DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

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Misinformation on Chiropractic Services

Background

This fact sheet is being provided by the Centers for Medicare & Medicaid Services (CMS) to correct misinformation in the chiropractic community, relating to Medicare and its regulations as it relates to chiropractic services. This fact sheet is informational only and represents no changes to existing Medicare policy.

CMS is providing this fact sheet in order to clarify specific issues. The issues being addressed are as follows:

Misinformation #1: There is a 12 visit cap or limit for chiropractic services.

Correction: There are no caps/limits in Medicare for covered chiropractic care rendered by chiropractors who meet Medicare's licensure and other requirements as specified in the "Medicare Benefit Policy Manual," Chapter 15, Section 30.5 (this manual is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html on the CMS website). Your Medicare Administrative Contractor (MAC) may have review screens (numbers of visits at which the MAC might require a review of documentation before allowing further care), but caps/limits are not allowed.

Misinformation #2: If you are a non-participating (non-par) provider, you do not have to worry about billing Medicare.

Correction: Being non-par does not mean you don't have to bill Medicare. All Medicare Part B covered services must be billed to Medicare by the provider or the provider could face penalties. This is known as the "Mandatory Claim Submission Rule" (an exception to this is when the beneficiary has signed a valid Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, with Option #2 selected—see "Misinformation #5" for further information).

A non-par provider is actually someone who has enrolled to be a Medicare provider but chooses to receive payment in a different method and amount than Medicare providers classified as participating. Non-par providers may receive reimbursement for rendered services directly from their Medicare patients; however, they still must submit a bill to Medicare so the beneficiary may be reimbursed for the portion of the charges for which Medicare is responsible.

It is important to note that non-par providers may also choose to accept assignment; therefore, the amount paid by the beneficiary must be reported in Item 29 of the CMS 1500 claim form or its electronic equivalent. This ensures that the beneficiary is reimbursed (if applicable) prior to Medicare sending payment to the provider.

Whether or not non-par providers choose to accept assignment on all claims or on a claim-by-claim basis, Medicare reimbursement is five percent less than for a participating provider, as reflected in the annual Medicare Physician Fee Schedule.

You can find a copy of the Medicare Participating Provider Agreement at **http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html** on the CMS website. The form contains important information regarding the participation process and the annual opportunity you have to make or change your participation decision. Additional information is available in the "Medicare Benefit Policy Manual" (Chapter 15; Covered Medical and Other Health Services) at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf** and the "Medicare Claims Processing Manual" (Chapter 12; Physician/Nonphysician Practitioners) at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf** on the CMS website.

Misinformation #3: If you are a non-par provider, you will never be audited nor have claims reviewed.

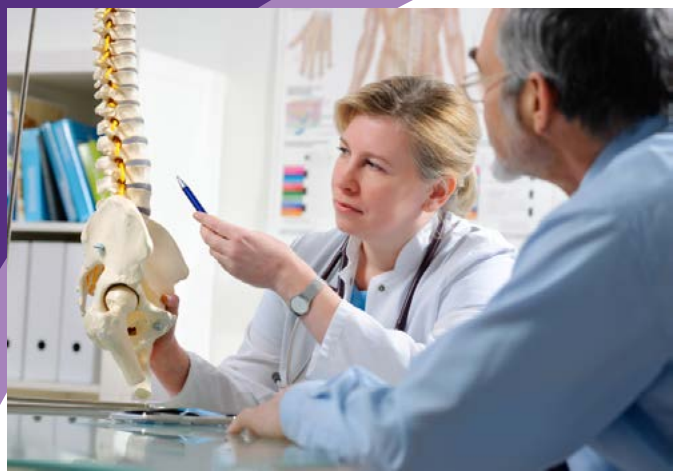
Correction: Any Medicare claim submitted can be audited/reviewed; the participation status of the physician does not affect the possibility of this occurring. CMS audits/reviews are intended to protect Medicare trust funds and also to identify billing errors so providers and their billing staff can be alerted of errors and educated on how to avoid future errors. Correct coverage, reimbursement, and billing requirements are readily available to assist you in understanding Medicare requirements.

This information is in Medicare manuals that are at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html** on the CMS website. In addition, an excellent way to stay informed about changes to Medicare billing and coverage requirements is to monitor MLN Matters® Articles, which are available at **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** on the same site.

Misinformation #4: You can opt out of Medicare.

Correction: Doctors of Chiropractic (DC) may not opt out of Medicare. Note that opting out and being non-participating are not the same things. Chiropractors may decide to be participating or non-participating with regard to Medicare, but they may not opt out. (Opt out refers to physicians' ability to decide not to bill Medicare at all and then entering into private contracts with Medicare beneficiaries they treat. Services furnished under these private contracts that meet the opt out requirements are not covered services under Medicare and no payment is made for those services by Medicare.)

