic theory and experience and traditional medicine due to fundamental differences regarding etiology and theories of the pathogenesis of disease. Judgments about the reasonableness of chiropractic treatment must be based on the application of chiropractic principles." Centers for Medicare and Medicaid Services, Medicare Benefit Policy Manual, CMS Pub. 100-02, Chap. 15, Sec. 240. Additionally, the second sentence, "Maintenance therapy for cervicogenic headaches will not be allowed," is unnecessary and should be deleted, as maintenance therapy for ALL conditions will not be allowed.

Contractor response: Thank you for your comment. The statement will be removed.

Comment #4: A comment was received suggesting objective measures should be "required" rather than "recommended" as stated in the draft LCD. The policy would be more effective if it required objective measures to quantify progress and support justifications for continued treatment. Chiropractors should not feel obligated to include supporting evidence that is recommended.

Contractor response: Thank you for your comment and suggestion. However, Medicare Benefit Policy Manual, Chapter 15: 240 Chiropractic Services states the treatment plan '**should'** include the following: Recommended level of care (duration and frequency of visits); Specific treatment goals; and Objective measures to evaluate treatment effectiveness. Language quoted from Centers for Medicare & Medicaid Services (CMS) coverage provisions in interpretive manuals are not subject to the LCD Review Process and cannot be changed.