Avoiding Mistakes in Medicare

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Presented for the

Arizona Association of Chiropractic

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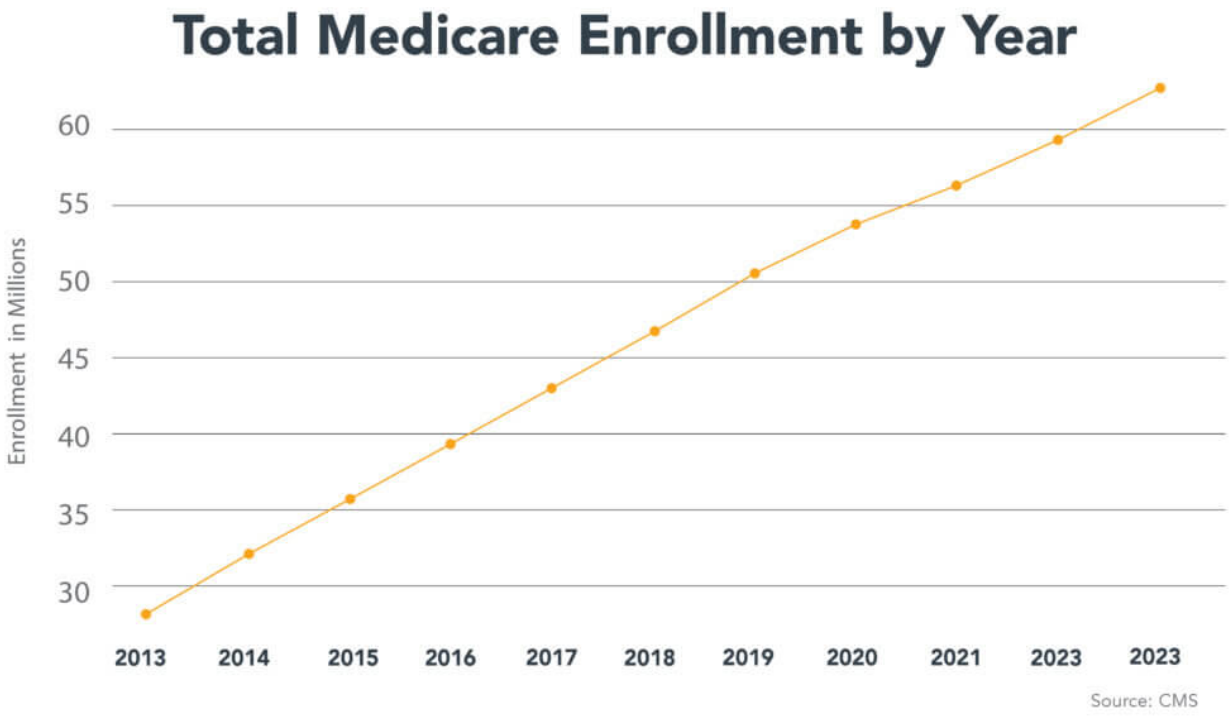
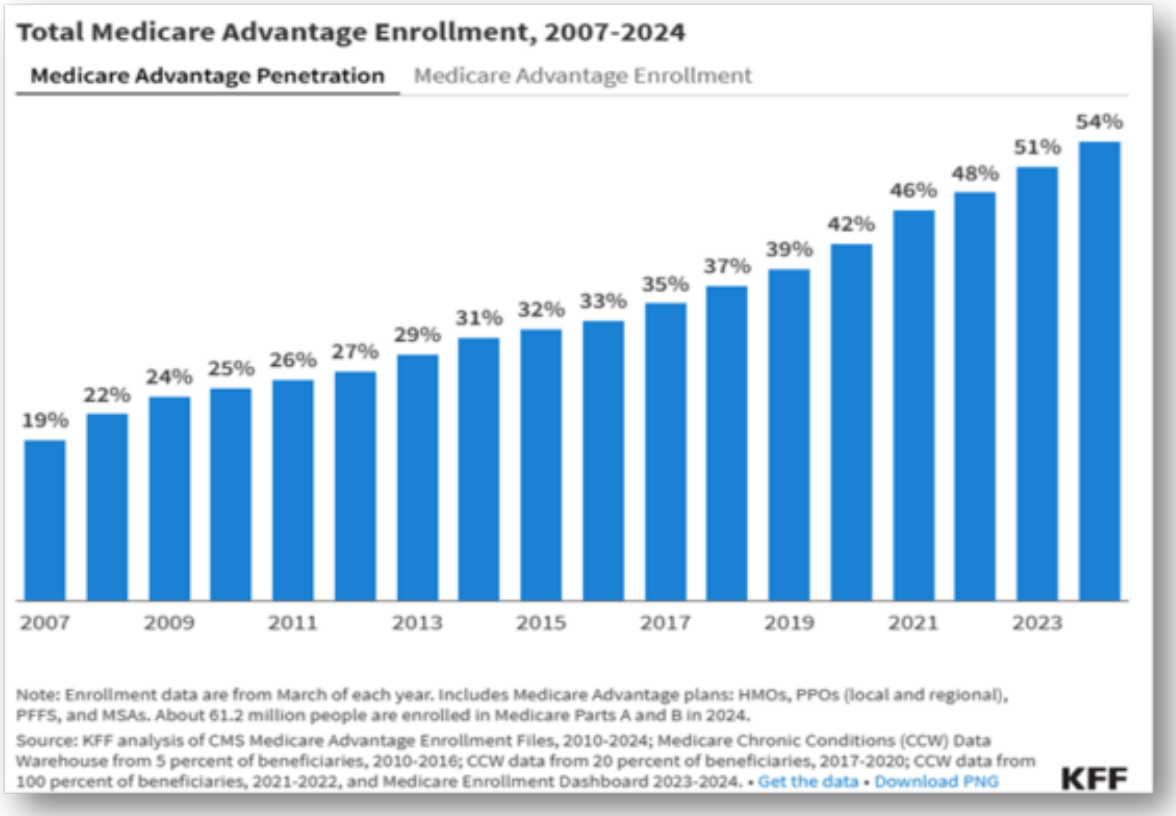
Baby Boomer Effect in Medicare

