medicare

getting your share

S A M
C O L L I N S

3.7.2024

H.J. Ross Company, one of the most highly trusted billing, coding, and compliance companies, has streamlined insurance operations for thousands of chiropractors nationwide for over 40 years. Clients can depend on the H.J. Ross Company to provide the most up to date protocols and procedures, and to be your coach, making it easy for you and your staff to adapt to the changing climate within the insurance industry including codes, laws, and regulations related to the practice of chiropractic.

As director, Dr. Sam Collins believes that you should get paid. His history is firmly rooted in chiropractic, both as a chiropractor from a chiropractic family and now, as he is proudly regarded as The Billing Expert in the chiropractic profession.

Due to our unique ability to stay ahead of the curve on the latest trends and changes in billing and coding by utilizing our direct channel of communication with the insurance companies and organizations that set the guidelines, you can trust you are in good hands!

There is a reason Chiropractors who trusted us with their business 40 years ago still trust us today

Platinum Membership

Expert support for billing & coding logistics, with state-specific compliance

Unlimited phone and email access

Keep **Updated** to stay fully compliant

Review denied claims and revise for ensuring proper reimbursement

CPT & ICD-10 Coding, general health insurance, workers' compensation, personal injury, Medicare, and VA

1 complimentary **Seminar** for the Practitioner *or* Staff Member

Annual **Fee Schedule** adjustments

Online **Document Library**: digital coding reference bank, insurance verification, informed consent, HIPPA, personal injury, fight-back letters, customizable office forms, and more!

ROI : On average, our clients generate >3x the amount of income through proper filing of claims

Monthly **Strategy** Meetings

SIGN UP HERE

2023 EDITION

Medicare Beneficiaries

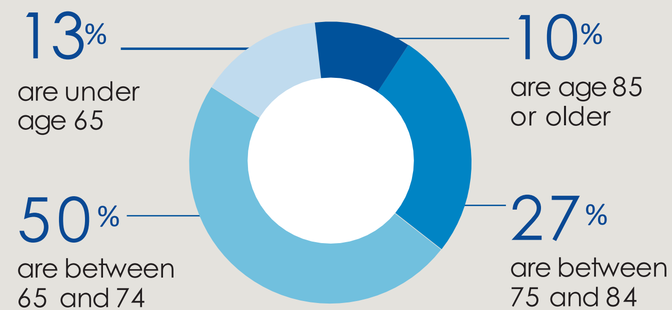
AT A GLANCE

WHO'S COVERED BY MEDICARE — 2021:

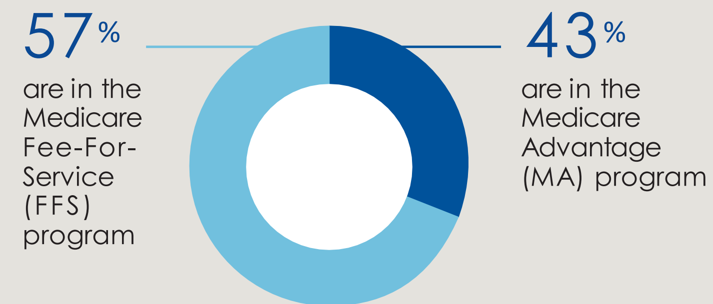
63.9M
Americans are enrolled in Medicare

3.8M
are new enrollees

WHO THEY ARE



TYPE OF MEDICARE COVERAGE

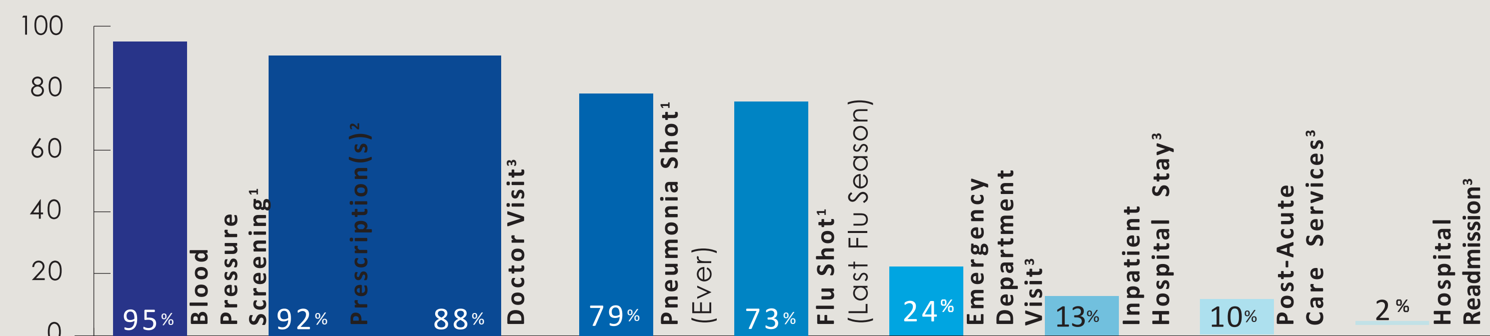


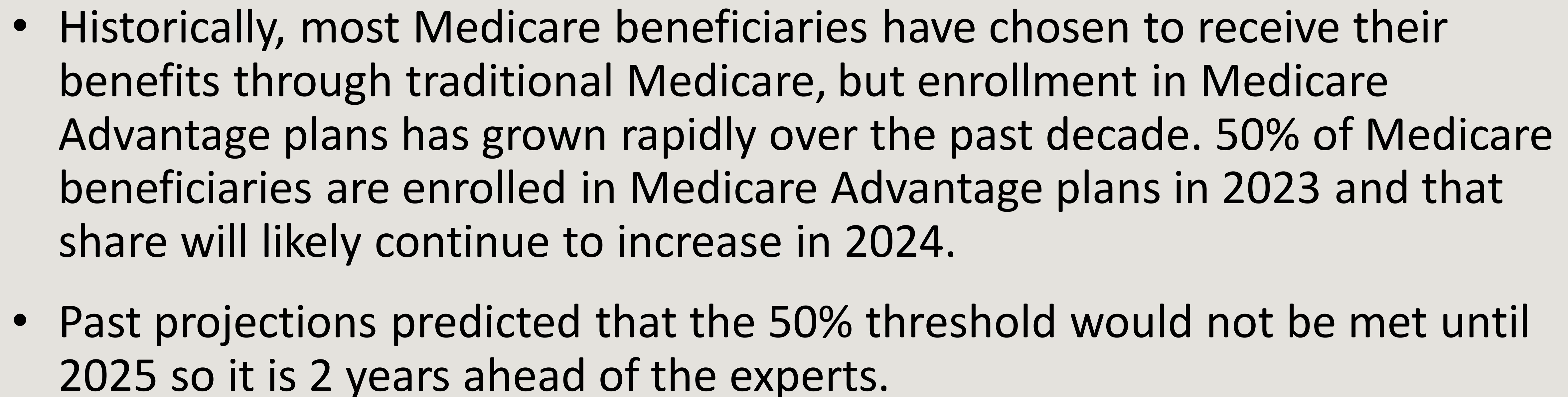
83% live in an urban metro area

18% are also enrolled in Medicaid

76% of Medicare beneficiaries also have Part D coverage

USE OF MEDICARE SERVICES

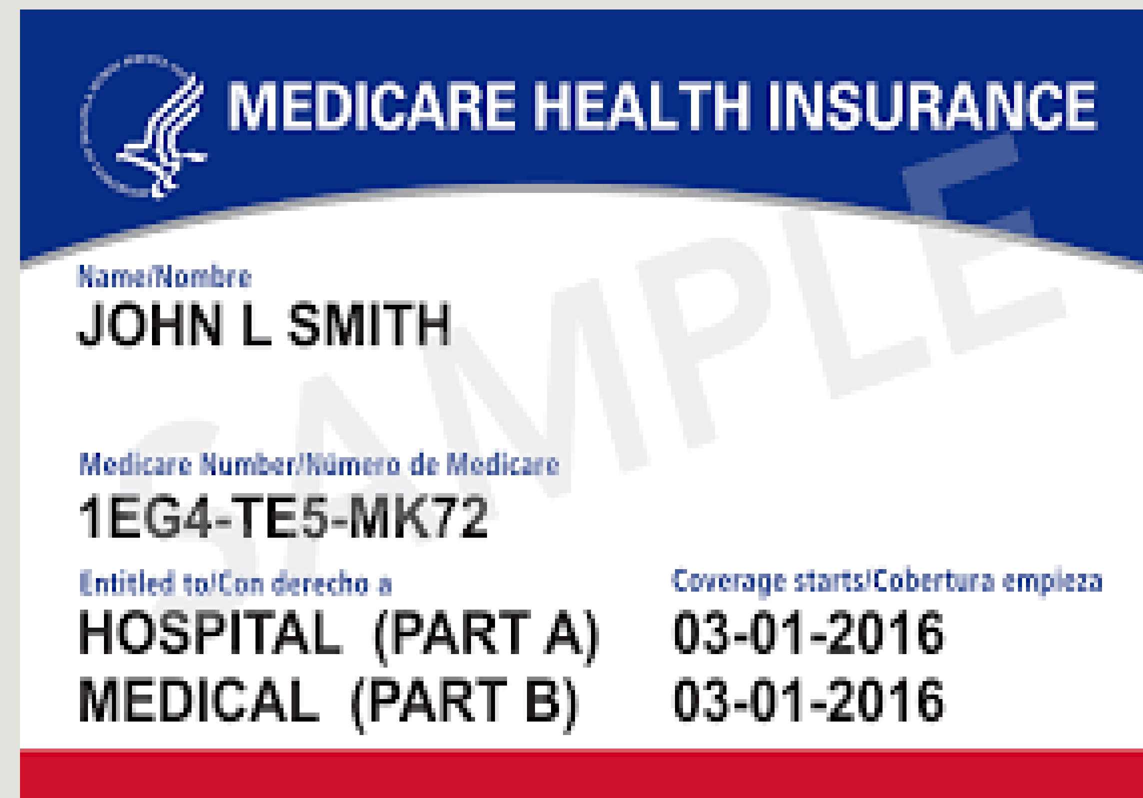




- Historically, most Medicare beneficiaries have chosen to receive their benefits through traditional Medicare, but enrollment in Medicare Advantage plans has grown rapidly over the past decade. 50% of Medicare beneficiaries are enrolled in Medicare Advantage plans in 2023 and that share will likely continue to increase in 2024.
- Past projections predicted that the 50% threshold would not be met until 2025 so it is 2 years ahead of the experts.

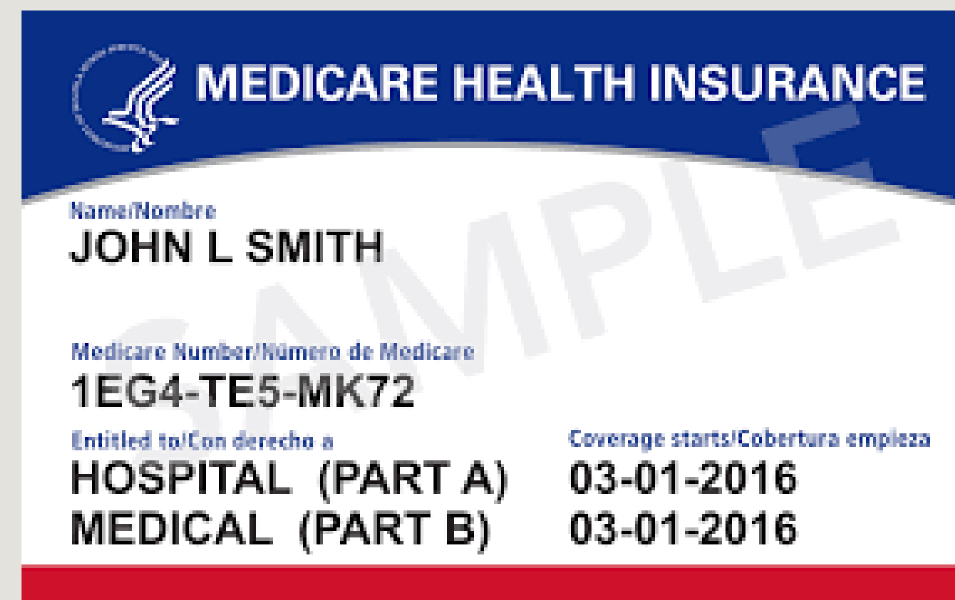
Medicare Patients

- By 2030, all baby boomers will be older than age 65. This will expand the size of the older population so that 1 in every 5 residents will be retirement age
- By 2035, there will be 78.0 million people 65 years and older compared to 76.7 million (previously 76.4 million) under the age of 18



Medicare Plans

- **Original Medicare**
- Original Medicare includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- Part B has the coverage for Chiropractic
- Medicare drug coverage (Part D).
- Beneficiaries may use any doctor or hospital that takes Medicare, anywhere in the U.S.



Medicare Advantage

(also known as Part C)

- Medicare Advantage is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These "bundled" plans include Part A, Part B, and usually Part D (drug plan).
- In most cases, patients will need to use doctors who are in the plan's network.
- Plans may have lower out-of-pocket costs than Original Medicare.
- Plans may offer some extra benefits that Original Medicare doesn't cover—like expanded chiropractic benefits, acupuncture, vision, hearing, and dental services.

UnitedHealthcare | Community Plan

UnitedHealthcare Dual Complete ONE

Health Plan (80840) 911-86047-08

UHC Medicare ID: 9999999999 Group Number: NJDUALCM

Member:
Subscriber Brown

UHC Medicaid ID: 9999999999

PCP Name:
Provider Brown

PCP Phone: (999)999-9999

Payer ID: 86047

MedicareRx
Prescription Drug Coverage

Rx Bin: 610097
Rx Grp: MPDACUNJ
Rx PCN: 8500

Copay: No Copays

Dental Benefits Included
H3113 PBP# 005

UnitedHealthcare Dual Complete ONE(HMO SNP)

UnitedHealthcare

Health Plan (80840): **911-87726-04**

Member ID: 999999999-99 Group Number: 99999

Member:
SUBSCRIBER BROWN

GROUP NAME

Payer ID:
87726

MedicareRx
Prescription Drug Coverage

RxBIN: 610097
RxPCN: 9999
RxGrp: COS

Copay: PCP $XX
Spec $XX

ER $XX

H9999 PBP# 999

UnitedHealthcare Group Medicare Advantage (PPO)
Plan pays up to Medicare Limiting Charges.

Original Medicare

Chiropractic and acupuncture (Medicare-covered)

- **Centers for Medicare & Medicaid Services (CMS): CMS.HHS.gov**
- **Medicare: Medicare.gov**

Chiropractic and acupuncture (routine)

N/A

Policy guidelines

Chiropractic and acupuncture (Medicare-covered)

UHCprovider.com >Resources >Health plans, policies, protocols and guides >For Medicare Advantage Plans >Coverage Summaries for Medicare Advantage Plans >

- Complementary, Alternative Medicine, and Chiropractic Services —Medicare Advantage Coverage Summary

Chiropractic and acupuncture (routine)

- **Phone: 800-873-4575**
- **Online: myoptumhealthphysicalhealth.com**

Questions?

If you have questions, please contact your physician advocate, provider relations or network management representative at UHCprovider.com/contactus >Network Help.

Chiropractic services

What's covered?

Chiropractic (Medicare-covered)

Medicare covers only manual manipulation of the spine to correct subluxation.

Chiropractic (routine)

Routine chiropractic is a supplemental benefit offered on some UnitedHealthcare Medicare Advantage plans that covers chiropractic services that aren't covered under Original Medicare. This benefit allows members to visit chiropractors for pain relief, neuromusculoskeletal disorders and nausea.

Chiropractic CPT codes

Medicare-covered: Chiropractic manipulations for subluxation*	
98940	Chiropractic manipulative treatment; spinal (1 to 2 regions)
98941	Spinal (3 to 4 regions)
98942	Spinal (5 regions)
Modifier: AT	• This modifier should be used when reporting service 98940, 98941, 98942 • This modifier shouldn't be used when providing maintenance therapy

*For more information on Medicare-covered chiropractic services, including links to supporting policies on cms.gov, visit UHCprovider.com > Resources >Health plans, policies, protocols and guides >For Medicare Advantage Plans >Coverage Summaries for Medicare Advantage Plans > Complementary, Alternative Medicine, and Chiropractic Services —Medicare Advantage Coverage Summary.

Routine: Chiropractic manipulations and other services for indications other than subluxation	
98940	Chiropractic manipulative treatment; spinal (1 to 2 regions)
98941	Spinal (3 to 4 regions)
98942	Spinal (5 regions)
98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions
Modifier: AT	• Routine chiropractic claims shouldn't contain the AT modifier
Other routine chiropractic common codes (not a complete list)	
Therapeutic	
97110	Therapeutic exercise (15 minutes)
97112	Neuromuscular re-education
97140	Manual therapy (for example, myofascial release; 15 minutes)
Radiology	
72010	Spine, entire, survey study, A-P and lateral
72040	Spine, cervical (2 or 3 views)
72070	Spine, thoracic (2 views)
72100	Spine, lumbosacral (2 or 3 views)
Durable medical equipment	
A4565	Sling (arm)
E0190	Lumbar cushion/Cervical pillow
L0120	Cervical collar (flexible foam)
L0210	Thoracic (rib belt)
L3332	Heel lift
L3908	Wrist hand orthosis (wrist extension control cock-up)
L3914	Wrist hand orthosis, wrist extension control
Code ranges for per visit fee schedule	
A4206-A9999, E0100-E0930, E0936-E2621, G0108-G0109, G0237-G0283, G0420-G0439, K0001-K0899, Q3014, S8948, 29000-29799, 36415, 70010-79999, 80047-89399, 90281-96117, 97001-97814, 98925-98969, 99000-99091, 99201-99499	

Notes:

- Refer to your Supplemental/Routine Fee Schedule for covered chiropractic services
- All codes are subject to change
- Please follow Original Medicare-covered indications and coding rules when billing Medicare-covered services and review codes at cms.gov before submitting claims

Medicare Supplemental Plans

Plan E is a Medicare supplement (Medigap) plan that has not been available to new Medicare subscribers since 2009.

- Supplemental plans only cover the 20% not paid on covered Medicare services
- For chiropractic this means 20% of spinal manipulation only

Medicare Supplemental Plans

Plan F is a Medicare supplement (Medigap) plan for persons who enrolled between 2011-2019

- Supplemental plans only cover the 20% not paid on covered Medicare services
- For chiropractic this means 20% of spinal manipulation only

Medicare Supplemental Plans

Plan G is a Medicare supplement (Medigap) plan for persons who enrolled after 2020

- Supplemental plans only cover the 20% not paid on covered Medicare services
- For chiropractic this means 20% of spinal manipulation only
- There are multiple lettered supplements with differences in cost and coverage but for chiropractic only offer the 20% of CMT as a benefit

Medicare Secondary Plans

- Secondary indicates separate insurance not a supplement that has standard coverage benefits
- This may include all services such as exams, x-rays, and therapies
- These are also very rare and more likely when the person is working and has insurance through their employer, and they also enrolled in Medicare.
- If a Medicare recipient enrolls in a large employer group health plan, Medicare becomes secondary to the employer plan assuming there are 20 or more employees.

Medicare and Chiropractic

- Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation, i.e., by use of the 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.

Excluded Services

No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's 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.

Does a Chiropractor have to enroll in Medicare?

In order to stay in compliance with Medicare law, a physician (chiropractor) who treats a Medicare beneficiary for a Medicare-covered service must either:

1. Enroll in Medicare and submit a claim on that beneficiary's behalf for those services

2. Opt out of Medicare and enter a private contract with the beneficiary for those services(not available to Doctor's of Chiropractic); or

3. Furnish the Medicare-covered services for free.

Mandatory Claims Submission

- Section 1848(g)(4) of the Social Security Act requires that you submit claims for all your Medicare patients for services rendered. This requirement applies to all physicians and suppliers <u>who provide covered services to Medicare beneficiaries</u>.

  In order to submit a claim to Medicare as a non opt out provider you must be enrolled.

  This is why a DC must enroll with Medicare as you must be enrolled to submit a claim and claim submission is mandatory

- You may not charge your patients for preparing or filing a Medicare claim. The requirement to submit Medicare claims does not mean you must accept assignment.

  Compliance of the claims mandatory claim filing requirements is monitored by carriers. Violations of the requirement may be subject to a civil monetary penalty of up to $2,000 for each violation and/or Medicare program exclusion.

Re: Mandatory Submission of Medicare Claims – Inactive Provider Identifiers
Patient: Claim
Date(s) of Service: February December

Dear Provider:

Section 1848(g)(4) of the Social Security Act requires physicians and suppliers of covered Medicare services to submit claims on behalf of all Medicare patients. This requirement was effective for services rendered on or after September 1, 1990. It has come to our attention you are treating Medicare patients and not submitting claims as required by law.

Palmetto GBA monitors compliance with the mandatory claim filing requirement. Failure to follow this requirement may result in sanctions being imposed, as outlined in section 1848(g)(4) of the Act. Violators of the requirement may be subject to a civil monetary penalty of up to $2,000 for each violation and/or Medicare program exclusion.

To meet the mandatory claim submission requirement, you must enroll as a Medicare provider. To do this please complete the appropriate Medicare enrollment form (CMS-855). A link to the paper CMS-855 applications is available on our Web site, http://www.palmettogba.com/J1B , by using the *Provider Application Finder* tool located under "Self Service Tools". For your convenience, you can also find a link to *Internet-based PECOS* if you prefer to complete the CMS-855 online.

For more information regarding mandatory claim submission please refer to the following links:

- SSA 1848(g)(4)(A): *Physician Submission of Claims*
  www.ssa.gov/OP_Home/ssact/title18/1848.htm
- Palmetto GBA Web site: *Physician/Supplier Guide to Medicare*
  http://www.palmettogba.com/J1B/guide
    - Select *Mandatory Claims Filing Requirements*

If you would like to discuss this issue further, please contact the Provider Contact Center (PCC) at 1-866-931-3901.

