Dynamic Chiropractic

Cross-Referencing Regions of Complaint, PART Findings, Diagnoses and CPT Codes

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In 2012 the Centers for Medicare and Medicaid Services and CMS-contracted reviewers performed chiropractic Medicare reviews nationwide. The results of their efforts were not good news for the chiropractic profession. The reviews pointed to poor record-keeping and billing practices throughout the profession. Claims were also made of inappropriate billing of maintenance care resulting in significant overpayments for chiropractic services.[1] Unfortunately, these findings were consistent with previous CMS chiropractic reviews.[2]

Of the current review findings, the one that is most disappointing is our consistency from one CMS review to the next. It is difficult to respond to our many Medicare problems all at once. It can be overwhelming. However, while we cannot fix everything at once, we can fix something.

There are a specific set of closely related problems that can and should be addressed together. In actuality, the problems are so intertwined that they are really a single concern: matching the number of symptomatic spinal / pelvic regions; the number of spinal /pelvic regions with PART and/or X-ray findings of subluxation; the number of diagnoses, the number of regions adjusted; and the CPT code used to bill for the adjustment.

Volumes have already been written about this concern. Here, I offer a set of questions to help guide doctors in documenting the number of patient complaints, subluxations, diagnoses, regions adjusted and the appropriate billing codes. This series of questions is accompanied by comments and tables to clarify the importance of each question.

Questions to Ask Yourself After Examining a Medicare Patient

1. How many regions of the spine / pelvis did the patient list as painful or symptomatic? Medicare is not purely subluxation based, despite the original and lasting rule that a subluxation must be documented in any region adjusted. The diagnostic criteria also require a symptom code for each region of subluxation. With this in mind, Medicare assumes the patient to have a complaint in each region treated and that the patient reported these complaints during their history. This is a common expectation for many other carriers as well. Carriers do not feel treatment of a region that ivs asymptomatic is necessary. "Asymptomatic" for Medicare and many other carriers translates to "no problem or no condition."

In regard to asymptomatic areas, every chiropractor has had a patient react to examination of an area(s) by saying, "I didn't know that was tender until you pushed on it." We understand and expect this reaction. However, this understanding and expectation are not shared by Medicare.

Table 1: The Medicare PART System

P = Pain
A = Asymmetry
R = Range of Motion
T = Tissue Tone

If you choose to adjust an asymptomatic region, you must have appropriate documentation demonstrating the relationship to the patient's reported complaint(s) and necessity of the treatment. Chiropractors understand the overlapping relationships of spinal / pelvic structures / conditions, but it must be documented. Documenting the pain or "P" category of PART (Table 1) provides a minimal degree of the necessary documentation. Additional PART findings must also be documented for these areas.

2. How many regions of the spine / pelvis did I examine? PART examination is the minimum level of examination required for a spinal / pelvis region.

3. How many regions exhibited PART examination findings? PART examination findings are required in order to adjust any region. There must be findings for at least two of the four PART categories for each region, and one of the categories must be the A category or the R category.

If PART findings are not present in the region(s) considered for adjustment, recent X-rays (within three months of onset) showing subluxation(s) in those region(s) qualify as documentation of the subluxation(s).

4. How many regions are documented as having both symptoms and subluxation(s)? Each region to be treated must have symptoms and subluxations.

5. How many regions does my documentation justify diagnosing and adjusting? Each region to be adjusted must have subluxation and symptom diagnoses. This means each region will have a pair of diagnoses. There will never be an odd number of Medicare diagnoses.

6. Which CPT code matches the number of spinal / pelvic regions diagnosed and requiring adjustment? Each code must match the number of regions the doctor adjusted.

7. Do the number of regions the patient reports as symptomatic, the number of regions examined, the number of regions with PART / X-ray findings of subluxation, the number of regions with subluxation and symptom diagnoses, and the code for the number of regions adjusted match? (Table 2) If the numbers for each of these items are not the same, documentation is insufficient.

8. Which pair(s) of diagnoses represents the most problematic / serious condition(s)? The diagnostic codes for the most significant conditions should be placed on the Medicare claim form (two pairs of subluxation and symptom codes; four codes total). The remaining diagnoses should be placed in a prominent location in the patient's records and in *some* situations can also be placed in the box marked "Reserved for Local Use" or box 19 of the CMS 1500 form.

Placement of additional diagnoses on the claim form is dependent upon local Medicare carrier requirements and the capability of billing software.

Once the doctor has answered the questions above and the numbers are found to match (Table 2), it is easier to prove the necessity of care. An additional step to improve the odds of this information standing the test of a review is to have the information for answering the questions in one place or as close to each other as possible in the patient's record. Make the information easy for anyone to

find. If it isn't in plain sight, most reviewers are not going to dig to find it.

Table 2: Cross-ReferencingSymptoms, PART Findings, Diagnoses and CPT Manipulation Codes		
Number of Regions of Complaint andPART Findings	Number of Diagnoses	CPT Code
Symptoms and PART findings for 1-2 of the following regions; cervical,thoracic, lumbar, sacral, pelvic	*Two or four diagnoses:* • One or two pairs of subluxation / symptom codes • The first code in each pair must be a 739 code • The second code in each pair must be a symptom /condition code	98940 1-2 regions
Symptoms and PART findings for 3-4 of the following regions; cervical,thoracic, lumbar, sacral, pelvic	*Six or eight diagnoses:* • Three or four pairs of subluxation/symptom codes • The first code in each pair must be a 739 code • The second code in each pair must be a symptom /condition code	98941 3-4 regions
Symptoms and PART findings for all 5 of the following regions; cervical,thoracic, lumbar, sacral, pelvic	*10 diagnoses:* • Five pairs of subluxation / symptom codes • The first code in each pair must be a 739 code • The second code in each pair must be a symptom /condition code	98942 5 regions

References

1. Centers for Medicare & Medicaid Services: *Comparative Billing Report on Chiropractic*, 2013.
2. Department of Health and Human Services, Office of the Inspector General: *Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis*, 2005.

General Resources

- *Medicare Benefit Policy Manual*, Chapter 15. Centers for Medicare & Medicaid Services, 2011.
- *Medicare Rules & Regulations: A Survival Guide to Policies, Procedures and Payment Reform*. Practice Management Information Corporation (PMIC), Los Angeles, 2012.
- *Chiropractic Coding and Compliance Manual, 17th Edition*. American Chiropractic Association, 2012.