For further discussions of the Medicare "opt out" provision, see the "Medicare Benefit Policy Manual" (Chapter 15, Section 40; Definition of Physician/Practitioner) at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf** on the CMS website.



Misinformation #5: You should get an Advance Beneficiary Notification (ABN) signed once for each patient and it will apply to all services, all visits.

Correction: The decision to deliver an ABN to a beneficiary must be based on the expectation that Medicare will not pay for a particular service because that service will not be considered medically reasonable and necessary in this instance. The ABN then allows the beneficiary to make an informed decision about receiving and paying for the service.

The ABN has 3 option boxes, and the beneficiary must choose one before signing the ABN for it to be considered valid liability notification.

Option #1:
If the beneficiary selects option #1, s/he is agreeing to pay out of pocket for the service in question and requests that the chiropractor file a claim for that service with Medicare. With option #1 selected, the beneficiary retains appeals rights if s/he disagrees with Medicare's claim decision. The chiropractor is permitted to ask for payment from the beneficiary before the claim is filed if option #1 is chosen. (Beneficiaries who have secondary insurance may need a Medicare denial on a claim to enable reimbursement from their secondary insurance plan.)

Option #2:
A beneficiary selects option #2 when s/he agrees to pay out of pocket for the service in question and does not want a claim sent to Medicare. In accordance with the ABN, the provider would not file a claim, and the beneficiary would not have appeal rights since no claim is being submitted. (Please note that the patient can change his/her mind at a future time and request the claim be submitted.)

Option #3:
Option #3 is selected by the beneficiary who chooses not to receive and pay for the service. No service is rendered, and no claim is filed. Since no claim is filed, the patient cannot appeal to Medicare for a payment decision.

An ABN is issued each time a patient receives a Medicare covered service that the provider believes might be considered not medically reasonable and necessary and thus not payable by Medicare. Providers may issue a single ABN to a patient receiving the same service multiple times on a continuing basis (for example, lumbar spinal manipulation monthly for a year). ABNs for repetitive services can be effective for up to one year. The ABN for ongoing services must describe the specific service(s) and frequency of delivery. If delivery of the repetitive service exceeds one year or the service provided changes, a new ABN must be issued. When a beneficiary with an ABN on file for repetitive services receives a different service that is not listed on the ABN, and for which Medicare payment is not expected, a separate ABN must be issued for the service which is not listed. For further information, see the "Medicare Claims Processing Manual" (Chapter 30) at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf** and the "Medicare Benefit Policy Manual" (Chapter 15) at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf** on the CMS website. Also, see the booklet titled, "Advance Beneficiary Notice of Non-Coverage (ABN) Part A and Part B" at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf** on the CMS website.

Misinformation #6: Maintenance care is not a covered service under Medicare.

Correction: Spinal manipulation is a covered service under Medicare. However, maintenance care is not considered by Medicare to be medically reasonable and necessary, and is not reimbursable by Medicare. Only acute and chronic spinal manipulation services are considered active care and may, therefore, be reimbursable. Maintenance therapy is defined (per Chapter 15, Section

30.5.B. of the "Medicare Benefit 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. When further clinical improvement cannot reasonably be expected from continuous ongoing care, the treatment is then considered maintenance therapy.

See MM3449 (Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy) at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm3449.pdf on the CMS website. This article contains important information on completing claims and how to identify acute and chronic adjustments as opposed to maintenance adjustments. When a maintenance spinal manipulation treatment is being provided, the ABN must be issued before the service is rendered. Additional details are available in the "Medicare Benefit Policy Manual," Chapter 15, Section 30.5 (Chiropractor's Services) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf on the CMS website.

Misinformation #7: Non-par providers do not have the same documentation requirements as par providers.

Correction: Chiropractic care has documentation requirements. The participating status of the provider is irrelevant to the documentation requirements. Specific details regarding documentation requirements are in the "Medicare Benefit Policy Manual" (Chapter 15, Sections 30.5 and 240) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf on the CMS website. Also, see the "Medicare Claims Processing Manual" (Chapter 12, Section 220) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf on the CMS website.

Misinformation #8: DME ordered by a DC will be reimbursed by CMS.

Correction: A chiropractor may act as supplier of durable medical equipment (DME) if s/he has a valid supplier number assigned by the National Supplier Clearinghouse, but a chiropractor will not be reimbursed if s/he orders DME.

Additional Information

If you have any questions regarding chiropractic issues, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

The Social Security Act (Section 1862 (a)(1) at http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the Internet) provides that Medicare will only pay for items or services it determines to be "reasonable and necessary" and, if those items or services can be shown to be "reasonable and necessary," then those items or services are covered and will be paid by Medicare.

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