Sincerely,
C76

Palmetto GBA

CMS-Contracted Medicare Administrative Contractor

Excluded – Non-Covered Medicare Services

- You are not required to file non-covered Medicare services. However, many Medicare secondary insurance policies pay for services that Medicare does not allow and they may require a Medicare denial notice.
- **This means any and all services other than CMT to spine. (exams, x-rays, physical medicine et al)**

Medicare Enrollment

- A doctor of chiropractic may enroll in Medicare and may choose
  - Participating or
  - Nonparticipating.
- Do not confuse non-participating or non-par as not being part of Medicare. Non-Par is an enrolled provider and is simply classified as non-par

Participating - PAR

- Must accept assignment (await payment from Medicare 80% by Medicare and 20% by patient

Non – Participating – Non-Par

- May collect at time of service in full up to the limiting charge (highest allowed & 15% higher than Medicare approved rate)
- Meaning they do not accept assignment and patient awaits payment from Medicare
- However, payment to the patient is limited to the "non par" rate which is the lowest allowed and 5% below the "par" approved rate
- Note some states have lower rates allowed for the limiting charge and PA does not allow the limiting charge to non par providers.

www.hjrosscompany.com

New York
2024 CHIROPRACTIC FEE SCHEDULE
National Government Services

Locality/Area	Counties
01	Manhattan
02	Bronx, Brooklyn, Nassau, Rockland, Staten Island, Suffolk, Westchester
03	Columbia, Delaware, Dutchess, Greene, Orange, Putnam, Sullivan, Ulster
04	Queens
99	Albany, Oneida, Allegany, Onondaga, Broome, Ontario, Cattaraugus, Orleans, Cayuga, Oswego, Chautauqua, Otsego, Chemung, Rensselaer, Chenango, Saratoga, Clinton, Schenectady, Cortland, Schoharie, Erie, Schuyler, Essex, Seneca, Franklin, Steuben, Fulton, St. Lawrence, Genesee, Tioga, Hamilton, Tompkins, Herkimer, Warren, Jefferson, Washington, Lewis, Wayne, Livingston, Wyoming, Madison, Yates, Monroe Montgomery, Niagara

	Region	Par Fee	Non-Par Fee	Limiting Charge
98940	1	29.95	28.45	32.72
98941	1	42.86	40.72	46.83
98942	1	55.02	52.27	60.11
98940	2	30.42	28.90	33.24
98941	2	43.46	41.29	47.48
98942	2	55.71	52.92	60.86
98940	3	28.85	27.41	31.52
98941	3	41.39	39.32	45.22
98942	3	53.21	50.55	58.13
98940	4	28.85	27.41	31.52
98941	4	41.39	39.32	45.22
98942	4	53.21	50.55	58.13
98940	99	26.18	24.87	28.60
98941	99	37.78	35.89	41.27
98942	99	48.76	46.32	53.27

2024 Medicare Fee Schedule California

2024 Deductible $240

Procedure Code	Par Fee	Nonpar Fee	Limiting Charge
Southern California – Area 17 (Ventura County)			
98940	$29.22	$27.76	$31.92
98941	$41.88	$39.79	$45.76
98942	$53.77	$51.08	$58.74
Southern California – Area 18 (Los Angeles County) & 26 (Orange County)			
98940	$29.60	$28.12	$32.34
98941	$42.44	$40.32	$46.37
98942	$54.48	$51.76	$59.52
Southern California – Area 71 (Imperial County)			
98940	$27.99	$26.59	$30.58
98941	$40.22	$38.21	$43.94
98942	$51.75	$49.16	$56.53
Southern California – Area 72 (San Diego County)			
98940	$29.32	$27.85	$32.03
98941	$42.03	$39.93	$45.92
98942	$53.95	$51.25	$58.94
Southern California – Area 73 (San Luis Obispo County)			
98940	$28.43	$27.01	$31.06
98941	$40.81	$38.77	$44.59
98942	$52.44	$49.82	$57.29
Southern California – Area 74 (Santa Barbara County)			
98940	$29.04	$27.59	$31.73
98941	$41.64	$39.56	$45.49
98942	$53.47	$50.80	$58.42
Northern California – Area 62 (Riverside & San Bernadino Counties)			
98940	$28.09	$26.69	$30.69
98941	$40.33	$38.31	$44.06
98942	$51.85	$49.26	$56.65

Limiting charge applies to unassigned claims by non-participating providers.

Participating - PAR

- If deductible is not met may collect the “par allowable” though Medicare must be billed.

Non – Participating – Non-Par

- If accepting assignment, the payment is limited to the “non par” rate which is 95% of par rate

Pros and Cons
Par v Non-Par

- Non-participating doctors of chiropractic may be paid slightly more for services by choosing that status. However, these extra dollars come from the patient, not from Medicare.
- Participating providers have the advantage of being able to enter any fees they wish on the claim form when billing Medicare and the carrier will adjust the amount to reflect the current allowable fees determined by the fee schedule. This can be useful in times when the fee schedule levels are changing or uncertain and may ease the burden of locating the current values.
- Participating providers also would be listed in the MedParD (Medicare Participating Directory). This is a directory of all current participating providers and is sent to every Medicare beneficiary at the beginning of each year.

Can I Change My Status?

- You may only do so during the open enrollment period which is from mid November to December 31
- Verify with your Medicare Administrative Contractor (MAC) to the exact dates the participation agreement will be accepted and where to send it.

Enrollment

- Enrollment forms are essentially the same when registering for Medicare whether on paper or online
- Forms 855I for individual and 855B for group
- EFT 588 (electronic payment form)
- The difference for a par provider is you must also do a participating provider agreement form **CMS460** in addition to the other required forms
- You will automatically be designated non-par without a CMS460

What Does Medicare Pay For?

- Chiropractic spinal manipulation
- All other services performed or ordered by a chiropractor are excluded and due and payable by the patient
- However, payment requires the primary diagnosis must be "subluxation"
- There must be an associated secondary condition or diagnosis related to the subluxation (note most states require this secondary diagnosis on the claim form while others it must be part of the patient record)

EXPLANATION OF MEDICARE BENEFITS FOR CHIROPRACTIC SERVICES

____
Patient's Name

DEDUCTIBLE
Medicare requires that you pay a yearly deductible of $240 towards your Part B medical expenses. If you have already been treated by other doctors this year, those may apply to your deductible.

MEDICARE COVERAGE
Medicare in a chiropractic office only covers manual manipulation of the spine (commonly referred to as a spinal adjustment or CMT). Medicare pays 80% of the service and you are liable for 20% after the deductible is met. <u>All other services other than spinal manipulation are your responsibility</u> and are outlined below in detail.

EXAMINATIONS
To determine the extent of your condition and the type of treatment you will need, the doctor will examine you before the initiation of treatment, and periodically thereafter. <u>Medicare will not reimburse you for examination charges</u>; therefore, you are responsible for these charges.

X-RAYS
Medicare does not require x-rays as a requirement for chiropractic care. However, your condition may require x-rays as necessary to fully assess your condition. If x-rays are taken or ordered by your chiropractor, they are not covered by Medicare. <u>Medicare will not reimburse for x-ray charges.</u>

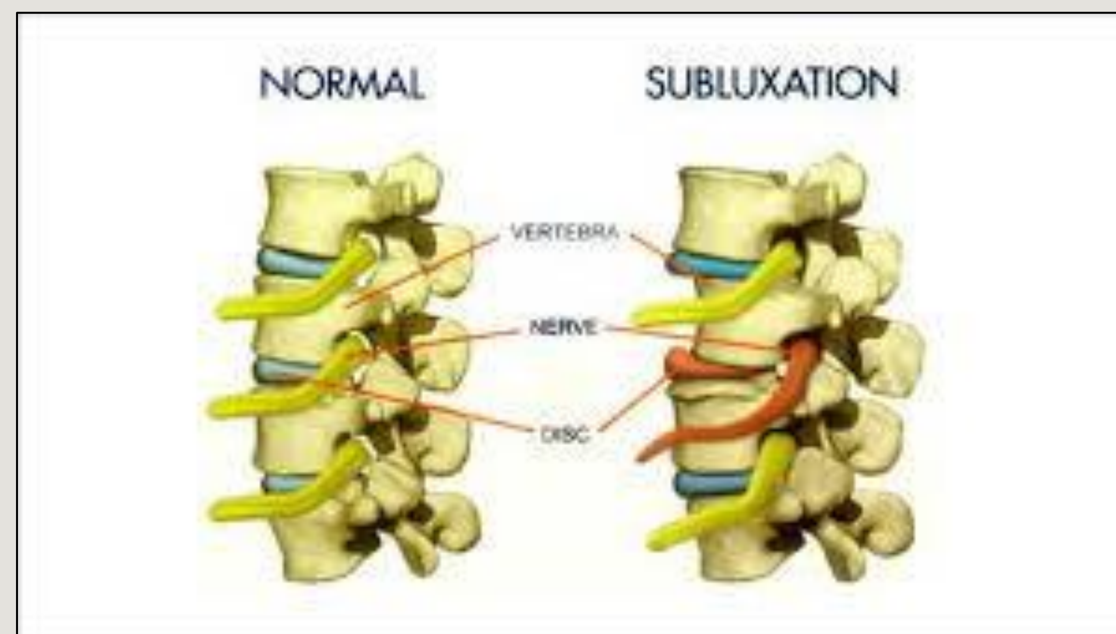
PHYSICAL MEDICINE, SUPPLEMENTS, AND SUPPORTS
During your treatment in this office, the doctor may determine that certain physical therapy modalities or procedures, vitamin supplements, or orthopedic supports may be necessary to assist in the treatment of your condition. <u>Medicare will not reimburse you for any of these services; therefore, you are personally responsible for those charges.</u>

I understand that although the Chiropractic services listed above may be required for the treatment of my condition, these charges are not covered by Medicare, and I will be personally responsible for the payment of these charges.

______________________________ ______________________
Patient's Signature **Date**

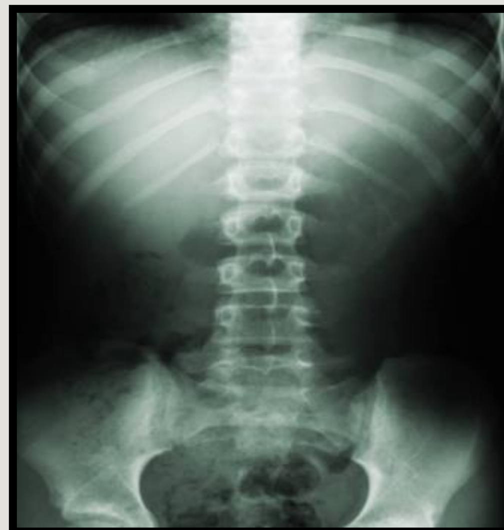
Subluxation

- Medicare definition
- Subluxation is defined as a motion segment, in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact.



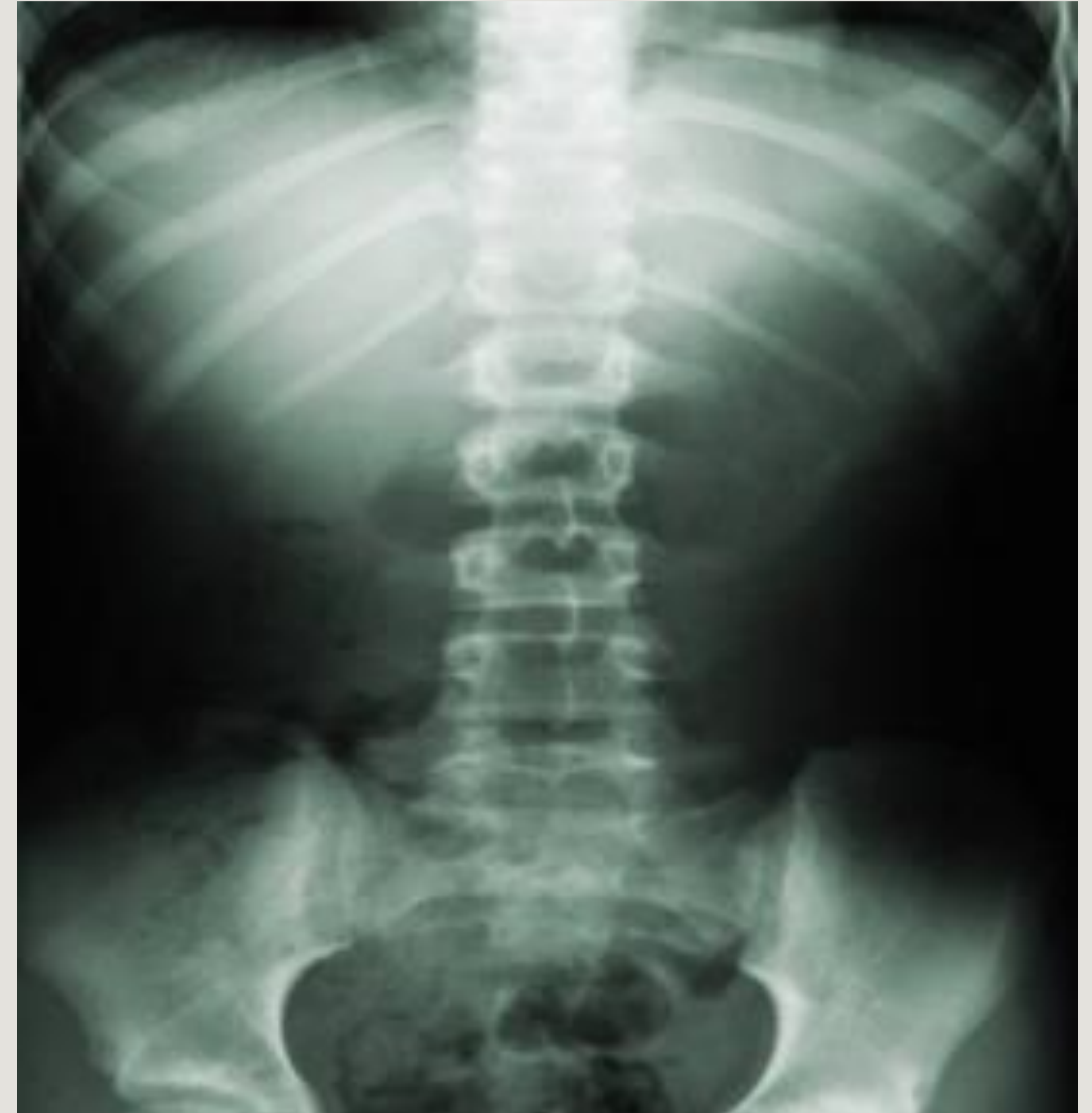
Step 1 – Diagnoses

- Primary diagnosis must be subluxation
- The subluxation may be demonstrated by an x-ray or by physical examination



Demonstrated by X-Ray

- An x-ray may be used to document subluxation.
- The x-ray must have been taken at a time reasonably proximate to the initiation of a course of treatment.
- Unless more specific x-ray evidence is warranted, an x-ray is considered reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of a course of chiropractic treatment. In certain cases of chronic subluxation (e.g., scoliosis), an older x-ray may be accepted provided the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent.
- A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated.



Demonstrated by Physical Examination

Evaluation to identify:

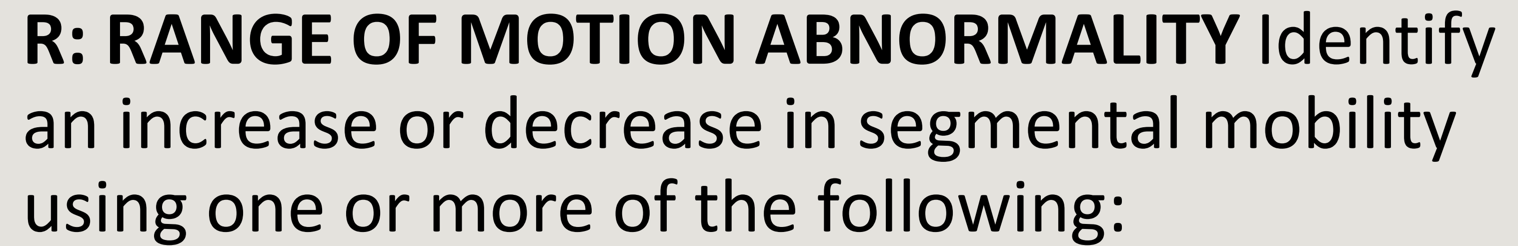
- **P**ain/tenderness evaluated in terms of location, quality, and intensity;
- **A**symmetry/misalignment identified on a sectional or segmental level;
- **R**ange of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); and –
- **T**issue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

Only 2 of the 4 factors are needed however 1 must be **asymmetry** or **range of motion**

- Observation: You can document, by personal observation, the pain that the patient exhibits during the course of the examination.
- Percussion, Palpation, or Provocation

A: ASYMMETRY/MISALIGNMENT
Identify on a sectional or segmental level by using one or more of the following:

- Observation: You can observe patient posture, analyze gait or plumb line. Static and Dynamic Palpation: Describe the spinal misaligned vertebrae, and symmetry.



R: RANGE OF MOTION ABNORMALITY Identify an increase or decrease in segmental mobility using one or more of the following:

- Observation: You can observe an increase or decrease in the patient's range of motion.
- Motion Palpation: You can record your palpation findings, including listing(s). Be sure to record the various areas that are involved and related to the regions manipulated.
- Range of Motion Measuring Devices: Devices such as goniometers or inclinometers can be used to record specific measurements. But be sure relates to a specific vertebrae

T: TISSUE, TONE CHANGES Identify using one or more of the following:

- Observation: Visible changes such as signs of spasm, inflammation, swelling, rigidity, etc.
- Palpation: Palpated changes in the tissue, such as hypertonicity, hypotonicity, spasm, inflammation, tautness, rigidity, flaccidity, etc. can be found on palpation

Following are some common examples of acceptable descriptive terms

- Off-centered
- Misalignment
- Malpositioning
- Spacing - abnormal, altered, decreased, increased
- Incomplete dislocation
- Rotation
- Listhesis - antero, postero, retro, lateral, spondylo
- Motion - limited, lost, restricted, flexion, extension, hypermobility, hypomobility, aberrant
- Other terms may be used. If they are understood clearly to refer to bone or joint space or position (or motion) changes of vertebral elements, they are acceptable.

Example of a PART Exam

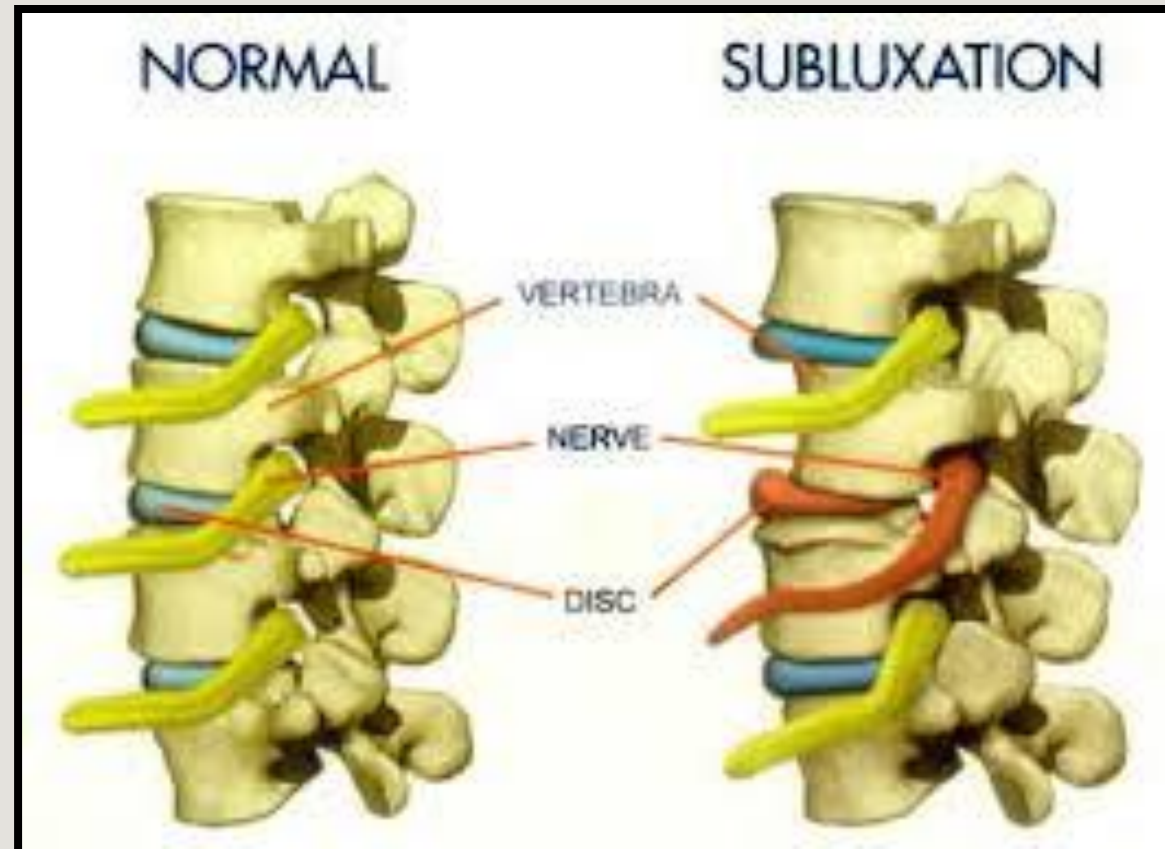
P- tenderness/pain noted at C2, C3, C6, & T6

R- hypomobility on motion palpation at C2, C3, C6 and T6

This would indicate subluxation at each vertebra listed as each vertebra has 2 of the 4 factors of PART including pain/tenderness and range of motion.

Subluxation

- **P**
- **A**
- **R**
- **T**



Vertebrae Must be Documented

- Occiput (Occ, CO), (note this is part of cervical not a separate or 6th region)
- Neck (Cervical) C1 thru C7, Atlas (C1), Axis (C2)
- Dorsal D1 thru D12 or Thoracic T1 thru T12 or Costovertebral R1 thru R12 or Costotransverse R1 thru R12
- Low Back - Lumbar L1 thru L5
- Pelvis - Iiii, r and l (I, Si)
- Sacral - Sacrum, Coccyx, S, SC

Primary Diagnosis

- The primary diagnosis for Medicare must be subluxation (segmental dysfunction)
- This would be diagnosis **A** of the 1500 claim form

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M9901	B. M5412	C. M9902	D. M546
E.	F.	G.	H.
I.	J.	K.	L.

Diagnosis Code Requirements for Subluxation

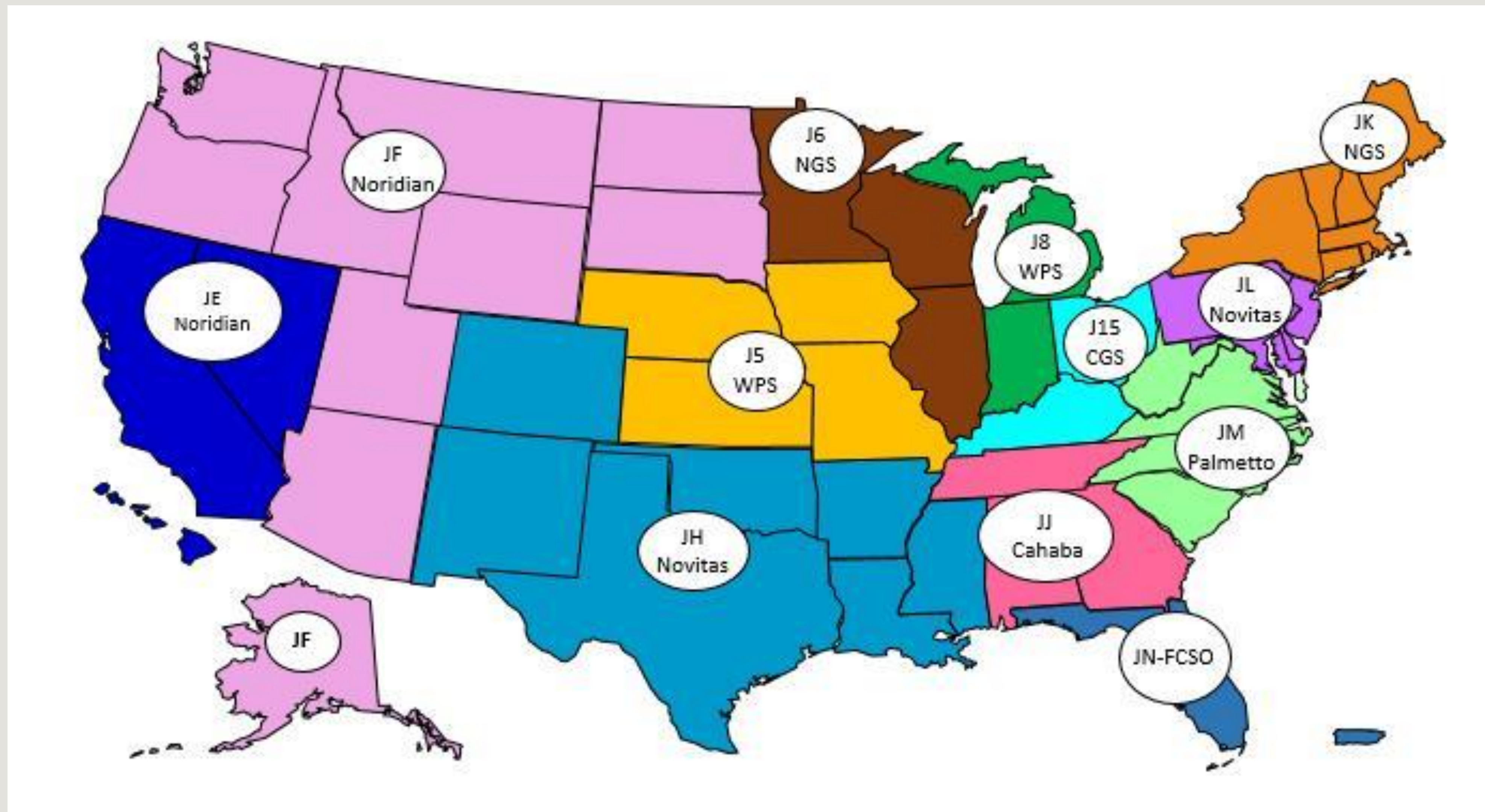
Segmental Dysfunction

- M99.00 to M99.05
- Please refer to the diagnosis for your MAC as some allow only M9901-M9905

Subluxation

- M99.10 to M99.15
- Please refer to the diagnosis for your MAC ***Noridian, Novitas, First Coast*** MAC do allow M9910-M9915

Medicare Administrative Carriers MAC



Noridian MAC allows either and M9900 and M9910 series

- **Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, North Dakota, Oregon, South Dakota, Washington, Utah, & Wyoming**
- **M99.00-M99.05**
- **M99.10-M9915**

Novitas MAC

- **Arkansas, Colorado Delaware, District of Columbia, Louisiana, Maryland, Mississippi, New Jersey, New Mexico, Pennsylvania, Oklahoma, & Texas (includes Indian Health and Veterans Affairs)**
- **M99.00-M99.05**
- **M99.10-M9915**

First Coast MAC

- **Florida, Puerto Rico, & U.S. Virgin Islands**
- **M99.00-M99.05**
- **M99.10-M9915**

CAHABA MAC & Palmetto MAC

- **Alabama, Georgia and Tennessee**
- **North Carolina, Railroad, South Carolina, Virginia, & West Virginia**
- **M99.01 to M99.05 only**

Wisconsin Physician Services (WPS) MAC

- **Indiana, Iowa, Kansas, Michigan, Missouri, & Nebraska**
- **M99.00 to M99.05**

National Government Services NGS

- **Connecticut, Illinois, Maine, Massachusetts, Minnesota, New Hampshire, New York, Rhode Island Vermont & Wisconsin**
- **M99.01 to M99.05**

CGS Celerian Group Company

- **Kentucky and Ohio**
- **M99.01 to M99.05**

Subluxation Documentation Requirement

- The vertebrae need not be listed on the claim form in block 21 use the proper diagnosis from the segmental dysfunction or subluxation.
- However, in the chart notes be sure each specific vertebrae is listed such as C5, T4, L3 and those specific vertebrae are documented as being adjusted/manipulated. Cervicothoracic, or lumbosacral is accepted as that refers to C7-T1 and L5-S1

Primary Diagnosis

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M9901	B. M5412	C. M9902	D. M546
E.	F.	G.	H.
I.	J.	K.	L.

