DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: SE1602 | **Related Change Request (CR) #: N/A**

Related CR Release Date: N/A | **Effective Date: N/A**

Related CR Transmittal #: NA | **Implementation Date: N/A**

Use of the AT modifier for Chiropractic Billing (new information along with information in MM3449)

Provider Types Affected

This Special Edition (SE) MLN Matters® article is intended for Chiropractors 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 prepared for Chiropractors by the Centers for Medicare & Medicaid Services (CMS) in response to the request for educational materials at the September 24, 2015, Special Open Door Forum titled: *Improving Documentation of Chiropractic Services.*

Provider Action Needed

The Active Treatment (AT) modifier was developed to clearly define the difference between active treatment and maintenance treatment. Medicare pays only for active/corrective treatment to correct acute or chronic subluxation. Medicare does not pay for maintenance therapy. Claims should include a primary diagnosis of subluxation and a secondary diagnosis that reflects the patient's neuro musculoskeletal condition. The patient's medical record should support the services submitted. Related MLN Matters Article **SE1601** discusses those medical record documentation requirements.

Be aware of these policies along with any local coverage determinations (LCDs) for these services in your area that might limit circumstances under which active/corrective chiropractic services are paid.

Background

In 2014, the Comprehensive Error Testing Program (CERT) that measures improper payments in the Medicare Fee-for-Service program reported a 54 percent error rate for Chiropractic services. The majority of those errors were due to insufficient documentation/documentation errors. Year after year these error rates appear. CMS is providing an explanation of the AT modifier to assist providers with correctly documenting claims for chiropractic services provided to Medicare beneficiaries.

The Active Treatment (AT) modifier defines the difference between active treatment and maintenance treatment. Effective October 1, 2004, the AT Modifier is required under Medicare billing to receive reimbursement for CPT codes 98940-98942. For Medicare purposes, the AT modifier is used only when chiropractors bill for active/corrective treatment (acute and chronic care). The policy requires the following:

1. Every chiropractic claim for 98940/98941/98942, with a date of service on or after October 1, 2004, should include the AT modifier if active/corrective treatment is being performed; and

2. The AT modifier should not be used if maintenance therapy is being performed. MACs deny chiropractic claims for 98940/98941/98942, with a date of service on or after October 1, 2004, that does not contain the AT modifier.

The following categories help determine coverage of treatment. (See the **Necessity for Treatment,** Chapter 15, Section 240.1.3, of the "Medicare Benefit Policy Manual" (pages 226-227)).

1. **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). (See **SE1601** for details of the x-ray and examination requirements.) The result of chiropractic manipulation is expected to be **an improvement in, or arrest of progression of**, the patient's condition.

2. **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.

   Both of the above scenarios are covered by CMS as long as there is active treatment which is well documented and improvement is expected.

Maintenance: 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.

Chiropractors should consider obtaining an Advance Beneficiary Notice (ABN) from beneficiaries in the event of a denial of a claim. Information about the ABN, including downloadable forms is available at **https://www.cms.gov/MEDICARE/medicare-general-information/bni/abn.html** on the CMS website. Also, see the "Medicare Claims Processing Manual," **Chapter 23 Section 20.9.1.1** pages 49 and 50, for important information about the use of an appropriate modifier on your claims with regard to the ABN.

Be aware that once the provider cannot determine there is any improvement, treatment becomes maintenance and is no longer covered by Medicare.

Key Points

For Medicare purposes, a chiropractor must place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However, the presence of the AT modifier may not in all instances indicate that the service is reasonable and necessary. As always, MACs may deny if appropriate after medical review determines that the medical record does not support active/corrective treatment.

Additional Information

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

To review MM3449, Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR3063 go to: **MM3449** on the CMS website.

Other articles in this series on chiropractic services are **SE1601**, which discusses Medicare's medical record documentation requirements for chiropractic services and **SE1603**, which lists a wide array of other materials to assist chiropractors in delivering covered services to Medicare beneficiaries and correctly billing for those services.