Secondary Diagnosis

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M9901 B. M5412 C. M9902 D. M546

E. F. G. H.

I. J. K. L.

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 demonstrated by x-ray or physical exam as described.

Medicare Required Secondary Diagnosis

- Some Medicare MAC's publish a specific list of secondary codes required for Medicare reimbursement.
- If a code is used that is not on the Medicare list for your given region it will result in an automatic denial for necessity.
- In all cases there must be some related condition that is a consequence or related to the spinal subluxation

Medicare requires 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 a reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine as demonstrated by an x-ray or physical exam.

The following diagnoses are published by Medicare Administrative Carriers (MAC) but not all MAC's publish lists. However, they will follow the same protocol of a primary subluxation with a secondary neuromusculoskeletal diagnosis. If you state is not listed among these please note to follow the diagnoses as noted and refer to your state for which primary diagnosis is required for subluxation earlier in this document.

WPS MEDICARE	Indiana, Iowa, Kansas, Michigan, Missouri, & Nebraska
ICD-10-CM CODE	**DESCRIPTION**
M99.00	Segmental and somatic dysfunction of head region
M99.01	Segmental and somatic dysfunction of cervical region
M99.02	Segmental and somatic dysfunction of thoracic region
M99.03	Segmental and somatic dysfunction of lumbar region
M99.04	Segmental and somatic dysfunction of sacral region
M99.05	Segmental and somatic dysfunction of pelvic region

SHORT-TERM TREATMENT

G43.009	Migraine without aura, not intractable, without status migrainosus
G43.019	Migraine without aura, intractable, without status migrainosus
G43.109	Migraine with aura, not intractable, without status migrainosus
G43.119	Migraine with aura, intractable, without status migrainosus
G43.A0	Cyclical vomiting, in migraine, not intractable
G43.A1	Cyclical vomiting, in migraine, intractable
G43.B0	Ophthalmoplegic migraine, not intractable
G43.B1	Ophthalmoplegic migraine, intractable
G43.C0	Periodic headache syndromes in child or adult, not intractable
G43.C1	Periodic headache syndromes in child or adult, intractable
G43.D0	Abdominal migraine, not intractable
G43.D1	Abdominal migraine, intractable
G43.909	Migraine, unspecified, not intractable, without status migrainosus
G43.919	Migraine, unspecified, intractable, without status migrainosus
G44.1	Vascular headache, not elsewhere classified
G44.209	Tension-type headache, unspecified, not intractable
M47.24	Other spondylosis with radiculopathy, thoracic region

M47.25	Other spondylosis with radiculopathy, thoracolumbar region
M47.26	Other spondylosis with radiculopathy, lumbar region
M47.27	Other spondylosis with radiculopathy, lumbosacral region
M47.28	Other spondylosis with radiculopathy, sacral and sacrococcygeal region
M47.811	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M48.11	Ankylosing hyperostosis [Forestier], occipito-atlanto-axial region
M48.12	Ankylosing hyperostosis [Forestier], cervical region
M48.13	Ankylosing hyperostosis [Forestier], cervicothoracic region
M48.14	Ankylosing hyperostosis [Forestier], thoracic region
M48.15	Ankylosing hyperostosis [Forestier], thoracolumbar region
M48.16	Ankylosing hyperostosis [Forestier], lumbar region
M48.17	Ankylosing hyperostosis [Forestier], lumbosacral region
M48.18	Ankylosing hyperostosis [Forestier], sacral and sacrococcygeal region
M48.19	Ankylosing hyperostosis [Forestier], multiple sites in spine
M54.2	Cervicalgia
M54.50	Low back pain, unspecified
M54.51	Vertebrogenic low back pain
M54.59	Other low back pain
M54.6	Pain in thoracic spine
M62.49	Contracture of muscle, multiple sites
M62.838	Other muscle spasm
R51.0	Headache with orthostatic component, not elsewhere classified
R51.9	Headache, unspecified
G43.009	Migraine without aura, not intractable, without status migrainosus

Moderate-Term Treatment

G54.0	Brachial plexus disorders
G54.1	Lumbosacral plexus disorders
G54.2	Cervical root disorders, not elsewhere classified
G54.3	Thoracic root disorders, not elsewhere classified
G54.4	Lumbosacral root disorders, not elsewhere classified
G54.8	Other nerve root and plexus disorders

G55	Nerve root and plexus compressions in diseases classified elsewhere
G57.01	Lesion of sciatic nerve, right lower limb
G57.02	Lesion of sciatic nerve, left lower limb
G57.03	Lesion of sciatic nerve, bilateral lower limbs
G57.21	Lesion of femoral nerve, right lower limb
G57.22	Lesion of femoral nerve, left lower limb
G57.23	Lesion of femoral nerve, bilateral lower limbs
G57.91	Unspecified mononeuropathy of right lower limb
G57.92	Unspecified mononeuropathy of left lower limb
G57.93	Unspecified mononeuropathy of bilateral lower limbs
M12.311	Palindromic rheumatism, right shoulder
M12.312	Palindromic rheumatism, left shoulder
M12.351	Palindromic rheumatism, right hip
M12.352	Palindromic rheumatism, left hip
M12.361	Palindromic rheumatism, right knee
M12.362	Palindromic rheumatism, left knee
M12.371	Palindromic rheumatism, right ankle and foot
M12.372	Palindromic rheumatism, left ankle and foot
M12.38	Palindromic rheumatism, other specified site
M12.39	Palindromic rheumatism, multiple sites
M12.411	Intermittent hydrarthrosis, right shoulder
M12.412	Intermittent hydrarthrosis, left shoulder
M12.451	Intermittent hydrarthrosis, right hip
M12.452	Intermittent hydrarthrosis, left hip
M12.461	Intermittent hydrarthrosis, right knee
M12.462	Intermittent hydrarthrosis, left knee
M12.471	Intermittent hydrarthrosis, right ankle and foot
M12.472	Intermittent hydrarthrosis, left ankle and foot
M12.48	Intermittent hydrarthrosis, other site
M12.49	Intermittent hydrarthrosis, multiple sites
M15.4	Erosive (osteo)arthritis
M15.8	Other polyosteoarthritis
M16.0	Bilateral primary osteoarthritis of hip
M16.11	Unilateral primary osteoarthritis, right hip
M16.12	Unilateral primary osteoarthritis, left hip
M25.011	Hemarthrosis, right shoulder
M25.012	Hemarthrosis, left shoulder
M25.051	Hemarthrosis, right hip
M25.052	Hemarthrosis, left hip
M25.061	Hemarthrosis, right knee

M25.062	Hemarthrosis, left knee
M25.071	Hemarthrosis, right ankle
M25.072	Hemarthrosis, left ankle
M25.074	Hemarthrosis, right foot
M25.075	Hemarthrosis, left foot
M25.08	Hemarthrosis, other specified site
M25.451	Effusion, right hip
M25.452	Effusion, left hip
M25.461	Effusion, right knee
M25.462	Effusion, left knee
M25.471	Effusion, right ankle
M25.472	Effusion, left ankle
M25.474	Effusion, right foot
M25.475	Effusion, left foot
M25.511	Pain in right shoulder
M25.512	Pain in left shoulder
M25.551	Pain in right hip
M25.552	Pain in left hip
M25.561	Pain in right knee
M25.562	Pain in left knee
M25.571	Pain in right ankle and joints of right foot
M25.572	Pain in left ankle and joints of left foot
M25.611	Stiffness of right shoulder, not elsewhere classified
M25.612	Stiffness of left shoulder, not elsewhere classified
M25.651	Stiffness of right hip, not elsewhere classified
M25.652	Stiffness of left hip, not elsewhere classified
M25.661	Stiffness of right knee, not elsewhere classified
M25.662	Stiffness of left knee, not elsewhere classified
M25.671	Stiffness of right ankle, not elsewhere classified
M25.672	Stiffness of left ankle, not elsewhere classified
M25.674	Stiffness of right foot, not elsewhere classified
M25.675	Stiffness of left foot, not elsewhere classified
M25.811	Other specified joint disorders, right shoulder
M25.812	Other specified joint disorders, left shoulder
M25.851	Other specified joint disorders, right hip
M25.852	Other specified joint disorders, left hip
M25.861	Other specified joint disorders, right knee
M25.862	Other specified joint disorders, left knee
M25.871	Other specified joint disorders, right ankle and foot
M25.872	Other specified joint disorders, left ankle and foot

M43.01	Spondylolysis, occipito-atlanto-axial region
M43.02	Spondylolysis, cervical region
M43.03	Spondylolysis, cervicothoracic region
M43.04	Spondylolysis, thoracic region
M43.05	Spondylolysis, thoracolumbar region
M43.06	Spondylolysis, lumbar region
M43.07	Spondylolysis, lumbosacral region
M43.08	Spondylolysis, sacral and sacrococcygeal region
M43.09	Spondylolysis, multiple sites in spine
M43.11	Spondylolisthesis, occipito-atlanto-axial region
M43.12	Spondylolisthesis, cervical region
M43.13	Spondylolisthesis, cervicothoracic region
M43.14	Spondylolisthesis, thoracic region
M43.15	Spondylolisthesis, thoracolumbar region
M43.16	Spondylolisthesis, lumbar region
M43.17	Spondylolisthesis, lumbosacral region
M43.18	Spondylolisthesis, sacral and sacrococcygeal region
M43.19	Spondylolisthesis, multiple sites in spine
M43.27	Fusion of spine, lumbosacral region
M43.28	Fusion of spine, sacral and sacrococcygeal region
M43.6	Torticollis
M46.01	Spinal enthesopathy, occipito-atlanto-axial region
M46.02	Spinal enthesopathy, cervical region
M46.03	Spinal enthesopathy, cervicothoracic region
M46.04	Spinal enthesopathy, thoracic region
M46.05	Spinal enthesopathy, thoracolumbar region
M46.06	Spinal enthesopathy, lumbar region
M46.07	Spinal enthesopathy, lumbosacral region
M46.08	Spinal enthesopathy, sacral and sacrococcygeal region
M46.09	Spinal enthesopathy, multiple sites in spine
M46.41	Discitis, unspecified, occipito-atlanto-axial region
M46.42	Discitis, unspecified, cervical region
M46.43	Discitis, unspecified, cervicothoracic region
M46.44	Discitis, unspecified, thoracic region
M46.45	Discitis, unspecified, thoracolumbar region
M46.46	Discitis, unspecified, lumbar region
M46.47	Discitis, unspecified, lumbosacral region
M50.11	Cervical disc disorder with radiculopathy, high cervical region
M50.120	Mid-cervical disc disorder, unspecified level
M50.121	Cervical disc disorder at C4-C5 level with radiculopathy

M50.122	Cervical disc disorder at C5-C6 level with radiculopathy
M50.123	Cervical disc disorder at C6-C7 level with radiculopathy
M50.13	Cervical disc disorder with radiculopathy, cervicothoracic region
M50.81	Other cervical disc disorders, high cervical region
M50.820	Other cervical disc disorders, mid-cervical region, unspecified level
M50.821	Other cervical disc disorders at C4-C5 level
M50.822	Other cervical disc disorders at C5-C6 level
M50.823	Other cervical disc disorders at C6-C7 level
M50.83	Other cervical disc disorders, cervicothoracic region
M50.91	Cervical disc disorder, unspecified, high cervical region
M50.920	Unspecified cervical disc disorder, mid-cervical region, unspecified level
M50.921	Unspecified cervical disc disorder at C4-C5 level
M50.922	Unspecified cervical disc disorder at C5-C6 level
M50.923	Unspecified cervical disc disorder at C6-C7 level
M50.93	Cervical disc disorder, unspecified, cervicothoracic region
M51.14	Intervertebral disc disorders with radiculopathy, thoracic region
M51.15	Intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.84	Other intervertebral disc disorders, thoracic region
M51.85	Other intervertebral disc disorders, thoracolumbar region
M51.86	Other intervertebral disc disorders, lumbar region
M51.87	Other intervertebral disc disorders, lumbosacral region
M53.0	Cervicocranial syndrome
M53.1	Cervicobrachial syndrome
M53.2X7	Spinal instabilities, lumbosacral region
M53.2X8	Spinal instabilities, sacral and sacrococcygeal region
M53.86	Other specified dorsopathies, lumbar region
M53.87	Other specified dorsopathies, lumbosacral region
M53.88	Other specified dorsopathies, sacral and sacrococcygeal region
M54.11	Radiculopathy, occipito-atlanto-axial region
M54.12	Radiculopathy, cervical region
M54.13	Radiculopathy, cervicothoracic region
M54.14	Radiculopathy, thoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M60.811	Other myositis, right shoulder
M60.812	Other myositis, left shoulder
M60.851	Other myositis, right thigh

M60.852	Other myositis, left thigh
M60.861	Other myositis, right lower leg
M60.862	Other myositis, left lower leg
M60.871	Other myositis, right ankle and foot
M60.872	Other myositis, left ankle and foot
M60.88	Other myositis, other site
M60.89	Other myositis, multiple sites
M62.830	Muscle spasm of back
M79.11	Myalgia of mastication muscle
M79.12	Myalgia of auxiliary muscles, head and neck
M79.18	Myalgia, other site
M79.7	Fibromyalgia
Q76.2	Congenital spondylolisthesis
R26.2	Difficulty in walking, not elsewhere classified
R29.4	Clicking hip
S13.4XXA	Sprain of ligaments of cervical spine, initial encounter
S13.8XXA	Sprain of joints and ligaments of other parts of neck, initial encounter
S16.1XXA	Strain of muscle, fascia and tendon at neck level, initial encounter
S23.3XXA	Sprain of ligaments of thoracic spine, initial encounter
S23.8XXA	Sprain of other specified parts of thorax, initial encounter
S29.012A	Strain of muscle and tendon of back wall of thorax, initial encounter
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
S33.6XXA	Sprain of sacroiliac joint, initial encounter
S33.8XXA	Sprain of other parts of lumbar spine and pelvis, initial encounter
S39.012A	Strain of muscle, fascia and tendon of lower back, initial encounter
S39.013A	Strain of muscle, fascia and tendon of pelvis, initial encounter

Long-Term Treatment

M48.01	Spinal stenosis, occipito-atlanto-axial region
M48.02	Spinal stenosis, cervical region
M48.03	Spinal stenosis, cervicothoracic region
M48.04	Spinal stenosis, thoracic region
M48.05	Spinal stenosis, thoracolumbar region
M48.061	Spinal stenosis, lumbar region without neurogenic claudication
M48.062	Spinal stenosis, lumbar region with neurogenic claudication
M48.07	Spinal stenosis, lumbosacral region
M48.31	Traumatic spondylopathy, occipito-atlanto-axial region
M48.32	Traumatic spondylopathy, cervical region
M48.33	Traumatic spondylopathy, cervicothoracic region

M48.34	Traumatic spondylopathy, thoracic region
M48.35	Traumatic spondylopathy, thoracolumbar region
M48.36	Traumatic spondylopathy, lumbar region
M48.37	Traumatic spondylopathy, lumbosacral region
M48.38	Traumatic spondylopathy, sacral and sacrococcygeal region
M50.21	Other cervical disc displacement, high cervical region
M50.220	Other cervical disc displacement, mid-cervical region, unspecified level
M50.221	Other cervical disc displacement at C4-C5 level
M50.222	Other cervical disc displacement at C5-C6 level
M50.223	Other cervical disc displacement at C6-C7 level
M50.23	Other cervical disc displacement, cervicothoracic region
M50.31	Other cervical disc degeneration, high cervical region
M50.320	Other cervical disc degeneration, mid-cervical region, unspecified level
M50.321	Other cervical disc degeneration at C4-C5 level
M50.322	Other cervical disc degeneration at C5-C6 level
M50.323	Other cervical disc degeneration at C6-C7 level
M50.33	Other cervical disc degeneration, cervicothoracic region
M51.24	Other intervertebral disc displacement, thoracic region
M51.25	Other intervertebral disc displacement, thoracolumbar region
M51.26	Other intervertebral disc displacement, lumbar region
M51.27	Other intervertebral disc displacement, lumbosacral region
M51.34	Other intervertebral disc degeneration, thoracic region
M51.35	Other intervertebral disc degeneration, thoracolumbar region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M96.1	Postlaminectomy syndrome, not elsewhere classified
M99.20	Subluxation stenosis of neural canal of head region
M99.21	Subluxation stenosis of neural canal of cervical region
M99.22	Subluxation stenosis of neural canal of thoracic region
M99.23	Subluxation stenosis of neural canal of lumbar region
M99.30	Osseous stenosis of neural canal of head region
M99.31	Osseous stenosis of neural canal of cervical region
M99.32	Osseous stenosis of neural canal of thoracic region
M99.33	Osseous stenosis of neural canal of lumbar region
M99.40	Connective tissue stenosis of neural canal of head region
M99.41	Connective tissue stenosis of neural canal of cervical region

M99.42	Connective tissue stenosis of neural canal of thoracic region
M99.43	Connective tissue stenosis of neural canal of lumbar region
M99.50	Intervertebral disc stenosis of neural canal of head region
M99.51	Intervertebral disc stenosis of neural canal of cervical region
M99.52	Intervertebral disc stenosis of neural canal of thoracic region
M99.53	Intervertebral disc stenosis of neural canal of lumbar region
M99.60	Osseous and subluxation stenosis of intervertebral foramina of head region
M99.61	Osseous and subluxation stenosis of intervertebral foramina of cervical region
M99.62	Osseous and subluxation stenosis of intervertebral foramina of thoracic region
M99.63	Osseous and subluxation stenosis of intervertebral foramina of lumbar region
M99.70	Connective tissue and disc stenosis of intervertebral foramina of head region
M99.71	Connective tissue and disc stenosis of intervertebral foramina of cervical region
M99.72	Connective tissue and disc stenosis of intervertebral foramina of thoracic region
M99.73	Connective tissue and disc stenosis of intervertebral foramina of lumbar region
Q76.2	Congenital spondylolisthesis

Novitas Medicare Diagnosis

Arkansas, Colorado Delaware, District of Columbia, Louisiana, Maryland, Mississippi, New Jersey, New Mexico, Pennsylvania, Oklahoma, & Texas (includes Indian Health and Veterans Affairs)

Primary diagnosis must be category 1 segmental dysfunction and secondary must be Category A-D

Twelve (12) chiropractic manipulation treatments for **Group A diagnoses**.
Eighteen (18) chiropractic manipulation treatments for **Group B diagnoses**.
Twenty-four (24) chiropractic manipulation treatments for **Group C diagnoses**.
Thirty (30) chiropractic manipulation treatments for **Group D diagnoses**.

ICD-10 CODE	DESCRIPTION
M99.00	Segmental and somatic dysfunction of head region
M99.01	Segmental and somatic dysfunction of cervical region
M99.02	Segmental and somatic dysfunction of thoracic region
M99.03	Segmental and somatic dysfunction of lumbar region
M99.04	Segmental and somatic dysfunction of sacral region
M99.05	Segmental and somatic dysfunction of pelvic region
M99.10	Subluxation complex (vertebral) of head region
M99.11	Subluxation complex (vertebral) of cervical region
M99.12	Subluxation complex (vertebral) of thoracic region
M99.13	Subluxation complex (vertebral) of lumbar region
M99.14	Subluxation complex (vertebral) of sacral region
M99.15	Subluxation complex (vertebral) of pelvic region

Group A Diagnoses

ICD-10 CODE	DESCRIPTION
G44.209	Tension-type headache, unspecified, not intractable
G44.86	Orthostatic Headache
M25.50	Pain in unspecified joint (specify as spine)
M54.03	Panniculitis affecting regions of neck and back, cervicothoracic region
M54.04	Panniculitis affecting regions of neck and back, thoracic region
M54.05	Panniculitis affecting regions of neck and back, thoracolumbar region
M54.06	Panniculitis affecting regions of neck and back, lumbar region
M54.07	Panniculitis affecting regions of neck and back, lumbosacral region
M54.08	Panniculitis affecting regions of neck and back, sacral and sacrococcygeal region
M54.09	Panniculitis affecting regions, neck and back, multiple sites in spine
M54.2	Cervicalgia
M54.50	Unspecified Low back pain
M54.51	Vertebrogenic low bak pain
M54.59	Other, low back pain
M54.6	Pain in thoracic spine
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified
M62.40	Contracture of muscle, unspecified site
M62.411	Contracture of muscle, right shoulder
M62.412	Contracture of muscle, left shoulder
M62.419	Contracture of muscle, unspecified shoulder
M62.421	Contracture of muscle, right upper arm
M62.422	Contracture of muscle, left upper arm
M62.429	Contracture of muscle, unspecified upper arm
M62.431	Contracture of muscle, right forearm
M62.432	Contracture of muscle, left forearm
M62.439	Contracture of muscle, unspecified forearm
M62.441	Contracture of muscle, right hand
M62.442	Contracture of muscle, left hand
M62.449	Contracture of muscle, unspecified hand
M62.451	Contracture of muscle, right thigh
M62.452	Contracture of muscle, left thigh
M62.459	Contracture of muscle, unspecified thigh
M62.461	Contracture of muscle, right lower leg
M62.462	Contracture of muscle, left lower leg
M62.469	Contracture of muscle, unspecified lower leg
M62.471	Contracture of muscle, right ankle and foot
M62.472	Contracture of muscle, left ankle and foot
M62.479	Contracture of muscle, unspecified ankle and foot
M62.48	Contracture of muscle, other site

M62.49	Contracture of muscle, multiple sites
M62.830	Muscle spasm of back
M62.831	Muscle spasm of calf
M62.838	Other muscle spasm
R51.0	Orthostatic Headache
R51.9	Headache

Group B Diagnosis

	DESCRIPTION
M46.00	Spinal enthesopathy, site unspecified
M46.01	Spinal enthesopathy, occipito-atlanto-axial region
M46.02	Spinal enthesopathy, cervical region
M46.03	Spinal enthesopathy, cervicothoracic region
M46.04	Spinal enthesopathy, thoracic region
M46.05	Spinal enthesopathy, thoracolumbar region
M46.06	Spinal enthesopathy, lumbar region
M46.07	Spinal enthesopathy, lumbosacral region
M46.08	Spinal enthesopathy, sacral and sacrococcygeal region
M46.09	Spinal enthesopathy, multiple sites in spine
M47.10	Other spondylosis with myelopathy, site unspecified
M47.11	Other spondylosis with myelopathy, occipito-atlanto-axial region
M47.12	Other spondylosis with myelopathy, cervical region
M47.13	Other spondylosis with myelopathy, cervicothoracic region
M47.20	Other spondylosis with radiculopathy, site unspecified
M47.21	Other spondylosis with radiculopathy, occipito-atlanto-axial region
M47.22	Other spondylosis with radiculopathy, cervical region
M47.23	Other spondylosis with radiculopathy, cervicothoracic region
M47.24	Other spondylosis with radiculopathy, thoracic region
M47.25	Other spondylosis with radiculopathy, thoracolumbar region
M47.811	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.819	Spondylosis without myelopathy or radiculopathy, site unspecified
M47.891	Other spondylosis, occipito-atlanto-axial region
M47.892	Other spondylosis, cervical region
M47.893	Other spondylosis, cervicothoracic region
M47.894	Other spondylosis, thoracic region
M47.895	Other spondylosis, thoracolumbar region
M47.899	Other spondylosis, site unspecified

M47.9	Spondylosis, unspecified
M48.10	Ankylosing hyperostosis [Forestier], site unspecified
M48.11	Ankylosing hyperostosis [Forestier], occipito-atlanto-axial region
M48.12	Ankylosing hyperostosis [Forestier], cervical region
M48.13	Ankylosing hyperostosis [Forestier], cervicothoracic region
M48.14	Ankylosing hyperostosis [Forestier], thoracic region
M48.15	Ankylosing hyperostosis [Forestier], thoracolumbar region
M48.16	Ankylosing hyperostosis [Forestier], lumbar region
M48.17	Ankylosing hyperostosis [Forestier], lumbosacral region
M48.18	Ankylosing hyperostosis [Forestier], sacral and sacrococcygeal region
M48.19	Ankylosing hyperostosis [Forestier], multiple sites in spine
M53.3	Sacrococcygeal disorders, not elsewhere classified
M60.80	Other myositis, unspecified site
M60.811	Other myositis, right shoulder
M60.812	Other myositis, left shoulder
M60.819	Other myositis, unspecified shoulder
M60.821	Other myositis, right upper arm
M60.822	Other myositis, left upper arm
M60.829	Other myositis, unspecified upper arm
M60.831	Other myositis, right forearm
M60.832	Other myositis, left forearm
M60.839	Other myositis, unspecified forearm
M60.841	Other myositis, right hand
M60.842	Other myositis, left hand
M60.849	Other myositis, unspecified hand
M60.851	Other myositis, right thigh
M60.852	Other myositis, left thigh
M60.859	Other myositis, unspecified thigh
M60.861	Other myositis, right lower leg
M60.862	Other myositis, left lower leg
M60.869	Other myositis, unspecified lower leg
M60.871	Other myositis, right ankle and foot
M60.872	Other myositis, left ankle and foot
M60.879	Other myositis, unspecified ankle and foot
M60.88	Other myositis, other site
M60.89	Other myositis, multiple sites
M60.9	Myositis, unspecified
M72.9	Fibroblastic disorder, unspecified
M79.12	Myalgia of auxiliary muscles, head and neck (new 10-1-2018)
M79.18	Myalgia, other site (new 10-1-2018)
M79.7	Fibromyalgia
S13.4XXA	Sprain of ligaments of cervical spine, initial encounter
S13.8XXA	Sprain of joints and ligaments of other parts of neck, initial encounter
S16.1XXA	Strain of muscle, fascia and tendon at neck level, initial encounter

S23.3XXA	Sprain of ligaments of thoracic spine, initial encounter
S23.8XXA	Sprain of other specified parts of thorax, initial encounter
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
S33.6XXA	Sprain of sacroiliac joint, initial encounter
S33.8XXA	Sprain of other parts of lumbar spine and pelvis, initial encounter

Group C Diagnoses

ICD-10 CODE	DESCRIPTION
G54.0	Brachial plexus disorders
G54.1	Lumbosacral plexus disorders
G54.2	Cervical root disorders, not elsewhere classified
G54.3	Thoracic root disorders, not elsewhere classified
G54.4	Lumbosacral root disorders, not elsewhere classified
G54.8	Other nerve root and plexus disorders
G55	Nerve root and plexus compressions in diseases classified elsewhere
M43.6	Torticollis
M46.41	Discitis, unspecified, occipito-atlanto-axial region
M46.42	Discitis, unspecified, cervical region
M46.43	Discitis, unspecified, cervicothoracic region
M46.44	Discitis, unspecified, thoracic region
M46.45	Discitis, unspecified, thoracolumbar region
M46.46	Discitis, unspecified, lumbar region
M46.47	Discitis, unspecified, lumbosacral region
M48.01	Spinal stenosis, occipito-atlanto-axial region
M48.02	Spinal stenosis, cervical region
M48.03	Spinal stenosis, cervicothoracic region
M50.10	Cervical disc disorder with radiculopathy, unspecified cervical region
M50.11	Cervical disc disorder with radiculopathy, high cervical region
M50.121	Cervical disc disorder at C4-C5 level with radiculopathy
M50.122	Cervical disc disorder at C5-C6 level with radiculopathy
M50.123	Cervical disc disorder at C6-C7 level with radiculopathy
M50.13	Cervical disc disorder with radiculopathy, cervicothoracic region
M50.80	Other cervical disc disorders, unspecified cervical region
M50.81	Other cervical disc disorders, high cervical region
M50.821	Other cervical disc disorders at C4-C5 level
M50.822	Other cervical disc disorders at C5-C6 level
M50.823	Other cervical disc disorders at C6-C7 level
M50.83	Other cervical disc disorders, cervicothoracic region
M50.90	Cervical disc disorder, unspecified, unspecified cervical region
M50.91	Cervical disc disorder, unspecified, high cervical region
M50.921	Unspecified cervical disc disorder at C4-C5 level

M50.922	Unspecified cervical disc disorder at C5-C6 level
M50.923	Unspecified cervical disc disorder at C6-C7 level
M50.93	Cervical disc disorder, unspecified, cervicothoracic region
M51.84	Other intervertebral disc disorders, thoracic region
M51.85	Other intervertebral disc disorders, thoracolumbar region
M51.86	Other intervertebral disc disorders, lumbar region
M51.87	Other intervertebral disc disorders, lumbosacral region
M53.0	Cervicocranial syndrome
M53.1	Cervicobrachial syndrome
M54.11	Radiculopathy, occipito-atlanto-axial region
M54.12	Radiculopathy, cervical region
M54.13	Radiculopathy, cervicothoracic region
M99.20	Subluxation stenosis of neural canal of head region
M99.21	Subluxation stenosis of neural canal of cervical region
M99.30	Osseous stenosis of neural canal of head region
M99.31	Osseous stenosis of neural canal of cervical region
M99.40	Connective tissue stenosis of neural canal of head region
M99.41	Connective tissue stenosis of neural canal of cervical region
M99.50	Intervertebral disc stenosis of neural canal of head region
M99.51	Intervertebral disc stenosis of neural canal of cervical region
M99.60	Osseous and subluxation stenosis of intervertebral foramina of head region
M99.61	Osseous and subluxation stenosis of intervertebral foramina of cervical region
M99.70	Connective tissue and disc stenosis of intervertebral foramina of head region
M99.71	Connective tissue and disc stenosis of intervertebral foramina of cervical region

Group D Diagnoses

ICD-10 CODE	DESCRIPTION
M43.00	Spondylolysis, site unspecified
M43.01	Spondylolysis, occipito-atlanto-axial region
M43.02	Spondylolysis, cervical region
M43.03	Spondylolysis, cervicothoracic region
M43.04	Spondylolysis, thoracic region
M43.05	Spondylolysis, thoracolumbar region
M43.06	Spondylolysis, lumbar region
M43.07	Spondylolysis, lumbosacral region
M43.08	Spondylolysis, sacral and sacrococcygeal region
M43.09	Spondylolysis, multiple sites in spine
M43.10	Spondylolisthesis, site unspecified
M43.11	Spondylolisthesis, occipito-atlanto-axial region
M43.12	Spondylolisthesis, cervical region
M43.13	Spondylolisthesis, cervicothoracic region
M43.14	Spondylolisthesis, thoracic region
M43.15	Spondylolisthesis, thoracolumbar region

M43.16	Spondylolisthesis, lumbar region
M43.17	Spondylolisthesis, lumbosacral region
M43.18	Spondylolisthesis, sacral and sacrococcygeal region
M43.19	Spondylolisthesis, multiple sites in spine
M43.27	Fusion of spine, lumbosacral region
M43.28	Fusion of spine, sacral and sacrococcygeal region
M47.14	Other spondylosis with myelopathy, thoracic region
M47.15	Other spondylosis with myelopathy, thoracolumbar region
M47.16	Other spondylosis with myelopathy, lumbar region
M47.26	Other spondylosis with radiculopathy, lumbar region
M47.27	Other spondylosis with radiculopathy, lumbosacral region
M47.28	Other spondylosis with radiculopathy, sacral and sacrococcygeal region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M47.896	Other spondylosis, lumbar region
M47.897	Other spondylosis, lumbosacral region
M47.898	Other spondylosis, sacral and sacrococcygeal region
M48.04	Spinal stenosis, thoracic region
M48.05	Spinal stenosis, thoracolumbar region
M48.061	Spinal stenosis, lumbar region without neurogenic claudication
M48.062	Spinal stenosis, lumbar region with neurogenic claudication
M48.07	Spinal stenosis, lumbosacral region
M48.30	Traumatic spondylopathy, site unspecified
M48.31	Traumatic spondylopathy, occipito-atlanto-axial region
M48.32	Traumatic spondylopathy, cervical region
M48.33	Traumatic spondylopathy, cervicothoracic region
M48.34	Traumatic spondylopathy, thoracic region
M48.35	Traumatic spondylopathy, thoracolumbar region
M48.36	Traumatic spondylopathy, lumbar region
M48.37	Traumatic spondylopathy, lumbosacral region
M48.38	Traumatic spondylopathy, sacral and sacrococcygeal region
M50.20	Other cervical disc displacement, unspecified cervical region
M50.21	Other cervical disc displacement, high cervical region
M50.221	Other cervical disc displacement at C4-C5 level
M50.222	Other cervical disc displacement at C5-C6 level
M50.223	Other cervical disc displacement at C6-C7 level
M50.23	Other cervical disc displacement, cervicothoracic region
M50.30	Other cervical disc degeneration, unspecified cervical region
M50.31	Other cervical disc degeneration, high cervical region
M50.321	Other cervical disc degeneration at C4-C5 level
M50.322	Other cervical disc degeneration at C5-C6 level
M50.323	Other cervical disc degeneration at C6-C7 level
M50.33	Other cervical disc degeneration, cervicothoracic region

M51.14	Intervertebral disc disorders with radiculopathy, thoracic region
M51.15	Intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.24	Other intervertebral disc displacement, thoracic region
M51.25	Other intervertebral disc displacement, thoracolumbar region
M51.26	Other intervertebral disc displacement, lumbar region
M51.27	Other intervertebral disc displacement, lumbosacral region
M51.34	Other intervertebral disc degeneration, thoracic region
M51.35	Other intervertebral disc degeneration, thoracolumbar region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M53.2X7	Spinal instabilities, lumbosacral region
M53.2X8	Spinal instabilities, sacral and sacrococcygeal region
M53.3	Sacrococcygeal disorders, not elsewhere classified
M53.86	Other specified dorsopathies, lumbar region
M53.87	Other specified dorsopathies, lumbosacral region
M53.88	Other specified dorsopathies, sacral and sacrococcygeal region
M54.14	Radiculopathy, thoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.30	Sciatica, unspecified side
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.40	Lumbago with sciatica, unspecified side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M96.1	Postlaminectomy syndrome, not elsewhere classified
M99.12	Subluxation complex (vertebral) of thoracic region
M99.13	Subluxation complex (vertebral) of lumbar region
M99.14	Subluxation complex (vertebral) of sacral region
M99.22	Subluxation stenosis of neural canal of thoracic region
M99.23	Subluxation stenosis of neural canal of lumbar region
M99.32	Osseous stenosis of neural canal of thoracic region
M99.33	Osseous stenosis of neural canal of lumbar region
M99.42	Connective tissue stenosis of neural canal of thoracic region
M99.43	Connective tissue stenosis of neural canal of lumbar region
M99.52	Intervertebral disc stenosis of neural canal of thoracic region
M99.53	Intervertebral disc stenosis of neural canal of lumbar region
M99.62	Osseous and subluxation stenosis of intervertebral foramina of thoracic region
M99.63	Osseous and subluxation stenosis of intervertebral foramina of lumbar region
M99.72	Connective tissue and disc stenosis of intervertebral foramina of thoracic region
M99.73	Connective tissue and disc stenosis of intervertebral foramina of lumbar region

Code	Description
Q76.2	Congenital spondylolisthesis
S13.100A	Subluxation of unspecified cervical vertebrae, initial encounter
S13.101A	Dislocation of unspecified cervical vertebrae, initial encounter
S13.110A	Subluxation of C0/C1 cervical vertebrae, initial encounter
S13.111A	Dislocation of C0/C1 cervical vertebrae, initial encounter
S13.120A	Subluxation of C1/C2 cervical vertebrae, initial encounter
S13.121A	Dislocation of C1/C2 cervical vertebrae, initial encounter
S13.130A	Subluxation of C2/C3 cervical vertebrae, initial encounter
S13.131A	Dislocation of C2/C3 cervical vertebrae, initial encounter
S13.140A	Subluxation of C3/C4 cervical vertebrae, initial encounter
S13.141A	Dislocation of C3/C4 cervical vertebrae, initial encounter
S13.150A	Subluxation of C4/C5 cervical vertebrae, initial encounter
S13.151A	Dislocation of C4/C5 cervical vertebrae, initial encounter
S13.160A	Subluxation of C5/C6 cervical vertebrae, initial encounter
S13.161A	Dislocation of C5/C6 cervical vertebrae, initial encounter
S13.170A	Subluxation of C6/C7 cervical vertebrae, initial encounter
S13.171A	Dislocation of C6/C7 cervical vertebrae, initial encounter
S13.180A	Subluxation of C7/T1 cervical vertebrae, initial encounter
S13.181A	Dislocation of C7/T1 cervical vertebrae, initial encounter
S14.2XXA	Injury of nerve root of cervical spine, initial encounter
S14.3XXA	Injury of brachial plexus, initial encounter
S23.0XXA	Traumatic rupture of thoracic intervertebral disc, initial encounter
S23.100A	Subluxation of unspecified thoracic vertebra, initial encounter
S23.101A	Dislocation of unspecified thoracic vertebra, initial encounter
S23.110A	Subluxation of T1/T2 thoracic vertebra, initial encounter
S23.111A	Dislocation of T1/T2 thoracic vertebra, initial encounter
S23.120A	Subluxation of T2/T3 thoracic vertebra, initial encounter
S23.121A	Dislocation of T2/T3 thoracic vertebra, initial encounter
S23.122A	Subluxation of T3/T4 thoracic vertebra, initial encounter
S23.123A	Dislocation of T3/T4 thoracic vertebra, initial encounter
S23.130A	Subluxation of T4/T5 thoracic vertebra, initial encounter
S23.131A	Dislocation of T4/T5 thoracic vertebra, initial encounter
S23.132A	Subluxation of T5/T6 thoracic vertebra, initial encounter
S23.133A	Dislocation of T5/T6 thoracic vertebra, initial encounter
S23.140A	Subluxation of T6/T7 thoracic vertebra, initial encounter
S23.141A	Dislocation of T6/T7 thoracic vertebra, initial encounter
S23.142A	Subluxation of T7/T8 thoracic vertebra, initial encounter
S23.143A	Dislocation of T7/T8 thoracic vertebra, initial encounter
S23.150A	Subluxation of T8/T9 thoracic vertebra, initial encounter
S23.151A	Dislocation of T8/T9 thoracic vertebra, initial encounter
S23.152A	Subluxation of T9/T10 thoracic vertebra, initial encounter
S23.153A	Dislocation of T9/T10 thoracic vertebra, initial encounter
S23.160A	Subluxation of T10/T11 thoracic vertebra, initial encounter
S23.161A	Dislocation of T10/T11 thoracic vertebra, initial encounter

S23.162A	Subluxation of T11/T12 thoracic vertebra, initial encounter
S23.163A	Dislocation of T11/T12 thoracic vertebra, initial encounter
S23.170A	Subluxation of T12/L1 thoracic vertebra, initial encounter
S23.171A	Dislocation of T12/L1 thoracic vertebra, initial encounter
S24.2XXA	Injury of nerve root of thoracic spine, initial encounter
S33.0XXA	Traumatic rupture of lumbar intervertebral disc, initial encounter
S33.100A	Subluxation of unspecified lumbar vertebra, initial encounter
S33.101A	Dislocation of unspecified lumbar vertebra, initial encounter
S33.110A	Subluxation of L1/L2 lumbar vertebra, initial encounter
S33.111A	Dislocation of L1/L2 lumbar vertebra, initial encounter
S33.120A	Subluxation of L2/L3 lumbar vertebra, initial encounter
S33.121A	Dislocation of L2/L3 lumbar vertebra, initial encounter
S33.130A	Subluxation of L3/L4 lumbar vertebra, initial encounter
S33.131A	Dislocation of L3/L4 lumbar vertebra, initial encounter
S33.140A	Subluxation of L4/L5 lumbar vertebra, initial encounter
S33.141A	Dislocation of L4/L5 lumbar vertebra, initial encounter
S33.2XXA	Dislocation of sacroiliac and sacrococcygeal joint, initial encounter
S34.21XA	Injury of nerve root of lumbar spine, initial encounter
S34.22XA	Injury of nerve root of sacral spine, initial encounter
S34.4XXA	Injury of lumbosacral plexus, initial encounter

Noridian Medicare

Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, North Dakota, Oregon, South Dakota, Washington, Utah, & Wyoming

	Primary Subluxation Diagnosis
M99.00	Segmental somatic dysfunction head region (occipital)
M99.01	Segmental somatic dysfunction cervical region
M99.02	Segmental somatic dysfunction thoracic region
M99.03	Segmental and somatic dysfunction, lumbar region
M99.04	Segmental and somatic dysfunction, sacral region
M99.05	Segmental and somatic dysfunction, pelvic region
M99.10	Subluxation complex (vertebral) of head region
M99.11	Subluxation complex (vertebral) of cervical region
M99.12	Subluxation complex (vertebral) of thoracic region
M99.13	Subluxation complex (vertebral) of Lumbar region
M99.14	Subluxation complex (vertebral) of sacral region
M99.15	Subluxation complex (vertebral) of pelvic region

Category I Generally requires short term treatment

Code	Description
G44.1	Vascular headache, not elsewhere classified
G44.209	Tension-type headache, unspecified, not intractable
G44.219	Episodic tension-type headache, not intractable
G44.229	Chronic tension-type headache, not intractable
M24.50	Contracture, unspecified joint
M47.10	Other spondylosis with myelopathy, site unspecified
M47.21	Other spondylosis with radiculopathy, occipito-atlanto-axial region
M47.22	Other spondylosis with radiculopathy, cervical region
M47.23	Other spondylosis with radiculopathy, cervicothoracic region
M47.24	Other spondylosis with radiculopathy, thoracic region
M47.25	Other spondylosis with radiculopathy, thoracolumbar region
M47.26	Other spondylosis with radiculopathy, lumbar region
M47.27	Other spondylosis with radiculopathy, lumbosacral region
M47.28	Other spondylosis with radiculopathy, sacral and sacrococcygeal region
M47.811	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M47.819	Spondylosis without myelopathy or radiculopathy, site unspecified
M47.891	Other spondylosis, occipito-atlanto-axial region
M47.892	Other spondylosis, cervical region
M47.893	Other spondylosis, cervicothoracic region
M47.894	Other spondylosis, thoracic region
M47.895	Other spondylosis, thoracolumbar region
M47.896	Other spondylosis, lumbar region
M47.897	Other spondylosis, lumbosacral region
M47.898	Other spondylosis, sacral and sacrococcygeal region
M48.10	Ankylosing hyperostosis [Forestier], site unspecified
M48.11	Ankylosing hyperostosis [Forestier], occipito-atlanto-axial region
M48.12	Ankylosing hyperostosis [Forestier], cervical region
M48.13	Ankylosing hyperostosis [Forestier], cervicothoracic region
M48.14	Ankylosing hyperostosis [Forestier], thoracic region
M48.15	Ankylosing hyperostosis [Forestier], thoracolumbar region
M48.16	Ankylosing hyperostosis [Forestier], lumbar region
M48.17	Ankylosing hyperostosis [Forestier], lumbosacral region
M48.18	Ankylosing hyperostosis [Forestier], sacral and sacrococcygeal region
M48.19	Ankylosing hyperostosis [Forestier], multiple sites in spine

M54.2	Cervicalgia
M54.50	Low back pain, unspecified
M54.51	Vertebrogenic low back pain
M54.59	Other Low back pain
M54.6	Pain in thoracic spine
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified
R51.0	Orthostatic Headache
R51.9	Headache

Category II Generally requires moderate term treatment

G54.0	Brachial plexus disorders
G54.1	Lumbosacral plexus disorders
G54.2	Cervical root disorders, not elsewhere classified
G54.3	Thoracic root disorders, not elsewhere classified
G54.4	Lumbosacral root disorders, not elsewhere classified
G54.8	Other nerve root and plexus disorders
G55	Nerve root and plexus compressions in diseases classified elsewhere
M25.50	Pain in unspecified joint (specify spine)
M43.01	Spondylolysis, occipito-atlanto-axial region
M43.02	Spondylolysis, cervical region
M43.03	Spondylolysis, cervicothoracic region
M43.04	Spondylolysis, thoracic region
M43.05	Spondylolysis, thoracolumbar region
M43.06	Spondylolysis, lumbar region
M43.07	Spondylolysis, lumbosacral region
M43.08	Spondylolysis, sacral and sacrococcygeal region
M43.09	Spondylolysis, multiple sites in spine
M43.11	Spondylolisthesis, occipito-atlanto-axial region
M43.12	Spondylolisthesis, cervical region
M43.13	Spondylolisthesis, cervicothoracic region
M43.14	Spondylolisthesis, thoracic region
M43.15	Spondylolisthesis, thoracolumbar region
M43.16	Spondylolisthesis, lumbar region
M43.17	Spondylolisthesis, lumbosacral region
M43.18	Spondylolisthesis, sacral and sacrococcygeal region
M43.19	Spondylolisthesis, multiple sites in spine
M43.27	Fusion of spine, lumbosacral region
M43.28	Fusion of spine, sacral and sacrococcygeal region
M43.6	Torticollis
M46.01	Spinal enthesopathy, occipito-atlanto-axial region
M46.02	Spinal enthesopathy, cervical region
M46.03	Spinal enthesopathy, cervicothoracic region
M46.04	Spinal enthesopathy, thoracic region

M46.05	Spinal enthesopathy, thoracolumbar region
M46.06	Spinal enthesopathy, lumbar region
M46.07	Spinal enthesopathy, lumbosacral region
M46.08	Spinal enthesopathy, sacral and sacrococcygeal region
M46.09	Spinal enthesopathy, multiple sites in spine
M48.01	Spinal stenosis, occipito-atlanto-axial region
M48.02	Spinal stenosis, cervical region
M48.03	Spinal stenosis, cervicothoracic region
M48.04	Spinal stenosis, thoracic region
M48.05	Spinal stenosis, thoracolumbar region
M48.061	Spinal stenosis, lumbar region without neurogenic claudication
M48.062	Spinal stenosis, lumbar region with neurogenic claudication
M48.07	Spinal stenosis, lumbosacral region
M50.11	Cervical disc disorder with radiculopathy, high cervical region C2-3 C3-4
M50.120	Mid-cervical disc disorder, unspecified
M50.121	Cervical disc disorder at C4-C5 level with radiculopathy
M50.122	Cervical disc disorder at C5-C6 level with radiculopathy
M50.123	Cervical disc disorder at C6-C7 level with radiculopathy
M50.13	Cervical disc disorder with radiculopathy, cervicothoracic region
M50.820	Other cervical disc disorders, mid-cervical region, unspecified level
M50.821	Other cervical disc disorders at C4-C5 level
M50.822	Other cervical disc disorders at C5-C6 level
M50.823	Other cervical disc disorders at C6-C7 level
M50.83	Other cervical disc disorders, cervicothoracic region
M50.90	Cervical disc disorder, unspecified, unspecified cervical region
M50.91	Cervical disc disorder, unspecified, high cervical region C2-3 C3-4
M50.920	Unspecified cervical disc disorder, mid-cervical region, unspecified level
M50.921	Unspecified cervical disc disorder at C4-C5 level
M50.922	Unspecified cervical disc disorder at C5-C6 level
M50.923	Unspecified cervical disc disorder at C6-C7 level
M50.93	Cervical disc disorder, unspecified, cervicothoracic region
M51.14	Intervertebral disc disorders with radiculopathy, thoracic region
M51.15	Intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.84	Other intervertebral disc disorders, thoracic region
M51.85	Other intervertebral disc disorders, thoracolumbar region
M51.86	Other intervertebral disc disorders, lumbar region
M51.87	Other intervertebral disc disorders, lumbosacral region
M53.0	Cervicocranial syndrome
M53.1	Cervicobrachial syndrome
M53.2X7	Spinal instabilities, lumbosacral region
M53.2X8	Spinal instabilities, sacral and sacrococcygeal region
M53.3	Sacrococcygeal disorders, not elsewhere classified
M53.86	Other specified dorsopathies, lumbar region

M53.87	Other specified dorsopathies, lumbosacral region
M53.88	Other specified dorsopathies, sacral and sacrococcygeal region
M54.11	Radiculopathy, occipito-atlanto-axial region
M54.12	Radiculopathy, cervical region
M54.13	Radiculopathy, cervicothoracic region
M54.14	Radiculopathy, thoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M60.811	Other myositis, right shoulder
M60.812	Other myositis, left shoulder
M60.821	Other myositis, right upper arm
M60.822	Other myositis, left upper arm
M60.831	Other myositis, right forearm
M60.832	Other myositis, left forearm
M60.841	Other myositis, right hand
M60.842	Other myositis, left hand
M60.851	Other myositis, right thigh
M60.852	Other myositis, left thigh
M60.861	Other myositis, right lower leg
M60.862	Other myositis, left lower leg
M60.871	Other myositis, right ankle and foot
M60.872	Other myositis, left ankle and foot
M60.89	Other myositis, multiple sites
M60.9	Myositis, unspecified
M62.830	Muscle spasm of back
M79.12	Myalgia auxiliary muscles of head and neck
M79.18	Myalgia, other region
M79.7	Fibromyalgia
M99.20	Subluxation stenosis of neural canal of head region
M99.21	Subluxation stenosis of neural canal of cervical region
M99.22	Subluxation stenosis of neural canal of thoracic region
M99.23	Subluxation stenosis of neural canal of lumbar region
M99.30	Osseous stenosis of neural canal of head region
M99.31	Osseous stenosis of neural canal of cervical region
M99.32	Osseous stenosis of neural canal of thoracic region
M99.33	Osseous stenosis of neural canal of lumbar region
M99.40	Connective tissue stenosis of neural canal of head region
M99.41	Connective tissue stenosis of neural canal of cervical region
M99.42	Connective tissue stenosis of neural canal of thoracic region
M99.43	Connective tissue stenosis of neural canal of lumbar region
M99.50	Intervertebral disc stenosis of neural canal of head region
M99.51	Intervertebral disc stenosis of neural canal of cervical region
M99.52	Intervertebral disc stenosis of neural canal of thoracic region
M99.53	Intervertebral disc stenosis of neural canal of lumbar region

M99.60	Osseous and subluxation stenosis of intervertebral foramina of head region
M99.61	Osseous and subluxation stenosis of intervertebral foramina of cervical region
M99.62	Osseous and subluxation stenosis of intervertebral foramina of thoracic region
M99.63	Osseous and subluxation stenosis of intervertebral foramina of lumbar region
M99.70	Connective tissue and disc stenosis of intervertebral foramina of head region
M99.71	Connective tissue and disc stenosis of intervertebral foramina of cervical region
M99.72	Connective tissue and disc stenosis of intervertebral foramina of thoracic region
M99.73	Connective tissue and disc stenosis of intervertebral foramina of lumbar region
Q76.2	Congenital spondylolisthesis
S13.4XXA	Sprain of ligaments of cervical spine, initial encounter
S13.4XXD	Sprain of ligaments of cervical spine, subsequent encounter
S13.4XXS	Sprain of ligaments of cervical spine, sequelae
S13.8XXA	Sprain of joints and ligaments of other parts of neck, initial encounter
S13.8XXD	Sprain of joints and ligaments of other parts of neck, subsequent encounter
S13.8.XXS	Sprain of joints and ligaments of other parts of neck, sequelae
S16.1XXA	Strain of muscle, fascia and tendon at neck level, initial encounter
S16.1XXD	Strain of muscle, fascia and tendon at neck level, subsequent encounter
S16.1XXS	Strain of muscle, fascia and tendon at neck level, sequelae
S23.3XXA	Sprain of ligaments of thoracic spine, initial encounter
S23.3XXD	Sprain of ligaments of thoracic spine, subsequent encounter
S23.3XXS	Sprain of ligaments of thoracic spine, sequelae
S23.8XXA	Sprain of other specified parts of thorax, initial encounter
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
S33.5XXD	Sprain of ligaments of lumbar spine, subsequent encounter
S33.5XXS	Sprain of ligaments of lumbar spine, sequelae
S33.6XXA	Sprain of sacroiliac joint, initial encounter
S33.6XXD	Sprain of sacroiliac joint, subsequent encounter
S33.6XXS	Sprain of sacroiliac joint, sequelae
S33.8XXA	Sprain of other parts of lumbar spine and pelvis, initial encounter
S33.8XXD	Sprain of other parts of lumbar spine and pelvis, subsequent encounter
S33.8XXS	Sprain of other parts of lumbar spine and pelvis, sequelae
S39.012A	Strain of muscle, tendon, fascia of lower back, initial encounter
S39.012D	Strain of muscle, tendon, fascia of lower back, subsequent encounter
S39.012S	Strain of muscle, tendon, fascia of lower back, sequelae

Category III May require long term treatment

M48.31	Traumatic spondylopathy, occipito-atlanto-axial region
M48.32	Traumatic spondylopathy, cervical region
M48.33	Traumatic spondylopathy, cervicothoracic region
M48.34	Traumatic spondylopathy, thoracic region
M48.35	Traumatic spondylopathy, thoracolumbar region

M48.36	Traumatic spondylopathy, lumbar region
M48.37	Traumatic spondylopathy, lumbosacral region
M48.38	Traumatic spondylopathy, sacral and sacrococcygeal region
M50.20	Other cervical disc displacement, unspecified cervical region
M50.21	Other cervical disc displacement, high cervical C2-C3, C3-C4
M50.220	Other cervical disc displacement, mid-cervical region, unspecified level
M50.221	Other cervical disc displacement at C4-C5 level
M50.222	Other cervical disc displacement at C5-C6 level
M50.223	Other cervical disc displacement at C6-C7 level
M50.23	Other cervical disc displacement, cervicothoracic region
M50.30	Other cervical disc degeneration, unspecified cervical region
M50.31	Other cervical disc degeneration, high cervical region C2-3 C3-4
M50.320	Other cervical disc degeneration, mid-cervical region, unspecified level
M50.321	Other cervical disc degeneration at C4-C5 level
M50.322	Other cervical disc degeneration at C5-C6 level
M50.323	Other cervical disc degeneration at C6-C7 level
M50.33	Other cervical disc degeneration, cervicothoracic region
M51.24	Other intervertebral disc displacement, thoracic region
M51.25	Other intervertebral disc displacement, thoracolumbar region
M51.26	Other intervertebral disc displacement, lumbar region
M51.27	Other intervertebral disc displacement, lumbosacral region
M51.34	Other intervertebral disc degeneration, thoracic region
M51.35	Other intervertebral disc degeneration, thoracolumbar region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M96.1	Postlaminectomy syndrome, not elsewhere classified

Wisconsin Physician Services (WPS) MAC

- **Indiana, Iowa, Kansas, Michigan, Missouri, & Nebraska**
- **M99.00 to M99.05**
- **Retired their LCD Local Coverage Determination however, billing and coding should follow standard protocols of primary diagnosis of subluxation and secondary NMS conditions.**
- **The retired diagnosis list does appear to provide a reference of coding and you will note similarity.**

First Coast MAC

- **Florida, Puerto Rico, & U.S. Virgin Islands**
- The level of the subluxation must be specified on the claim and must be listed as the primary diagnosis. The neuromusculoskeletal condition necessitating the treatment should be listed as the secondary diagnosis.
- *However, First Coast, does not published a specified list of NMS secondary diagnosis therefore we encourage utilizing the other lists for codes that have been approved by Medicare (MAC's)*

CAHABA MAC & Palmetto MAC

- **Alabama, Georgia and Tennessee**
- **North Carolina, Railroad, South Carolina, Virginia, & West Virginia**
- **M99.01 to M99.05 only and does not require a secondary diagnosis on the claim form. However, there should be clear indication in the notes of the condition related to the subluxation to demonstrate the necessity of care and the patients progress to care.**

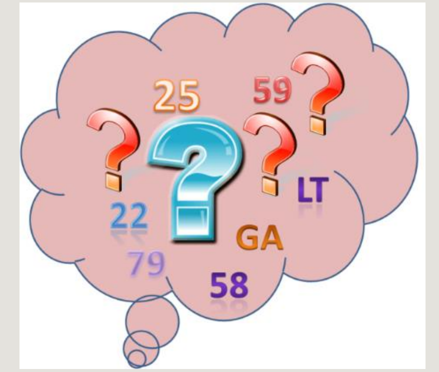
National Government Services NGS

- **Connecticut, Illinois, Maine, Massachusetts, Minnesota, New Hampshire, New York, Rhode Island Vermont & Wisconsin**
- **M99.01 to M99.05 only and does not require a secondary diagnosis on the claim form. However, there should be clear indication in the notes of the condition related to the subluxation to demonstrate the necessity of care and the patients progress to care.**

GS Celerian Group Company

- **Kentucky and Ohio**
- **M99.01 to M99.05 LCD was revised and removed all billing and coding policy details. However, maintain the same protocol of subluxation with a secondary diagnosis related.**

Step 2 - Modifiers



- AT = Acute Treatment
- GY = Excluded Service
- GP = Physical Medicine (new for chiro)
- GA = Waiver on File (maintenance)

AT Modifier

- AT is to demonstrate that care is acute and/or corrective
- 98940 AT
- If there is no AT on the CMT code it is an automatic denial

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M9901 B. M5412 C. M9902 D. M546
E. M9903 F. M5459 G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A.	DATE(S) OF SERVICE From			To			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
	MM	DD	YY	MM	DD	YY													
1	01	05	23	01	05	23	11		98940	AT				A	35 00	1		NPI	
2	01	05	23	01	05	23	11		97110	GY	GP			A	40 00	1		NPI	
3	01	05	23	01	05	23	11		99213	25	GY			A	80 00	1		NPI	
4																		NPI	
5																		NPI	
6																		NPI	

PHYSICIAN OR SUPPLIER INFORMATION

EXCLUDED SERVICES

- **<u>ALL</u>** Services except spinal manipulation
- If billing for a denial for a secondary insurance
- Use modifier **GY**

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M9901 B. M5412 C. M9902 D. M546
E. M9903 F. M5459 G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	05	23	01	05	23	11		98940	AT				A	35 00	1		NPI	
2	01	05	23	01	05	23	11		97110	GY	GP			A	40 00	1		NPI	
3	01	05	23	01	05	23	11		99213	25	GY			A	80 00	1		NPI	
4																		NPI	
5																		NPI	
6																		NPI	

PHYSICIAN OR SUPPLIER INFORMATION

Physical Medicine Services

- **ALL** physical medicine services 97010-97799
- Must have modifier GP to indicate a physical medicine plan of care
- Order does not matter

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M9901 B. M5412 C. M9902 D. M546
E. M9903 F. M5459 G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	05	23	01	05	23	11		98940	AT				A	35 00	1		NPI	
2	01	05	23	01	05	23	11		97110	GY	GP			A	40 00	1		NPI	
3	01	05	23	01	05	23	11		99213	25	GY			A	80 00	1		NPI	
4																		NPI	
5																		NPI	
6																		NPI	

PHYSICIAN OR SUPPLIER INFORMATION

- There is no requirement to bill Medicare for excluded services.
- When payment is sought from a secondary payer then the excluded services must be billed to receive a denial from Medicare with “patient responsibility” so that the secondary payer may make payment.
- If services are not billed to Medicare the patient is still liable for payment of those services.

Maintenance Care Modifier GA

- When you have determined <u>spinal manipulation</u> is maintenance or will be likely denied due to medical necessity by Medicare…
- Patient must be provided and sign an Advanced Beneficiary notice (ABN)

	MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS	MODIFIER				POINTER	$ CHARGES	UNITS
1	06	05	22	06	05	22	11		98940	GA				A	35 00	1

ABN Notices

- ABNs allow Medicare patients to make an informed decision about whether to receive a service that is likely to be non-covered for maintenance or “not reasonable and medically necessary”.
- If you have a signed, valid ABN on file and your office receives a Medical Necessity denial for services, you may collect the billed amount from the patient for the services indicated.

The Requirements of the ABN

- Providers must use the CMS-R-131 Form, which can be copied on your letterhead.
- It must be given to the patient before the service is rendered and must relate to a covered service (CMT for Chiro) and those services will not be covered.
- Repetitive notices are acceptable, if necessary. The ABN may be completed prior to the patient's arrival for the provider's convenience (Blanks A-F), with the beneficiary or representative responsible for filling out their section (Blanks G-I).
- Keep a copy of the ABN in the patient's file for documentation purposes.
- A copy must also be provided for the patient.

When Should The ABN Be Used?

If medical necessity per Medicare standards is not met, or if the patient is receiving a screening service with frequency limitations, then the ABN should be delivered as described above.

A. Notifier:
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D.____________below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**____________below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**________________listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.
☐**OPTION 1.** I want the **D.**______________listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐**OPTION 2.** I want the **D.**_______________listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
☐**OPTION 3.** I don't want the **D.**_____________listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp.01/31/2026) Form Approved OMB No. 0938-0566

A. Notifier:
B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D.____________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.____________** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

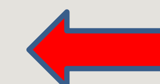
Use this version if Non-Par

WHAT YOU NEED TO DO NOW:

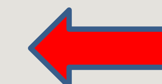
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.______________** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.
☐**OPTION 1.** I want the **D.____________** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. ~~If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.~~ ☐**OPTION 2.** I want the **D.______________** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed. ☐**OPTION 3.** I don't want the **D.____________** listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.



H. Additional Information: "This supplier doesn't accept payment from Medicare for the item(s) listed in the table above. If I checked Option 1 above, I am responsible for paying the supplier's charge for the item(s) directly to the supplier. If Medicare does pay, Medicare will pay me the Medicare-approved amount for the item(s), and this payment to me may be less than the supplier's charge."



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Form CMS-R-131 (Exp.01/31/2026) Form Approved OMB No. 0938-0566

Use of the AT and GA HCPCS Modifiers

Chiropractic claims submitted with HCPCS modifier AT indicate that the provider is supplying active/corrective treatment to treat acute or chronic subluxation. The AT HCPCS modifier may not be submitted with services that meet the definition of maintenance therapy.

AT and GA HCPCS modifiers on the same line, will reject

Rejected claims do not have appeal rights and should be resubmitted with appropriate corrections.

Medicare Categorization

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 continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.
- 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.

Medicare Categorization

Acute subluxation:

- A patient's condition is considered acute when the patient is being treated for a new injury, identified by 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.

Chronic subluxation:

- A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as in the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

Medicare Categorization

Exacerbations:

- An exacerbation is a temporary marked deterioration of the patient's condition due to flare-up of the condition being treated. This must be documented on the claim form and must be documented in the patient's clinical record, including the date of occurrence, nature of the onset or other pertinent factors that will support the reasonableness and necessity of treatments for this condition.

Recurrence:

- A recurrence is a return of symptoms of a previously treated condition that has been quiescent for 30 or more days. This may require the reinstitution of therapy.

Regular Fees May Be Charged When Maintenance

Medicare Claims Processing Manual Section 50.9

- A beneficiary who has been given a properly written and delivered ABN and agrees to pay may be held liable. The charge may be the supplier/provider’s usual and customary fee for that item or service and is not limited to the Medicare fee schedule.

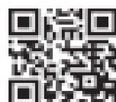
What If You Forget To Provide An ABN?

- Modifier GZ is appended to the CMT code
- Item or Service Expected to Be Denied as Not Reasonable and Necessary. This modifier should be applied when an ABN may be required but was not obtained.

Step 3 – Claim Form 1500

Claim form must be completed and conform to Medicare standards

(not the same as a claim form for insurance)



Save and Print Options

Medicare Claim Format

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA | CARRIER

1. MEDICARE [X] (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1EG4TE5MK72

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Madden, Poppy

3. PATIENT'S BIRTH DATE: 09 02 1934 — SEX: F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Only use if MC is secondary

5. PATIENT'S ADDRESS (No., Street): 1234 Maine Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Any City — STATE

8. RESERVED FOR NUCC USE

CITY — STATE

ZIP CODE: 00000 — TELEPHONE (Include Area Code): (555) 555-1212

ZIP CODE — TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: None (requried whenMedicare is primary)

a. OTHER INSURED'S POLICY OR GROUP NUMBER: XDU555 (secondary plan information)

a. EMPLOYMENT? (Current or Previous) YES NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Blue Sjhield

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, complete items 9, 9a, and 9d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File — DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Signature on File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 01 05 2024 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): X-ray and Date (if x-ray is used for subluxation)

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind.

A. M9901 B. M5412 C. M9902 D. M546
E. M9903 F. M5459 G. H.
I. J. K. L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER		E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	05	24	01	05	24	11		98940	AT		A	35 00			NPI	
2	01	05	24	01	05	24	11		97110	GY	GP	A	38 00			NPI	
3	01	05	24	01	05	24	11		99213	25	GY	A	85 00			NPI	
4																NPI	
5																NPI	
6																NPI	

25. FEDERAL TAX I.D. NUMBER: 987654321 — SSN EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO

28. TOTAL CHARGE: $ 158 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Jane Smith DC
SIGNED — DATE

32. SERVICE FACILITY LOCATION INFORMATION
Jane Smith DC
54321 Spine Ave
Any City
a. NPI b.

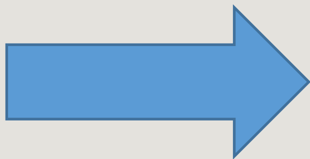
33. BILLING PROVIDER INFO & PH # (555) 888 8888
Jane Smith DC
54321 Spine Ave
Any City
a. 222333444 b.

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org — *PLEASE PRINT OR TYPE* — APPROVED OMB-0938-1197 FORM 1500 (02-12)

Calculations Off — Calculate Now

Novitas Pennsylvania & New Jersey



1. MEDICARE [X] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1EG4TE5MK72

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Madden, Poppy

3. PATIENT'S BIRTH DATE (MM DD YY): 09 02 1934 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Only use if MC is secondary

5. PATIENT'S ADDRESS (No., Street): 1234 Maine Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Any City STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 00000 TELEPHONE (Include Area Code): (555) 555-1212

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: None (requried whenMedicare is primary)

a. OTHER INSURED'S POLICY OR GROUP NUMBER: XDU555 (secondary plan information)

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Blue Sjhield

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Signature on File

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY): 01 05 2024 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): PART C5 T4 or X-Ray Date

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. M9901 B. M5412 C. M9902 D. M546

E. M9903 F. M5459 G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	05	24	01	05	24	11		98940	AT		A	35 00			NPI	
2	01	05	24	01	05	24	11		97110	GY	GP	A	38 00			NPI	

ER INFORMATION

Medicare Advantage Plans

Sample member ID card

United Healthcare
Health Plan (80840): **911-87726-04**
Member ID: 9999999999 Group Number: 99999
Member:
MEMBER K SAMPLE
GROUP NAME
Payer ID:
87726
MedicareRx
Prescription Drug Coverage
RxBIN: 610097
RxPCN: 9999
RxGrp: COS
Copay: PCP $XX
Spec $XX
ER $XX
UnitedHealthcare Group Medicare Advantage (PPO)
Plan pays up to Medicare Limiting Charges.
H2001-899-999

Sample member ID cards for illustration only; actual information varies depending on payer, plan and other requirements.

- Verify benefits and while all Medicare Advantage Plans are mandated to have the same benefits as Medicare some will have the added "rider" for services and conditions beyond spinal CMT
- Note some plans will require the provider to be a registered or "in-network" provider but many will make payment to any willing provider.

Medicare Advantage Claims

- Bill as you would to Medicare
- Diagnosis must be subluxation and secondary for spinal conditions
- Modifier AT for spinal CMT
- Do use GP on therapies
- Do not use GY or GA

Medicare Advantage Fees

- Payment will be in the Medicare fee schedule range
- However, even if you are out of network, in many instances you may not collect any amounts or balance bill above what the plans allow (there may be copays/coinsurance)
- This status or protocol is referred to as a “deemed provider”

Deemed Provider

- If you treat these patients and submit bills for their services, you are considered a "***deemed provider***" and automatically become part of the network while treating that patient. That makes you subject to all fee restrictions and appeals processes associated with this plan."

Deemed Provider

- The provider is aware in advance s/he will be providing services to a patient who is a member of a Private Fee-For-Service (PFFS) plan
- The provider has reasonable access to the plan's terms and conditions for payment
- The provider furnishes covered services to the enrolled member
- The provider agrees to submit the bill for Covered Services directly to the payer

Qualified Medical Beneficiary (QMB)

Medi-Medi

If you are not part of the Medicaid system you may not collect any fees (cost sharing) from the patient

This includes copays, deductibles, coinsurance and Medicare excluded services

May a Patient Elect to Not Use Medicare?

- The only situation in which non-opt-out physicians or practitioners, or other suppliers, are not required to submit claims to Medicare for covered services is where a beneficiary or the beneficiary's legal representative refuses, of his/her own free will, to authorize the submission of a bill to Medicare. However, the limits on what the physician, practitioner, or other supplier may collect from the beneficiary continue to apply to charges for the covered service, notwithstanding the absence of a claim to Medicare.

- *Per Medicare Benefit Policy Manual 40 - Effect of Beneficiary Agreements Not to Use Medicare Coverage (Rev. 1, 10-01-03) B3-3044, PM-B-97-17*

Common Errors

- Dates of birth must be 4 digits for year
- Block 11 must have the word “none” when Medicare is primary
- Block 14 must contain the date of initiation of the current course of care and should be updated when condition has had a flare up, exacerbation or recurrence
- Block 21 should contain the diagnosis numbers only, with no decimals and follow subluxation, secondary, subluxation, secondary order
- Block 19 for x-ray if used or for Novitas states PART
- Block 32 & 33 Requires the name and address of where services were provided even if it is the same as block 33.
- Block 33a has NPI and should not contain any PIN or other legacy number
- For a group practice (corporation) block 33a has NPI of corporation and block 24j has NPI of individual provider
- Claim form must be typed – No handwritten information is acceptable by Medicare

Common Denials and Corrections

Denial - D245

- The initial treatment date is not reported, or not a valid date.

Correction

- Resubmit the claim with the correct initial treatment date reported in block 14

Common Denials and Corrections

Denial - D552

- Claim does not include a subluxation diagnosis code
- Claim does not include proper secondary diagnosis

Correction

- The provider has not met the diagnosis requirements per the local coverage determination (LCD) for subluxation.

Common Denials and Corrections

Denial - D257

- Claim does not include proper secondary diagnosis listed in the LCD

Correction

- The provider has not met the diagnosis requirements per the local coverage determination (LCD) for subluxation. If there was a diagnosis not reported, then resubmit with proper diagnosis

Common Denials and Corrections

Denial - D257, D483 or D425	**Correction**
• Missing AT modifier	• If the AT modifier is appropriate for the service, use the claims correction feature or resubmit a new claim with the proper modifier

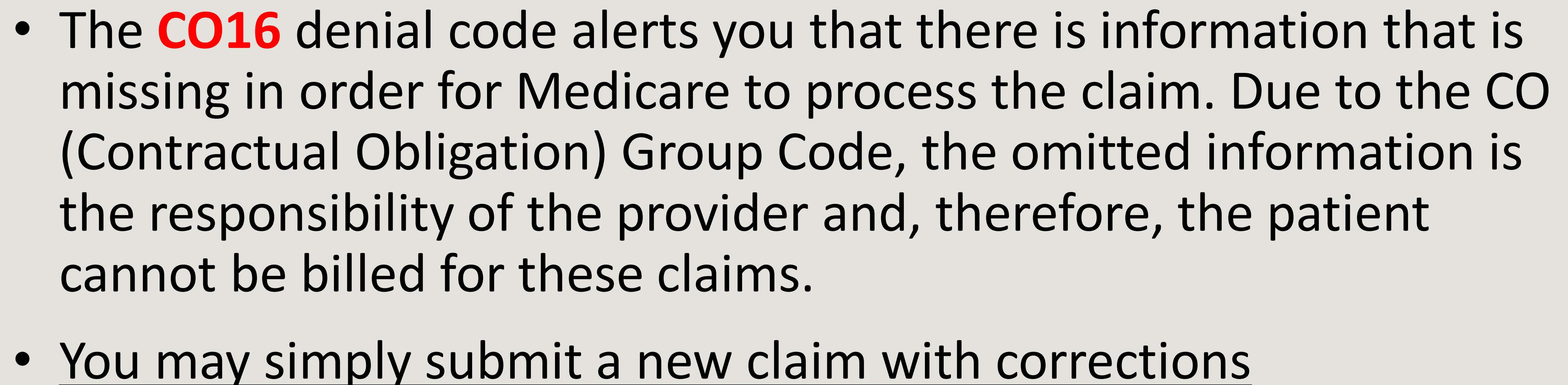
Common Denials and Corrections

Denial - D115

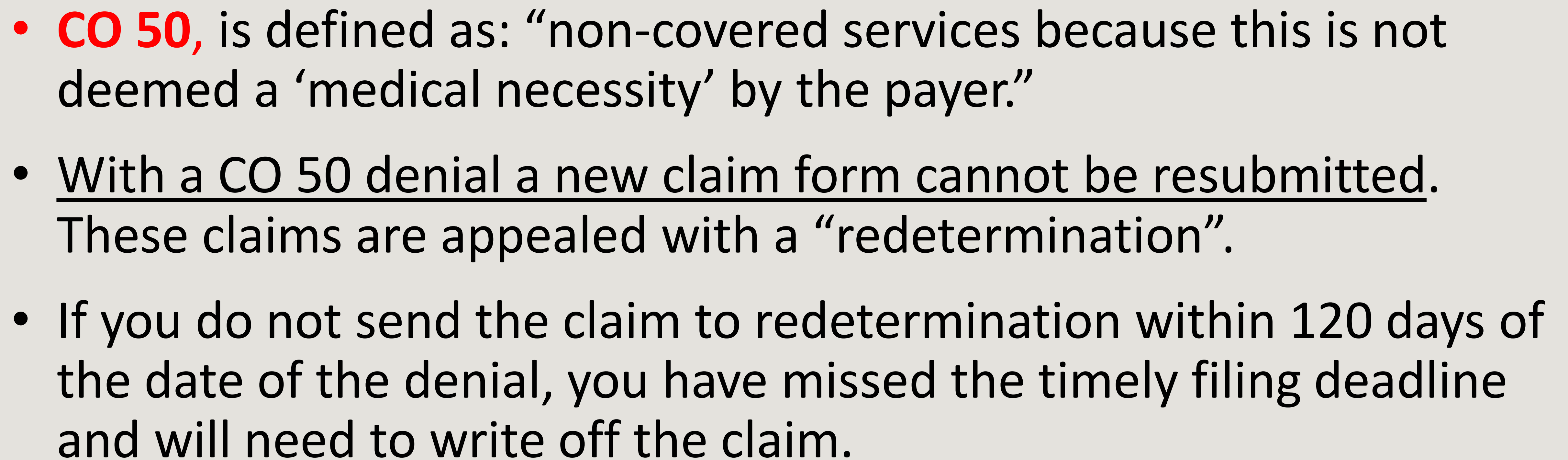
- The number of services exceeds the number of services allowed for the diagnosis group

Correction

- Claim denied for frequency of services. Refer to LCD to determine the number of covered services based on the diagnosis groups
- You may appeal with redetermination and evidence of functional change as a result of care



- The **CO16** denial code alerts you that there is information that is missing in order for Medicare to process the claim. Due to the CO (Contractual Obligation) Group Code, the omitted information is the responsibility of the provider and, therefore, the patient cannot be billed for these claims.
- You may simply submit a new claim with corrections



- **CO 50**, is defined as: “non-covered services because this is not deemed a ‘medical necessity’ by the payer.”
- With a CO 50 denial a new claim form cannot be resubmitted. These claims are appealed with a “redetermination”.
- If you do not send the claim to redetermination within 120 days of the date of the denial, you have missed the timely filing deadline and will need to write off the claim.

- **C109**- Medicare is no longer their insurance
- The second highest reason code for Medicare claim denials reported as OA109 or CO109: claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- The patient has traded their Medicare benefits to another plan (Medicare HMO) and that plan is to whom you would bill

Names

- Patient name and date of birth must match the Medicare card exactly
- No abbreviations unless that is how it is indicated on the Medicare card
- Provider name must be exactly as indicated on the Medicare enrollment and match the NPI name as well

mln
Educational Tool

KNOWLEDGE • RESOURCES • TRAINING

Medicare Documentation Job Aid for Chiropractic Doctors

What's Changed?

No substantive content updates.

Did you get a request from a Medicare contractor for chiropractic documentation? This tool will help you respond to documentation requests.

Documentation Basics

Chiropractic documentation should include:

Patient Information

- Include the patient's name and date of service on all documentation

Subluxation Documentation Requirements

- Include documentation of subluxation shown by x-ray or physical exam:
  - Include a CT scan and or MRI showing subluxation of spine
  - Include documentation of your review of the x-ray, MRI, or CT, noting level of subluxation
  - Include x-rays taken within 12 months before or 3 months following the beginning of treatment
    - In some cases of chronic subluxation (for example, scoliosis), Medicare may accept an older x-ray if the patient's health record shows the condition existed longer than 12 months and it's reasonable to conclude the condition is permanent

Or

- Include documentation of subluxation shown by physical examination. Documentation must show at least 2 elements of:
  - Pain
  - Asymmetry/misalignment
  - Range of motion abnormality
  - Tissue tone changes (P.A.R.T.), including 1 that falls under asymmetry/misalignment or range of motion abnormality
  - Include dated documentation of the first evaluation
  - Include primary diagnosis of subluxation (including level of subluxation)
- Include any documentation supporting medical necessity

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network

Initial Evaluation

- History
  - Date of initial treatment.
  - Description of current illness.
  - Symptoms related to level of subluxation causing patient to seek treatment.
  - Family history (recommended).
  - Past health history (recommended).
  - Mechanism of trauma (recommended).
  - Quality and character of symptoms or problem (recommended).
  - Onset, duration, intensity, frequency, location, and radiation of symptoms (recommended).
  - Aggravating or relieving issues (recommended).
  - Past interventions, treatments, medication, and secondary complaints (recommended).
- Contraindications (for example, risk of injury to patient from dynamic thrust or discussion of risk with patient) (recommended).
- Physical examination (P.A.R.T.).
  - Evaluation of musculoskeletal and nervous system through physical examination.
- Treatment given on day of visit (if relevant).
  - Include specific areas and levels of the spine that you manipulated.
  - Medicare may cover treatment using hand-held devices. But Medicare doesn't offer more payment or recognize an extra charge for use of the device.

Treatment Plan

- Frequency and duration of visits (recommended)
- Specific treatment goals (recommended)
- Objective measures to evaluate treatment effectiveness (recommended)

Subsequent Visits

- History
  - Review of chief complaint
  - Changes since last visit
  - System review, if relevant
- Physical examination (P.A.R.T.)
  - Assessment of change in patient's condition since last visit
  - Evaluation of treatment effectiveness
- Treatment given on day of visit (include specific areas and levels of spine that you manipulated)

General Guidelines

- □ Make sure medical records show that the service is a corrective treatment, not a maintenance treatment.
  - □ For Medicare purposes, place an AT modifier on a claim when you give active or corrective treatment for acute or chronic subluxation.
    - ▫ Don't use an AT modifier for maintenance therapy.
    - ▫ Only use an AT modifier when chiropractic manipulation is reasonable and necessary as defined by national and local policy.
    - ▫ **Note:** An AT modifier doesn't prove the service is reasonable and necessary. As always, contractors can deny a claim after medical review.

      Make sure you know these policies, along with any local coverage determination in your area, to better understand how active or corrective chiropractic services are covered.
- □ Include records for all dates of service on a claim.
- □ Make sure documentation is legible and complete, including signatures.
- □ Include legible signatures and credentials of professionals providing services.
  - □ If signatures are missing or illegible, include a completed signature attestation statement.
  - □ For illegible signatures, include a signature log.
  - □ For electronic health records, include a copy of electronic signature policy and procedures describing how notes and orders are signed and dated. Validating electronic signatures depends on getting this information.
- □ Include abbreviation key (if relevant).
- □ Include any other documentation to support medical necessity of services billed, as well as documentation specifically asked for in an additional documentation request (ADR) letter.
- □ Include a copy of the Advance Beneficiary Notice of Noncoverage (if relevant).

Resources

- Medicare Benefit Policy Manual, Chapter 15, Sections 30.5 and 240
- Medicare Claims Processing Manual, Chapter 12, Section 220
- MLN Matters® SE1601 Medicare Coverage for Chiropractic Services – Medical Record Documentation Requirements for Initial and Subsequent Visits
- MLN Matters® SE1603 Educational Resources to Assist Chiropractors with Medicare Billing

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John Doe, DC
21920 Broadway, Any City, USA 00000
555 -555-1212

Medicare Chiropractic SOAP Note

Patient Name: Mark Smith DOB: 3-7-1930 Date: 12/17/2023

Subjective (review of the chief complaint and changes since the last visit) –Pt states after last treatment pain in the neck 50% better and had no headache that evening with pain level about 3-4. Pain level today reported as 5, last visit was 7. States was better yesterday but stiffer and more pain upon awakening today. States able to do of daily tasks more easily post-treatment. No headaches since the last visit.

Objective

Palpation: +2/4 hypertonicity cervical and upper trapezius, scalene and para thoracic muscles slightly greater on the right.
ROM: cervical spine pain at the end range motion at C6-7 on flexion with hypomobility noted at C6-7
PART – P- tenderness/pain noted at C2, C3, C6, C7 & T6 R- hypomobility on motion palpation at C2, C3, C6, C7, and T6

Assessment

Diagnosis: M99.00 Cervical Subluxation, R51.9 Headache, M99.02 Thoracic Subluxation, M79.18 Myalgia

Treatment Plan: CMT 2x week for 2 weeks. Treatment goal to reduce VAS pain score to 3/10, with improved ability and tolerance to perform ADL's. Visit 4 of 8.
CMT (diversified technique) C2, C3, C6, C7, T6
Additional treatment & Comments: Adjustment tolerated well stating "less pain and looser" Advised to begin home stretching 3x30 seconds all planes of C spine. Shoulder rolls and shrugs 2x25 2x per day

Signature: Date: 12/17/2023

Forms

Completion of the CMS-1500 (02-12) Claim Form

Do not use the upper right margin of the claim form; the contractor uses it. Any obstructions in this area will hinder timely and accurate processing of claims.

The top right margin of the claim form should **not** contain:

any type of adhesive-backed label

printing or headings (including the Medicare contractor address)

ink, markers, whiteout, etc.

Please print legibly or type all information. Claims may also be computer-prepared.

Providers and suppliers must report 8-digit dates in all date of birth fields (items 3, 9b, and 11a), and either 6-digit or 8-digit dates in all other date fields (items 11b, 12, 14, 16, 18, 19, 24a, and 31).

Providers and suppliers have the option of entering either a 6 or 8-digit date in items 11b, 14, 16, 18, 19, or 24a. However, if a provider of service or supplier chooses to enter 8-digit dates for items 11b, 14, 16, 18, 19, or 24a, he or she must enter 8-digit dates for all these fields. Items 12 and 31 are exempt from this requirement.

MM = Month (e.g., December = 12)

DD = Day (e.g., Dec 15 = 15)

YY = 2 position Year (e.g., 2015 = 15)

CCYY = 4 position Year (e.g., 2015 = 2015)

(MM | DD | YY) or (MM | DD | CCYY) A space must be reported between month, day, and year (e.g., 12 | 15 | 15 or 12 | 15 | 2015). This space is delineated by a dotted vertical line on the Form CMS-1500

(MMDDYY) or (MMDDCCYY) No space between month, day, and year (e.g., 121515 or 12152015). The date must be one continuous number.

1500 (02-12) Claim Data Elements

ITEM 1

To show the type of health insurance coverage applicable to this claim, check the appropriate box, e.g., if a Medicare claim is filed check the Medicare box.

ITEM 1a INSURED'S I.D. NUMBER (associated with Block 1)

Enter the patient's Medicare Beneficiary ID Number whether Medicare is the primary or secondary payer.

Completion of this item is required for all claims.

ITEM 2 PATIENT'S NAME

Enter the patient's last name, first name, and middle initial, if any, exactly as shown on the patient's Medicare card.

Completion of this item is required for all claims.

ITEM 3 PATIENT'S BIRTH DATE AND SEX

Enter the patient's 8-digit birth date (MM | DD | CCYY) and sex.

Completion of this item is required for all claims.

ITEM 4 INSURED'S NAME

If there is insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word "SAME". If there is no insurance primary to Medicare, leave blank.

Completion of this item is conditional for insurance information.

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Jones, Jonathan J | 3. PATIENT'S BIRTH DATE MM DD YY 05 11 23 SEX M X F | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME

ITEM 5 PATIENT'S ADDRESS

Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and telephone number. If the patient has an unlisted telephone number or does not have a telephone number, enter 000-000-0000. Reminder, please report the address where the home visit occurred rather than the beneficiary's address if they are out of the area.

Completion of this item is required for all claims; address and telephone must be indicated.

ITEM 6 PATIENT RELATIONSHIP TO INSURED

Check the appropriate box for patient's relationship to the insured when item 4 is completed.

Completion of this item is conditional for insurance information when item 4 is completed.

ITEM 7 INSURED'S ADDRESS

Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4 and 11 are completed.

Completion of this item is conditional for insurance information when items 4, 6 and 11 are completed.

ITEM 8 PATIENT STATUS

Leave blank.

ITEM 9 OTHER INSURED’S NAME

Enter the last name, first name, and middle initial of the enrollee in a Medigap policy if it is different from that shown in item 2. Otherwise, enter the word "SAME". If no Medigap benefits are assigned, leave blank. This field may be used in the future for supplemental insurance plans.

Note: Only participating physicians and suppliers are to complete item 9 and its subdivisions and only when the beneficiary wishes to assign his / her benefits under a Medigap policy to the participating physician or supplier.

Participating physicians / suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for all Medicare patients. A claim for which a beneficiary elects to assign his / her benefits under a Medigap policy to a participating physician / supplier is called a mandated Medigap transfer.

A Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in 1882(g) (1) of Title XVIII of the Social Security Act (the Act) and the definition contained in the NAIC Model Regulation, which is incorporated by reference in the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the application of deductibles, coinsurance amounts or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees as well as that offered by a labor organization to members or former members.

Do not list other supplemental coverage in item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the A / B Medicare Administrative Contractor (MAC) (B) or Durable Medical Equipment (DME) MAC to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his / her own supplemental claim.

ITEM 9a OTHER INSURED'S POLICY OR GROUP NUMBER

Enter the policy and / or group number of the Medigap insured preceded by MEDIGAP, MG or MGAP.

Note: Complete Item 9d even when the provider enters a policy and / or group number in item 9a.

ITEM 9b OTHER INSURED'S DATE OF BIRTH

Leave blank.

ITEM 9c EMPLOYER'S NAME

Leave blank if item 9d is completed. Otherwise, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two-letter state postal code, and ZIP code copied from the Medigap insured's Medigap identification card.

For example:

1257 Anywhere Street
Baltimore, MD 21204

Is shown as "1257 Anywhere St MD 21204"

ITEM 9d INSURANCE PLAN NAME OR PROGRAM NAME

Enter the Coordination of Benefits Agreement (COBA) Medigap-based Identifier (ID). Refer to the CMS Claims Processing Manual Pub 100-04, Chapter 28, §70.6.4 for more information concerning the COBA Medigap claim based crossover process.

ITEM 10a THROUGH 10c IS PATIENT'S CONDITION RELATED TO

Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24.

Enter the state postal code.

Any item checked "YES" indicates there may be other insurance primary to Medicare. Identify primary insurance information in item 11.

Completion of items 10a-c is required for all claims; "Yes" or "No" must be indicated.

ITEM 10d RESERVED FOR LOCAL USE

Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by "MCD".

ITEM 11 INSURED'S POLICY, GROUP OR FECA NUMBER

When submitting paper or electronic claims, item 11 must be completed. By completing this information, the physician / supplier acknowledges having made a good faith effort to determine whether Medicare is the primary or secondary payer. Claims without this information will be returned for OCR references.

Note: If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to items 11a-11c.

If there is no insurance primary to Medicare, enter the word "NONE" in item 11 and proceed to item 12.

If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), enter the word "NONE" and proceed to item 11b.

If a lab previously collected and retained Medicare Secondary Payer (MSP) information for a beneficiary, the lab may use that information for billing purposes of the non-face-to-face lab service. If the lab has no MSP information for the beneficiary, enter the word "None" in item 11 of the CMS-1500, when submitting a claim for payment of a reference lab service.

Where there has been no face-to-face encounter with the beneficiary, the claim will follow the normal claims process. When a lab has a face-to-face encounter with a beneficiary, the lab is expected to collect the MSP information and bill accordingly.

Completion of item 11 (i.e., insured's policy / group number or "NONE") is required on all claims.

Completion of items 11b-c is conditional for insurance information primary to Medicare.

Circumstances under which Medicare may be secondary to another insurer, includes:

Group Health Plan Coverage

Working Aged;

Disability (Large Group Health Plan); and

End Stage Renal Disease

No Fault and / or other Liability

Work-Related Illness / Injury

Workers' Compensation;

Black Lung; and

Veterans Benefits

Note: For paper claims, to be considered for Medicare Secondary Payer benefits, a copy of the primary payer's Explanation of Benefits (EOB) notice must be forwarded along with the claim form. (See CMS' Medicare Secondary Payer Manual, Pub. 100-05, Chapter 3)

ITEM 11a INSURED'S DATE OF BIRTH

Enter the insured's 8-digit birth date (MM | DD | CCYY) and sex, if different from item 3.

ITEM 11b EMPLOYER'S NAME or SCHOOL NAME:

Provide this information to the right of the vertical dotted line.

Enter the employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter the word "Retired" followed by the six-digit or eight-digit retirement date (MM/DD/CCYY).

ITEM 11c INSURANCE PLAN NAME OR PROGRAM NAME

Enter the complete insurance plan or program name, e.g., Blue Shield of (State).

If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB.

Completion of this item is conditional for insurance information primary to Medicare.

ITEM 11d IS THERE ANOTHER HEALTH BENEFIT PLAN

Leave blank. Not required by Medicare.

ITEM 12 PATIENT OR AUTHORIZED PERSON'S SIGNATURE

The patient or authorized representative must sign and enter either a 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or an alpha-numeric date (e.g., January 1, 2015) unless the signature is on file.

The patient or an authorized representative must sign and enter the six-digit date (MMDDYY) for this item unless the patient is deceased, you do not have direct contact with the patient (laboratory), or the signature is on file.

Please use **Signature Exception** below for situations where the patient is deceased or you do not have direct contact with the patient (laboratory) or signature on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file. If the patient is physically or mentally unable to sign, a representative may sign on the patient’s behalf. In this event, the statement’s signature line must indicate the patient’s name followed by: "by" the representative’s name, address, relationship to the patient, and the reason the patient cannot sign the form. The signature on file authorization is effective indefinitely unless the patient or the patient’s representative revokes the arrangement.

The patient's signature authorizes the release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service and (or) supplier, when the provider of service and (or) supplier accepts assignment on the claim.

All claims must have item 12 completed. Failure to include an appropriate signature and six-digit, eight-digit date or a "signature on file" statement will result in a claim rejection. A Medigap authorization signature in item 13 does not satisfy the Block 12 signature requirement.

Signature By Mark (X) - When an illiterate or physically handicapped enrollee signs by mark, a witness must sign his / her name and address next to the mark.

Signature on File

Providers of service and (or) suppliers are permitted to obtain and retain on file a lifetime authorization from the beneficiary. This authorization allows the provider of service and (or) supplier to submit assigned and non-assigned claims on the beneficiary's behalf.

To utilize this procedure, the patient must sign and date a brief statement as follows:

(Name of Beneficiary) (Medicare Beneficiary ID Number)
"I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier.
I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service."
(Beneficiary Signature) (Date)

Once the provider of service and (or) supplier has obtained the patient's one-time authorization, any later Medicare claims may be submitted by the provider of service and (or) supplier without obtaining any additional signature and date from the patient. When submitting claims, the statement "Signature on file" must be reflected in the patient's signature space (item 12) of the Health Insurance Claim Form.

When using this procedure, the provider of service and / or supplier must:

Complete and submit the appropriate Medicare billing form for all services covered by the request for payment, even when the provider of service and (or) supplier has not accepted assignment.

Incorporate, by stamp or otherwise, on any bill sent to the beneficiary, information to the effect "Do not use this bill for claiming Medicare benefits. A claim has been or will be submitted to Medicare for you."

Cancel the authorization at the request of the patient.

Make the patient signature files available for contractor inspection upon request. Novitas Solutions will conduct periodic audits of signature files on a random basis. Completion of this item is required for all claims.

ITEM 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

The patient’s signature or the statement "signature on file" in this item authorizes payment of medical benefits to the physician or supplier.

The patient or his / her authorized representative signs this item or the signature must be on file separately with the provider as an authorization. However, when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating physician or supplier, a patient’s signature or a "signature on file" is not required in order for Medicare payment to be made directly to the physician or supplier.

The presence of or lack of a signature or "signature on file" in this field will be indicated as such to any downstream coordination of benefits trading partners (supplemental insurers) with whom CMS has a payer-to-payer coordination of benefits relationship. Medicare has no control over how supplemental claims are processed, so it is important that providers accurately address this field as it may affect supplemental payments to providers and / or their patients.

In addition, the signature in this item authorizes payment of mandated Medigap benefits to the participating provider of service and (or) supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his / her authorized representative signs this item, or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating physician / supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked.

Completion of this item is conditional for Medigap.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

Note: If you wish to report "Signature on File" in item 13 in lieu of the patient's actual signature, the following statement must be signed and dated by the patient and maintained in your records.

(Name of Beneficiary) (Medicare Beneficiary ID Number) (Medigap Policy Number)
"I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by that the provider of service and (or) supplier.
I authorize any holder of Medicare information about me to release to (Name of Medigap Insurer) any information needed to determine these benefits payable for related services."
(Beneficiary Signature) (Date)

ITEM 14 DATE OF CURRENT ILLNESS

Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy.

For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD |YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM| DD | YY) date in item 19.

Do not enter a qualifier in item 14.

Reminder: For date fields other than date of birth, report either 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date. Intermixing the two formats on the claim is not allowed.

Completion of this item is required for all chiropractic services; conditional for other services.

ITEM 15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS

Leave blank. Not required by Medicare.

ITEM 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

Enter the 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date the patient is unable to work in current employed occupation.

An entry in this item may indicate employment related insurance coverage.

Completion of this item is conditional for disability information.

ITEM 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data. Similarly, if Medicare policy requires you to report a supervising physician, enter this information in item 17. When multiple referring, ordering or supervising physicians, use a separate CMS-1500 claim form for each ordering, referring, or supervising physician.

Enter one of the following qualifiers as appropriate to identify the role this physician (or non-physician practitioner) is performing:

Qualifier Provider Role

DN Referring Provider

DK Ordering Provider

DQ Supervising Provider

Enter the qualifier to the left of the dotted vertical line on item 17.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
DN | Smith, Jane

Note: Under certain circumstances, Medicare permits a non-physician practitioner to perform these roles. Refer to the CMS Benefit Policy Manual, Pub 100-02, Chapter 15, for non-physician practitioner rules. Enter non-physician practitioner information according to the rules for physicians.

Referring Physician - A physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering Physician - A physician, or when appropriate, a non-physician practitioner who orders nonphysician services for the patient. Refer to the CMS Benefit Policy Manual, Pub 100-02, Chapter 15, for non-physician practitioner rules.

Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment and services incident to that physician's or non-physician practitioner's service.

All claims for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering / referring physician's name and National Provider Identifier (NPI).

The following situations / services require the submission of the referring / ordering provider information:

Parenteral and enteral nutrition;

Medicare covered services and items that are the result of a physician’s order or referral;

Immunosuppressive drugs claims;

Hepatitis B claims;

Diagnostic laboratory services;

Diagnostic radiology services;

Portable x-ray services;

Consultative services;

Durable medical equipment;

When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests).

When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17.

When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner.

All claims for physical therapy, occupational therapy, or speech-language pathology services, including those furnished incident to a physician or nonphysician practitioner, require the name and NPI of the certifying physician or nonphysician practitioner of the therapy plan of care be entered as the referring physician in Items 17 and 17b.

ITEM 17a – Leave Blank

ITEM 17b – Enter the NPI of the referring, ordering or supervising physician or non-physician practitioners listed in item 17. All physicians and non-physician practitioners who order services or refer Medicare beneficiaries must report this data.

ITEM 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

Enter either an 8-digit (MM | DD | CCYY) or a 6-digit (MM | DD | YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Completion of this item is conditional for medical services related to hospitalization.

ITEM 19 ADDITIONAL CLAIM INFORMATION (DESIGNATED BY NUCC)

Enter the six - digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date the patient was last seen and the NPI of his / her attending physician when a physician providing routine foot care submits claims.

Chiropractic

By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that the relevant information requirements (including level of subluxation) are on file, along with the appropriate x-ray and are available for review.

NOVITAS ONLY -A physical examination may be used to document subluxation if an x-ray is not used. Report all that apply by using the letters P, A, R and / or T (P - pain / tenderness; A - asymmetry / misalignment; R - range of motion; T - tissue); or enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services.

Unlisted Drug Codes

Enter the drug name and dosage when submitting a claim for a Not Otherwise Classified (NOC) drug.

Unlisted procedure code or NOC codes

Enter a concise description of an unlisted procedure code or a "not otherwise classified" code if one can be given within the confines of this box. Otherwise an attachment shall be submitted with the claim.

Multiple Modifiers (-99)

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

ITEM 20 OUTSIDE LAB

Complete this item when billing for diagnostic tests subject to the anti-markup payment limitation.

Enter the acquisition price under charges if the "yes" block is checked. "Yes" indicates that an entity other than the entity billing for the service performed the diagnostic test. "No" indicates, "no anti-markup tests are included on the claim."

When "yes" is annotated, item 32 shall be completed.

When billing for multiple anti-markup tests, each test shall be submitted on a separate claim form CMS-1500 (02-12).

Multiple anti-markup tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations.

Note: This item is a required when billing for diagnostic tests subject to the anti-markup payment limitation.

ITEM 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

Enter the patient's diagnosis / condition.

With the exception of claims submitted by ambulance suppliers (*specialty type 59*), all physician and nonphysician specialties (*i.e., PA, NP, CNS, CRNA*) use diagnosis codes to the highest level of specificity for the date of service.

Enter the diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A.	B.	C.	D.
E.	F.	G.	H.
I.	J.	K.	L.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A.	B.	C.	D.
E.	F.	G.	H.
I.	J.	K.	L.

The "**ICD Indicator**" identifies the ICD code set being reported. Enter the applicable ICD indicator according to the following:

Indicator Code Set

0 ICD-10-CM diagnosis

Enter the indicator as a single digit between the vertical, dotted lines.

Enter up to 12 diagnosis codes. Note that this information appears opposite lines with letters A-L.

Correlate lines A- L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.

Do not insert a period in the ICD-10-CM code.

Completion of this item is required for all claims, other than those submitted by ambulance suppliers.

ITEM 22 MEDICAID RESUBMISSION

Leave blank. Not required by Medicare.

ITEM 23 PRIOR AUTHORIZATION NUMBER

23. PRIOR AUTHORIZATION NUMBER
OKPAB00001

Enter the Investigational Device Exemption (IDE) when an investigational device is used in an FDA-approved clinical trial. The IDE number should be reported in Block 23 and the Clinical Trial Number in Block 19.

Refer to Block 19 instructions for submitting the Clinical Trail Number in addition to the IDE number that is required in Block 23.

Post Market Approval (PMA) numbers should also be placed here when applicable.

Repetitive Non-Emergent Ambulance Transport or Hyperbaric Oxygen (NJ only)

The Unique Tracking Number (UTN) must populate the first 14 positions. All other data submitted in item 23 must begin in position 15.

ITEM 24

The six service lines in item 24 have been divided horizontally to accommodate submission of supplemental information to support the billed service.

The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines.

NDC (National Drug Code) Red Shaded Portion

When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line item in positions 01 through 13 of Item 24.

The NDC is preceded with the qualifier N4 and followed immediately by the 11-digit NDC code (e.g., N499999999999).

Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is preceded by the appropriate qualifier:

Units (UN),

International units (F2),

Gram (GR), or

Milliliter (ML)

There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g. UN2 or F2999999).

ITEM 24A DATES OF SERVICE

Enter the six or eight - digit date (MMDDYY) (MMDDCCYY) for each procedure, service, or supply.

When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G.

Only report a range by month, do not combine months in a range date.

Completion of this item is required for all claims; all lines of service.

ITEM 24B PLACE OF SERVICE

Enter the appropriate Place of Service (POS) code from the list provided below. Identify the location where the item is used or the service is performed.

When a service is rendered to a patient who is a registered inpatient or an outpatient (off campus or on campus) of a hospital, use the inpatient hospital POS code 21, Off Campus-Outpatient Hospital POS code 19, or On Campus-Outpatient Hospital POS code 22, respectively.

Completion of this item is required for all claims; all lines of service.

POS Code / Name Description

01 / Pharmacy - A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.

03 / School – A facility whose primary purpose is education.

04 / Homeless Shelter - A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).

05 / Indian Health Service Free-standing Facility - A facility or location owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization. Not applicable for adjudication of Medicare claims.

06 / Indian Health Service Provider-based Facility - A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients. Not applicable for adjudication of Medicare claims.

07 / Tribal 638 Free-Standing Facility - A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not require hospitalization. Not applicable for adjudication of Medicare claims.

08 / Tribal 638 Provider-Based Facility - A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members admitted as inpatients or outpatients. Not applicable for adjudication of Medicare claims.

09 / Prison / Correctional Facility - A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.

11 / Office - Location, other than a hospital, Skilled Nursing Facility (SNF), military treatment facility, community health center, State or local public health clinic, or Intermediate Care Facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

12 / Home - Location, other than hospital or facility, where the patient receives care (private residence).

13 / Assisted Living Facility - Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, seven days a week, with the capacity to deliver or arrange for services including some health care and other services.

14 / Group Home - A residence with shared living areas, where clients receive supervision and other services, such as social and / or behavioral services, custodial services, and minimal services (e.g. medical administration).

15 / Mobile Unit - A facility / unit that moves from place-to-place, and is equipped to provide preventive, screening, diagnostic, and / or treatment services.

16 / Temporary Lodging - A short-term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.

17 / Walk-in Retail Health Clinic - A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code,

that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services not applicable for adjudication of Medicare claims

18 / Place of Employment / Worksite - A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual. Not applicable for adjudication of Medicare claims

19 / Off Campus-Outpatient Hospital - A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization (Effective 1/1/2016).

20 / Urgent Care Facility - Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

21 / Inpatient Hospital - A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

22 / On Campus-Outpatient Hospital - A portion of a hospital's main campus, which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective 1/1/2016)

23 / Emergency Room / Hospital - A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

24 / Ambulatory Surgical Center - A freestanding facility (other than a physician's office) where surgical and diagnostic services are provided on an ambulatory basis.

25 / Birthing Center - A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.

26 / Military Treatment Facility - A medical facility operated by one or more of the Uniformed Services Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

31 / Skilled Nursing Facility - A facility, which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

32 / Nursing Facility - A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.

33 / Custodial Care Facility - A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

34 / Hospice - A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.

41 / Ambulance—Land - A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

42 / Ambulance—Air or Water - An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

49 / Independent Clinic - A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.

50 / Federally Qualified Health Center - A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.

51 / Inpatient Psychiatric Facility - A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

52 / Psychiatric Facility-Partial Hospitalization - A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

53 / CMHC (Community Mental Health Center) - A facility that provides outpatient services, (including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility); 24 hours a day emergency care services; day treatment, other partial hospitalization services or psychosocial rehabilitation services; screening for admission to state mental health facilities; consultation and education services.

54 / Intermediate Care Facility / Mentally Retarded - A facility that primarily provides health-related care services above the level of custodial care to mentally retarded individuals, but does not provide the level of care or treatment available in a hospital or SNF.

55 / Residential Substance Abuse Treatment Facility - A facility that provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

56 / Psychiatric Residential Treatment Center - A facility or distinct part of a facility that provides 24-hour therapeutically, planned and professionally staffed group living and learning environment.

57 / Non-residential Substance Abuse Treatment Facility - A location that provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.

60 / Mass Immunization Center - A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass

immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.

61 / Comprehensive Inpatient Rehabilitation Facility - A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

62 / Comprehensive Outpatient Rehabilitation Facility - A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

65 / End-Stage Renal Disease Treatment Facility - A facility other than a hospital, that provides dialysis treatment, maintenance, and / or training to patients or caregivers on an ambulatory or home-care basis.

71 / State or Local Public Health Clinic - A facility maintained by either State or local health department that provides ambulatory primary medical care under the general direction of a physician.

72 / Rural Health Clinic - A certified facility, located in a rural medically, underserved area that provides ambulatory primary medical care under the general direction of a physician.

81 / Independent Laboratory - A laboratory certified to perform diagnostic and / or clinical tests independent of an institution or a physician's office.

99 / Other Place of Service - Other place of service not identified above.

ITEM 24C TYPE OF SERVICE

Not required by Medicare. Leave blank.

ITEM 24D PROCEDURES, SERVICES, OR SUPPLIES

Enter the procedures, services or supplies using the (Healthcare Common Procedure Coding System (HCPCS). When applicable, show the correct HCPCS modifiers with the HCPCS code. The CMS-1500 (02-12) claim form has the capacity to capture up to four modifiers.

Enter the acquisition cost for pharmaceutical or radiopharmaceutical diagnostic imaging agents or for therapeutic radionuclides. This is required in order to receive reimbursement. Please specify that the dollar amount listed is the acquisition cost.

PROCEDURES, SERVICES, OR SUPPLIES

(Explain Unusual Circumstances)

CPT / HCPCS | MODIFIER

Example:

A9500 | Acquisition Cost = $120.00

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or an not otherwise classified (NOC) code, include a narrative description in item 19, if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim. This is a required field.

Claim(s) will be returned as unprocessable if an "unlisted procedure code" or an NOC code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

Note- Physical medicine codes must be appended with modifier GP

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER			
43999				

ITEM 24E DIAGNOSIS CODE

Enter the diagnosis code as shown in item 21 to relate the date of service and the procedures performed for the primary diagnosis. Enter only one reference per line item. When multiple services are performed, enter the primary reference for each service.

The reference to supply in 24E will be a letter from A-L.

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.

ICD10:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. A10.0000 B. C. D.
E. F. G. H.
I. J. K. L.

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER
10	01	15	10	01	15	11		99213					A

Completion of this item is required for all claims, other than those submitted by ambulance suppliers.

ITEM 24F ($) CHARGES

Enter the charge for each listed service.

Completion of this item is required for all claims (all lines of service).

ITEM 24G DAYS OR UNITS

Enter the number of days or units.

This item is most commonly used for multiple visits, units of supplies, anesthesia minutes or oxygen volume. If only one service is performed, the number 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages or allergy testing procedures). When multiple services are provided, enter the actual number provided.

For anesthesia, show the elapsed time (minutes) in item 24G. Convert hours into minutes and enter the total minutes required for the procedure.

Suppliers must furnish the units of oxygen contents except for concentrators and initial rental claims for gas and liquid oxygen systems.

Rounding of oxygen contents is as follows:

For stationary gas system rentals, suppliers must indicate oxygen contents in unit multiples of 50 cubic feet in item 24G, rounded to the nearest increment of 50. For example, if 73 cubic feet of oxygen were delivered during the rental month, the unit entry "01" indicating the nearest 50 cubic foot increment is entered in item 24G.

For stationary liquid systems, units of contents shall be specified in multiples of 10 pounds of liquid contents delivered, rounded to the nearest 10 pound increment. For example, if 63 pounds of liquid oxygen were delivered during the applicable rental month billed, the unit entry "06" is entered in item 24G.

For units of portable contents only (i.e., no stationary gas or liquid system used) round to the nearest five feet or one liquid pound, respectively.

For ambulance mileage, enter the number of loaded miles traveled rounded up to the nearest tenth of a mile up to 100 miles. For mileage totaling 100 miles and greater, enter the number of covered miles rounded up to the nearest whole number miles. If the total mileage is less than 1

whole mile, enter a “0” before the decimal (e.g. 0.9). For more information on loaded miles and fractional mileage, please visit the CMS [Claims Processing Manual, Pub 100-04, Chapter 15, §§20.2 and 30.1.2].

Note: This field should contain an appropriate numerical value. The A / B MAC (B) will automatically default to "1" unit when the information in this field is missing to avoid returning as unprocessable, except on claims for ambulance mileage. For ambulance mileage claims, the system will automatically default to “0.1” unit when total mileage units are missing in this field.

Completion of this item is required for all claims, all lines of service.

ITEM 24H EPSDT FAMILY PLANNING

Leave blank. Not required by Medicare.

ITEM 24I

Enter the ID qualifier 1C in the shaded portion.

ITEM 24J

Enter the rendering provider's NPI number in the lower un-shaded portion.

In the case of an 'incident to' service of a physician or non-physician practitioner, enter the NPI of the supervisor (when the person who ordered the service is not supervising), in the lower un-shaded portion.

Do not report information in the shaded portion of 24J.

ITEM 25

Enter the provider or supplier Federal Tax ID (Employer Identification Number or Social Security Number) and check the appropriate box.

Medicare providers are not required to complete this item for crossover purposes since the Medicare contractor will retrieve the tax identification information from their internal provider file for inclusion on the Coordination of Benefits (COB) outbound claim. However, tax

identification information is used in the determination of accurate National Provider Identifier reimbursement.

Reimbursement may be delayed for claims submitted without tax identification information.

ITEM 26 PATIENT'S ACCOUNT NUMBER

Enter the patient's account number assigned by the provider of service and / or supplier's accounting system.

This is an optional item to enhance patient information.

ITEM 27 ACCEPT ASSIGNMENT

Check the appropriate item to indicate whether the provider of service and / or supplier accepts assignment of Medicare benefits. If MEDIGAP is indicated in item 9 and MEDIGAP payment authorization is given in item 13, the provider of service and / or supplier must also be a Medicare participating provider of service and / or supplier and must accept assignment of Medicare benefits for all covered charges for all patients.

27. ACCEPT ASSIGNMENT?
(For govt. claims, see back)
X YES NO

The following provider and / or supplier claims can only be paid on an assignment basis:

Clinical diagnostic laboratory services;

Physician services to individuals dually entitled to Medicare and Medicaid;

Participating provider of service and (or) supplier services;

Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers;

Ambulatory surgical center (ASC) services for covered ASC procedures;

Home dialysis supplies and equipment paid under Method II;

Ambulance Services;

Drugs and biologicals; and

Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine

ITEM 28 TOTAL CHARGE

Enter the total charge in item 28 for all services reported in item 24F.

All CMS 1500 (02-12) claim forms will be treated individually; therefore, when documentation is required it must be submitted for each claim form. Claims not submitted in this manner will be returned to the provider.

Multiple 1500 claim forms requiring the same attachment require photocopies for each individual claim form (i.e. (explanation of benefits (EOB); operative reports; medical records).

Completion of this item is required for all claims.

ITEM 29 AMOUNT PAID

Enter the total amount the patient paid on covered services.

The total amount should not exceed the total charges.

Completion of this item is required for all claims.

ITEM 30 BALANCE DUE

Leave blank. Not required by Medicare.

28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
$ 1000.00	$ 0.00	

ITEM 31 SIGNATURE OF THE PROVIDER OF SERVICE AND (OR) SUPPLIER INCLUDING DEGREE OR CREDENTIALS

Enter the signature of the provider and / or supplier, or his / her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alpha-numeric date (e.g., January 1, 2015) the form was signed.

When the ordering physician or non-physician practitioner is directly supervising the 'incident to' service, enter the signature of the ordering physician or non-physician practitioner in item 31.

When the ordering physician or non-physician practitioner is not supervising the 'incident to' service, enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31.

Completion of this item is required for all claims.

Note: This is a required field; however, the claim can be processed if a physician, supplier, or authorized person's signature is missing, but an authorization is attached to the claim; or if the signature field has a computer generated signature' or if "signature on file" is indicated. A computer generated "signature" that does not name an individual person is not acceptable.

For example, "ABC Anesthesia Group" would not be considered an acceptable computer generated signature.

ITEM 32 NAME, ADDRESS AND ZIP CODE OF THE SERVICE LOCATION

The name, address, and zip code of the service location is required for all services, including place of service home – 12.

Only one name, address and zip code may be entered in this item. If additional entries are needed, submit separate claim forms.

When billing for purchased diagnostic tests, providers (namely physicians) shall identify the supplier's name, address, and ZIP code. When more than one supplier is used, submit a separate claim form for each supplier.

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted CMS-1490S claim form, it should be determined if it is a foreign claim. If it is a foreign claim before it is entered in the system.

The A / B MAC (B) processing the foreign claim will verify that the claim is not returned as unprocessable due to the lack of a ZIP code.

For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DMEMAC only). This field is required.

When more than one supplier is used, submit a separate claim form for each supplier. This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

If a modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA) or Physician Scarcity Area (PSA), enter the physical location where the service was rendered if other than home.

If the supplier is a certified mammography-screening center, enter the 6-digit Federal Drug Administration (FDA) approved certification number.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed.

ITEM32a

If required by Medicare claims processing policy, enter the NPI of the service facility.

Beginning April 1, 2015, billing physician and supplier must report the NPI of the performing physician or supplier in Item 32a on all anti-markup and reference laboratory claims, even if the performing physician or supplier is enrolled in a different jurisdiction.

ITEM 32b

Not reported.

ITEM 33 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER

Enter the physician's individual / group or supplier's billing name, address (physical location, no PO Boxes), ZIP code, and telephone number.

This is a required field.

ITEM 33a

Enter the NPI of the billing provider or group. This is a required field.

ITEM 33b

Not generally reported. However, some Medicare policies may instruct to use this item.

CMS-1500 (02-12) Claim Form Instructions when Medicare is Secondary

Complete the items below on the CMS-1500 (02-12) claim form or electronic equivalent, in addition to all other claim form requirements, when Medicare is the secondary payer.

Note: The normal Medicare claims timely filing rules apply.

Item 4-Insured's Name: If the patient has insurance primary to Medicare, either through their own or their spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word "Same."

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Doe John or SAME

Item 7-Insured's Address: Enter the insured's address and telephone number. Enter the street address on the first line, the city and state on the second line and the ZIP code on the third line.

When the address is the same as the patient's, enter the word "Same." Complete this item **only** when Items 4 and 11 are completed.

7. INSURED'S ADDRESS (No., Street)

Check "Yes" or "No" to indicate whether employment, auto liability or accident applies to one or more of the services described in Item 24 (procedures). Enter the state postal code (e.g., Texas = TX) if auto accident is marked "Yes." In addition, a "Yes" checked in any of these fields indicates there may be another insurance primary to Medicare. Continue to Item 11 to identify primary insurance information.

Item 11-Insured's Policy Group or FECA Number: Enter the insured's policy or group number and then proceed to Items 11a–11c.

If there is no insurance primary to Medicare, enter the word “None”.

If there has been a change in the insured’s insurance status, e.g., retired, enter the word “None” and proceed to Item 11b.

11. INSURED'S POLICY GROUP OR FECA NUMBER

Item 11a-Insured's Date of Birth: Enter the insured’s eight-digit birth date (MM/DD/CCYY) and sex if different from Item 3.

a. INSURED'S DATE OF BIRTH MM | DD | YY ## | ## | #### SEX M ✓ F

Item 11b-Employer's Name or School Name: Enter the employer’s name, if applicable. If there is a change in the insured’s insurance status, e.g., retired, enter the word "Retired" followed by the six-digit or eight-digit retirement date (MM/DD/CCYY).

b. EMPLOYER'S NAME OR SCHOOL NAME
ABC Factory

Item 11c-Insurance Plan Name or Program Name: Enter the nine-digit payer identification (ID) number of the primary insurance plan or program.

If no Payer ID number exists, enter the complete primary payer’s program name or plan name.

If the primary payer’s explanation of benefits (EOB) does not contain the claims processing address, record the claims processing address directly on the EOB.

c. INSURANCE PLAN NAME OR PROGRAM NAME
#########

Item 29-Amount Paid: Enter only the amount the patient paid on Medicare covered services. **Note:** Providers should never enter the amount the primary insurance paid in Item 29 or the electronic equivalent.

29. AMOUNT PAID
$

For a paper claim to be considered for Medicare secondary payer benefits, a copy of the primary payer's EOB notice must be forwarded along with the claim form. The primary payer's EOB may be attached/stapled to the claim form.

Paper to Electronic Claim Crosswalk (5010)

The following chart provides a crosswalk for each block of the 1500 paper claim form and the equivalent electronic data in the ANSI ASC X12N format, version 5010.

The following cross-reference guide for providers who submit electronic claim files.

Field #	Claim Description	Loop	Segment	Electronic Description
1	Type of Health Insurance	2000B	SBR01	Receiving Payer Responsibility (P = Primary, S = Secondary T = Tertiary)
			SBR02	Individual relationship code (18 = Self is required)
			SBR09	Receiving Payer (MB=Medicare Part B is required)
1a	Patient's Medicare Beneficiary ID Number	2010BA	NM109	Subscriber Primary Identifier (Information can be found on the patient's Medicare card.)
2	Patient's Name (Enter as it appears on the Medicare card)	2010BA	NM103	Last name
			NM104	First name
			NM105	Middle name
			NM107	Suffix (e.g., Jr. Sr.)
3	Patient's Birth Date and Gender	2010BA	DMG02	Birth Date
			DMG03	Gender
4	Insured's Name (Complete for Medicare	2330A	NM103	Last name
			NM104	First name

	Secondary Payer (MSP) claims)		NM105	Middle name
5	Patient’s Address	2010BA	N301	Address line 1
			N302	Address line 2
			N401	City
			N402	State Code
			N403	ZIP code
6	Patient’s relationship to the insured (Complete for MSP claims)	2000B	SBR02	Self-relationship (18 = Self is required)
		2320	SBR02	For other insurance, any patient relations can be used depending on who owns the insurance.
7	Insured’s address (Complete for MSP claims)	2330A	N301	Address line 1
			N302	Address line 2
			N401	City
			N402	State Code
			N403	ZIP Code
9	Name of Enrollee in Medigap	2330A	NM103	Last name
			NM104	First name
			NM105	Middle name
9a	Medigap policy / group number	2330A	NM108	Code qualifier
			NM109	Insured’s Identifier
		2320	SBR01	Payer responsibility
			SBR03	Insured’s group / policy no.
9d		2330B	NM108	Payer’s identification qualifier

	The nine-digit payer ID number of the Medigap insurer or the program name or plan name		NM109	Payer last or organization name
			NM103	Insured's group / policy no.
		2320	SBR04	Insured's group name
10 a-c	Is patient's condition related to employment? Auto accident? Or other accident?	2300	DTP01	Date of accident
			CLM11-1	Employment / Auto / Other accident
			CLM11-4	Place (State abbreviation)
11	Insured's policy or group number and / or information This information should be completed for MSP purposes only	2320	SBR01	Payer responsibility P = Primary, S = Secondary. T = Tertiary
			SBR03	Insured's group or policy number
		2330A	NM108	Identification code qualifier
			NM109	Insured's identifier
		2000B	SBR05	Insurance Type Code (for MSP claims only) Indicator's must equal one of the following values: 12,13,14,15,16,41,42,43 or 47 if 2000B SBR01 = "T" or "S"
		2000B or 2320	SBR09	Claim filing indicator code. 2000B must be MB. 2320 must be anything other than MB.
		2300	CLM01	Claim submitter's identifier
			CLM02	Total Claim Charge Monetary amount
		2320	AMT01	Primary Paid Amount qualifier code = D

			AMT02	Monetary amount (Primary Paid Claim Level)
11 (cont)	Insured's policy or group number (continued) This information is for MSP purposes only	2320 or 2430	CAS01	Claim adjustment reason code (CO, PR, OA)
			CAS02	Claim adjustment reason codes
			CAS03	Adjustment amount (amount not paid by the primary)
			CAS04	Adjustment quantity
		2330B or 2430	DTP01	Primary insurance adjudication date
			DTP02	Date time period qualifier
			DTP03	Date paid/declined by primary =573
		2300 or 2400	CN102	OTAF amount
		2430	SVD01	Identification code
			SVD02	Primary payer paid amount (line level)
			SVD03	Medical procedure identifier
			SVD03-1	Service ID qualifier
			SVD03-2	Service ID
			SVD05	Quantity
		2330B	NM101	Entity identifier code
			NM102	Entity type code
			NM103	Last name or organization
			NM108	Identification code qualifier
			NM109	Identification code

11c	Insured’s date of birth and gender	2320	SBR04	Other insured’s group name
12	Patient or authorized	2300	CLM08	Condition or response code
			CLM09	Release of information code
13	Insured’s or Authorized Person’s Signature	2320	QI03	Assignment of Benefits Indicator
			QI06	Release of Information Code
14	Date of Current Illness, Injury or Pregnancy	2300	DTP01	Accident Qualifier = 439
			DTP03	Accident Date
			DTP01	Date Qualifier = 431
			DTP03	Onset of Current Illness or Injury date
		2300 or 2400	DTP01	Initial Treatment Qualifier = 454
			DTP03	Initial Treatment Date
16	Date patient unable to work in current occupation	2300	DTP01	Disability begin or end qualifier = 360 (Begin date) or 361 (End date)
			DTP02	Disability Qualifier
			DTP03	Disability begin date
			DTP03	Disability end date
17	Name of the Referring or Ordering Physician	2310A or 2420F	NM101	Entity Identifier code = DN
			NM102	Entity Type qualifier
			NM103	Referring provider last name
			NM104	Referring provider first name
			NM105	Referring provider middle name
		2420E	NM101	Entity Identifier code = DK

			NM102	Entity Type qualifier
			NM103	Ordering provider last name
			NM104	Ordering provider first name
			NM105	Ordering provider middle name
17b	NPI Number of Ordering or Referring Provider	2310A or 2420F	NM108	Identifier Code qualifier =XX
			NM109	Referring NPI ID
		2420E	NM108	Identifier Code qualifier =XX
			NM109	Ordering NPI ID
18	Hospitalization Dates related to current services	2300	DTP01	Admission or Discharge qualifier = 435 or 096
			DTP03	Admit date
			DTP03	Discharge date
19 (cont)	Routine Foot Care	2300 or 2400	DTP01	Date last seen qualifier = 304
			DTP02	Date qualifier
			DTP03	Date last seen
		2310D or 2420D	NM101	Entity identifier code =DQ
			NM102	Entity type qualifier
			NM103	Last name or organization name
			NM104	First name
			NM105	Middle name
			NM108	Identification code qualifier =XX
			NM109	Supervising provider's NPI
	Homebound	2300	CRC01	Homebound code category

			CRC02	Condition or response code
			CRC03	Condition indicator
	Not otherwise classified drugs or Unlisted procedure code (NOC)	2400	SV101-7	Name and dosage for drug codes. Description of service for unlisted procedure code (NOC)
	Hearing Aid	2300 or 2400	NTE01	Add = Additional information
			NTE02	Testing for Hearing Aid
	Extra Modifiers		NTE01	Add = Additional information
			NTE02	Extra modifiers
	Dental		NTE01	Add – Additional information
			NTE02	Specific surgery
	Low Osmolar		NTE01	Add = Additional information
			NTE02	Name and dosage
	Shared Postoperative Care	2300	DTP01	Date / Time Qualifier
			DTP02	Date format qualifier
			DTP03	Date assumed or relinquished care
19 (cont)	Demonstration ID	2300	REF01	Reference identification qualifier (P4 = Project code)
			REF02	Demonstration ID – number
	Chiropractor	2300 or 2400	DTP01	Date / Time qualifier 455 = Last X-ray date
			DTP02	Date format qualifier
			DTP03	Date last seen
	Patient refuses to pay	2300	CLM08	Patient refuses to sign

	Hematocrit / Hemoglobin / Creatine	2400	DTP01	Hemoglobin or Hematocrit
				Serum Creatine
			DTP02	Date format qualifier = 738 (Hematocrit/Hemoglobin) 739 (Creatine)
			DTP03	Test date performed
			MEA01	Measurement reference ID code =TR
			MEA02	Measurement qualifier R1 = Hemoglobin, R2 = Hematocrit, R4 = Creatine
			MEA03	Measurement values
20	Outside Lab charges	2400	PS101	Reference identification
			PS102	Amount of purchased test
21	Diagnosis / Condition	2300	HI01-1	ABK = Principal Diagnosis
			HI01-2	Primary diagnosis code
			HI02-1 to HI12-1	ABF = Diagnosis code
			HI02-2 to HI12-2	2nd through 12th diagnosis code
23	Prior Authorization number	2300	REF01	Reference identification qualifier =LX
			REF02 (LX)	IDE number
			REF01 (1J)	Facility ID qualifier =1J
			REF02	Home Health or Hospice
		2300B	REF01	Reference identification qualifier =G1

		or 2400	REF02 (G1)	QIO number
		2300 or 2400	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number
	Ambulance Point of Pickup	2310E	NM101	Entity identifier code =PW
			NM102	Entity type qualifier
		2310F	NM101	Entity identifier code = 45
			NM102	Entity type qualifier
		2310E or 2310F	N301	Address information line 1
			N302	Address information line 2
			N401	City name
			N402	State code
			N403	ZIP code
24	National Drug Code	2410	LIN02	Product or Service ID qualifier =N4
			LIN03	National Drug code
24a	Dates of Service	2400	DTP01	Date Time Qualifier =472
			DTP02	Date format qualifier D8 = CCYYMMDD RD8 = CCYYMMDD - CCYYMMDD
			DTP03	Date time period
24b	Place of Service	2300	CLM05-1	Place of Service code
			CLM05-2	Place of Service qualifier
			CLM05-3	Claim frequency type code. 1=initial claim is required.

		2400	SV105	Place of Service code
24d	Procedure code / Modifiers	2400	SV101-1	Service ID qualifier =HC
			SV101-2	Procedure code
			SV101-3	Procedure modifier 1
			SV101-4	Procedure modifier 2
			SV101-5	Procedure modifier 3
			SV101-6	Procedure modifier 4
24e	Diagnosis code reference	2400	SV107-1	Diagnosis code pointer
			SV107-2	(A submitter must point to the primary diagnosis for each service line)
			SV107-3	
			SV107-4	
24f	Charge Amount	2400	SV102	Line Item charge amount
24g	Days or Units	2400	SV103	Unit or basis for measurement code (UN = Unit or MJ = Minutes)
			SV104	Quantity – Units or Minutes
			SV104	
24j	Rendering Provider	2310B or 2420A	NM101	Rendering identifier code =82
			NM102	Person
			NM103	Last / Organization name
			NM104	First name
			NM105	Middle name
			NM108	Identification code qualifier = XX
			NM109	Identification code

25	Provider's Social Security or Tax Identification number	2010AA	REF01	Reference Identifier qualifier (EI = Tax ID, SY = Social Security)
			REF02	Reference Identification
26	Patient's Account number	2300	CLM01	Provider Assigned Account number
27	Accept Assignment	2300	CLM07	Medicare Assignment code A = Assigned B = Assignment accepted on clinical Lab service only C = Not assigned
28	Total Charges	2300	CLM02	Total charge amounts
29	Amount paid	2300	AMT01	Amount qualifier code =F5
			AMT02	Patient paid amount
31	Signature of physician or supplier and date signed	2300	CLM06	Physician or Supplier signature indicator
32	Service facility location	2310C or 2420C	NM101	Entity Identifier code =77
			NM102	Entity type code
			NM103	Facility name
			N301	Address
			N401,02, 03	City, State and ZIP code
32a	Service facility NPI	2310C or 2420C	NM108	Identification code qualifier =XX
			NM109	Laboratory / Facility qualifier
		2400	PS101	Purchased service provider Identifier
		2420B	NM101	Identification code qualifier =QB
			NM108	Identification code

			NM109	Identification code
		2300	REF01	Reference Identification qualifier =EW
			REF02	Mammogram FDA number
33	Billing Provider's Information	2010AA	NM101	Entity Identifier code =85
	Pay-to-provider	2010AB	NM101	Entity Identifier code =87
	Billing Provider's Information	2010AA or 2010AB	NM102	Entity Type code
			NM103	Organization name
			N301	Address
			N401	City
			N402	State
			N403	Zip Code
			PER03	Communication number qualifier =TE
			PER04	Telephone
33a	Billing Provider's NPI	2010AA or 2010AB	NM101	Entity Identifier code =85
			NM108	Identification code qualifier =XX
			NM109	Identification number

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Medicare Coverage for Chiropractic Services – Medical Record Documentation Requirements for Initial and Subsequent Visits

Note: CMS revised this article on May 7, 2019, to update sources of information regarding chiropractic services with additional references added to the Additional Information section of this article. We deleted resource references that are no longer available. All other information remains the same.

Provider Types Affected

This MLN Matters® Special Edition article is for doctors of chiropractic and other practitioners who submit claims to Medicare Administrative Contractors (MACs) for chiropractic services provided to Medicare beneficiaries.

This article is part of a series of Special Edition (SE) articles that the Centers for Medicare & Medicaid Services (CMS) prepared for doctors of chiropractic due to the request for educational materials at the September 24, 2015, Special Open Door Forum titled: "Improving Documentation of Chiropractic Services" and includes updated information. Other articles in the series are SE1602, which details the use of the AT modifier on chiropractic claims and SE1603, which identifies other useful resources to help doctors of chiropractic bill Medicare correctly for covered services.

Provider Action Needed

CMS is providing this SE article to help clarify CMS policy about Medicare coverage of chiropractic services for Medicare beneficiaries and documentation requirements for the beneficiary's initial visit and subsequent visits to the doctor of chiropractic. Know these policies along with any Local Coverage Determinations (LCDs) for these services in your

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area that might limit circumstances under which Medicare pays for active/corrective chiropractic services.

Background

In 2018, the Comprehensive Error Testing Program (CERT) that measures improper payments in the Medicare Fee-For-Service (FFS) program reported a 41 percent error rate on claims for chiropractic services. Most of those errors were due to insufficient documentation or other documentation errors.

Medicare limits coverage of chiropractic services to treatment by means of manual manipulation (that is, by use of the hands) of the spine to correct a subluxation. The patient must require treatment by means of manual manipulation of the spine to correct a subluxation, and the manipulative services the doctor of chiropractic provides must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. The doctor of chiropractic may use manual devices (that is, those that are hand-held with the thrust of the force of the device being controlled manually) in performing manual manipulation of the spine. However, Medicare makes no additional payment for use of the device, nor does Medicare recognize an extra charge for the device itself.

Doctors of chiropractic are limited to billing three Current Procedural Terminology (CPT) codes under Medicare: 98940 (chiropractic manipulative treatment; spinal, one to two regions), 98941 (three to four regions), and 98942 (five regions).When submitting manipulation claims, doctors of chiropractic must use an Acute Treatment (AT) modifier to identify services that are active/corrective treatment of an acute or chronic subluxation. The AT modifier, when used appropriately, should indicate expectation of functional improvement, regardless of the chronic nature or redundancy of the problem.

Documentation Requirements

The Social Security Act states that "no payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period." See the Social Security Act (**section 1833(e)**).

In addition, the Medicare Benefit Policy Manual requires that the initial visit and all subsequent visits meet specific documentation requirements. See Chapter 15 (**section 240.1.2**).

Documentation Requirements for the Initial Visit

The following documentation requirements apply for initial visits whether the subluxation is demonstrated by x-ray or by physical examination:

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1. History: The history the provider records in the patient record should include the following:

- Chief complaint including the symptoms causing patient to seek treatment
- Family history if relevant
- Past medical history (general health, prior illness, injuries, hospitalizations, medications; surgical history)

2. Present Illness: Description of the present illness including:

- Mechanism of trauma
- Quality and character of symptoms/problem
- Onset, duration, intensity, frequency, location, and radiation of symptoms
- Aggravating or relieving factors
- Prior interventions, treatments, medications, secondary complaints
- Symptoms causing patient to seek treatment

Note: Symptoms must be related to the level of the subluxation that the doctor of chiropractic cites. A statement on a claim that there is "pain" is insufficient. Describe the location of the pain and whether the vertebra you listed can produce pain in that area.

3. Physical Exam: Evaluation of musculoskeletal/nervous system through physical examination. If you demonstrate a subluxation you based on physical examination, two of the following four criteria (one of which must be asymmetry/misalignment or range of motion abnormality) are required and you need to document the criteria:

- **P - Pain/tenderness:** The perception of pain and tenderness is evaluated in terms of location, quality, and intensity. Most primary neuromusculoskeletal disorders manifest with a painful response. Pain and tenderness findings may be identified through one or more of the following: observation, percussion, palpation, provocation, and so forth. Furthermore, pain intensity may be assessed using one or more of the following; visual analog scales, algometers, pain questionnaires, and so forth.
- **A - Asymmetry/misalignment:** Asymmetry/misalignment may be identified on a sectional or segmental level through one or more of the following: observation (such as posture and heat analysis), static palpation for misalignment of vertebral segments, and/or diagnostic imaging.
- **R - Range of motion abnormality:** Changes in active, passive, and accessory joint movements may result in an increase or a decrease of sectional or segmental mobility. Range of motion abnormalities may be identified through one or more of the following: motion palpation, observation, stress diagnostic imaging, range of motion, and/or other measurement(s).
- **T -Tissue tone, texture, and temperature abnormality:** Changes in the characteristics of contiguous and associated soft tissue including skin, fascia, muscle, and ligament may be identified through one or more of the following procedures: observation, palpation, use of instrumentation, and/or test of length and/or strength.

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Note: The P.A.R.T. (**P**ain/tenderness; **A**symmetry/misalignment; **R**ange of motion abnormality; and **T**issue tone, texture, and temperature abnormality) evaluation process is recommended as the examination alternative to the previously mandated demonstration of subluxation by x-ray/MRI/CT for services beginning January 1, 2000. The acronym P.A.R.T. identifies diagnostic criteria for spinal dysfunction (subluxation).

4. Diagnosis: 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 bone named. The precise level of the subluxation must be specified by the doctor of chiropractic to substantiate a claim for manipulation of the spine. This designation is made in relation to the part of the spine in which the subluxation is identified as shown in the following table:

Area of Spine	Names of Vertebrae	Number of Vertebrae	Short Form or Other Name	Subluxation ICD-10 code
Neck	Occiput Cervical Atlas Axis	7	Occ, CO C1-C7 C1 C2	M99.00 M99.01
Back	Dorsal or Thoracic Costovertebral Costotransverse	12	D1-D12 T1-T12 R1-R12 R1-R12	M99.02
Low Back	Lumbar	5	L1-L5	M99.03
Pelvis	Ilii, R and L (I, Si)		I, Si	M99.05
Sacral	Sacrum, Coccyx		S, SC	M99.04

In addition to the vertebrae and pelvic bones listed, the Ilii (R and L) are included with the sacrum as an area where a condition may occur which would be appropriate for chiropractic manipulative treatment.

There are two ways you may specify the level of the subluxation in the patient's record.

- List the exact bones, for example: C5, C6, etc.
- The area may suffice if it implies only certain bones such as: occipito-atlantal (occiput and Cl (atlas)), lumbo-sacral (L5 and Sacrum) sacro-iliac (sacrum and ilium)

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Following are some common examples of acceptable descriptive terms for the nature of the abnormalities:

- Off-centered
- Misalignment
- Malpositioning
- Spacing - abnormal, altered, decreased, increased
- Incomplete dislocation
- Rotation
- Listhesis - antero, postero, retro, lateral, spondylo
- Motion - limited, lost, restricted, flexion, extension, hypermobility, hypomotility, aberrant

You may use other terms. If they are understood clearly to refer to bone or joint space or position (or motion) changes of vertebral elements, they are acceptable.

X-rays

As of January 1, 2000, Medicare does not require an x-ray to demonstrate the subluxation. However, you may use an x-ray for this purpose if you so choose.

The date of the x-ray must be reasonably close to (within 12 months prior or 3 months following) the beginning of treatment. In certain cases of chronic subluxation (for example, scoliosis), an older x-ray may be accepted if the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent.

A previous CT scan and/or MRI are acceptable evidence if a subluxation of the spine is demonstrated.

5. Treatment Plan: The treatment plan should include the following:

- Recommended level of care (duration and frequency of visits)
- Specific treatment goals
- Objective measures to evaluate treatment effectiveness

Date of the initial treatment.

The patient's medical record.

- Validate all the information on the face of the claim, including the patient's reported diagnosis(s), physician work (CPT code), and modifiers.
- Verify that all Medicare benefit and medical necessity requirements were met.

Documentation Requirements for Subsequent Visits

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

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1. **History**
   a. Review of chief complaint
   b. Changes since last visit
   c. Systems review if relevant
2. **Physical examination**
   a. Examination of area of spine involved in diagnosis
   b. Assessment of change in patient condition since last visit
   c. Evaluation of treatment effectiveness
3. **Documentation of treatment given on day of visit.**

Necessity for Treatment of Acute and Chronic Subluxation

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 examination, as described above.

Most spinal joint problems fall into the following categories:

- **Acute subluxation**-A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical examination as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.
- **Chronic subluxation**-A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition); however, the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

You must place the HCPCS modifier AT on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However, the presence of the HCPCS modifier AT may not in all instances indicate that the service is reasonable and necessary.

As shown in the Medicare Benefit Policy Manual, Chapter 15, Section 240, the doctor of chiropractic should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time. Acute subluxation (for example, strains or sprains) problems may require as many as three months of treatment but some require very little treatment. In the first several days,

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treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained.

Chronic spinal joint condition implies, of course, the condition has existed for a longer period of time and that, in all probability, the involved joints have already "set" and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

ICD-10 Codes that Support Medical Necessity for Chiropractic Services

The chiropractic LCDs for MACs include ICD-10 Coding Information for ICD-10 Codes that support the medical necessity for chiropractic services. There may be additional documentation information in your LCD. There are links to the chiropractic LCDs in MLN Matters SE article SE1603.

The **Group 1 (primary) codes** are the only covered ICD-10-CM codes that support medical necessity for chiropractic services.

- Primary: ICD-10-CM Codes (Names of Vertebrae)
- List the precise level of subluxation as the primary diagnosis.

The Groups 2, 3, and 4 ICD-10-CM codes support the medical necessity for diagnoses and involve short, moderate, and long-term treatment:

- **Group 2 Codes**: Category I - ICD-10-CM Diagnosis (diagnoses that generally require **short term treatment**)
- **Group 3 Codes**: Category II - ICD-10-CM Diagnosis (diagnoses that generally require **moderate term treatment**)
- **Group 4 Codes**: Category III - ICD-10-CM Diagnosis (diagnoses that may require **long term treatment**)

ICD-10 Codes that DO NOT Support Medical Necessity are **all** ICD-10-CM codes **not** listed in LCDs under *ICD-10-CM Codes That Support Medical Necessity*.

Additional Information

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

A new Medicare Learning Network Educational Tool, Medicare Documentation Job Aid For Doctors of Chiropractic, is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/MLN1232664.html.

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The Medicare Benefit Policy Manual, Chapter 15, Section 240 is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf.

The CERT 2018 Medicare Fee-For-Service Supplemental Improper Payment Data report is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2018MedicareFFSSuplementalImproperPaymentData.pdf.

Article SE1101, Overview of Medicare Policy Regarding Chiropractic Services, is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1101.pdf.

Article MM3449, Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR3063 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm3449.pdf.

Article SE0749, Addressing Misinformation Regarding Chiropractic Services and Medicare, is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0749.pdf.

Other articles in this series on chiropractic services include SE1602, which is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1602.pdf. SE1602 discusses the use of the AT modifier. Also, SE1603 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1603.pdf lists a wide array of other materials to assist doctors of chiropractic in delivering covered services to Medicare beneficiaries and correctly billing for those services.

Document History

- May 7, 2019 - CMS revised this article to update sources of information regarding chiropractic services with additional references added to the Additional Information section of this article. We deleted resource references that are no longer available. All other information remains the same.
- June 18, 2018 – We revised the article to delete the word “always” from the line for item 5 (Treatment Plan) on page 5. All other information remains the same.
- March 16, 2016 – Initial article released.

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