- Age 62 to 80
- 75 Million in the US
- Make up 25% of the total population
- Will all be enrolled in Medicare by 2029
- Wealthiest population on the earth
- Health oriented
- Pickleball, golf, eat well
- Workaholics
- Spend money wisely
- Struggle with chronic health problems
- Have been loyal to chiropractors
- All have chiropractic benefits


Total Medicare Enrollment by Year
Enrollment in Millions
60
55
50
45
40
35
30
2013
2014
2015
2016
2017
2018
2019
2020
2021
2023
2023
Source: CMS


Total Medicare Advantage Enrollment, 2007-2024
Medicare Advantage Penetration
Medicare Advantage Enrollment
19%
22%
24%
25%
26%
27%
29%
31%
32%
33%
35%
37%
39%
42%
46%
48%
51%
54%
2007
2009
2011
2013
2015
2017
2019
2021
2023
Note: Enrollment data are from March of each year. Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 61.2 million people are enrolled in Medicare Parts A and B in 2024.
Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2024; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; CCW data from 100 percent of beneficiaries, 2021-2022, and Medicare Enrollment Dashboard 2023-2024. • Get the data • Download PNG
KFF

Medicare In Chiropractic

Arizona Medicare Administrative Contractor (MAC)

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ARIZONA ASSOCIATION OF CHIROPRACTIC

2026 Medicare Physician Fee Schedule – January 1 – December 31, 2026

In December, Noridian Healthcare Solutions, the entity that manages Medicare B claims for the state of Arizona, released the 2026 Medicare Physician Fee Schedule for the state. The Medicare Physician Fee Schedules below contain the pricing information for Dates of Service January 1, 2026, through December 31, 2026, for non-QP practitioners. The fees apply to services provided in a non-facility setting.

Arizona – January 1 – December 31, 2026			
Code	2026 Par Amount	2026 Non-Par Amount	2026 Limiting Charge
98940	$26.32	$25.00	$28.75
98941	$37.90	$36.01	$41.41
98942	$49.16	$46.70	$53.71

Medicare Deductible for 2026: $283 [Up $26 from 2025 ($257)]

Medicare Fraud by Chiropractors

Improper Payments

According to the 2024 Medicare Fee-for-Service Supplemental Improper Payment Data, the improper payment rate for chiropractic services is 33.6%, with a projected improper payment amount of $178.3 million.

Denial Reasons

Insufficient documentation accounted for 95.5% of improper payments for chiropractic services during the 2024 reporting period, while no documentation (2.4%), incorrect coding (0.7%), medical necessity (0.6%), and other errors (0.9%) also caused improper payments.

Denial Culprits

- Lack of required/recommended history not documented
- Contraindications to care not documented properly
- PART exam to each area treated not documented properly
- Diagnosis to each area treated not documented properly
- Specific treatment plan not documented properly
- Objective measures to evaluate treatment effectiveness
- Subsequent visit notes not documented properly
- ABN at maintenance

Topics That Will Be Covered

- Do I Need to be a Medicare Provider?
- Participating vs. Non-Participating Providers
- “Opting Out” of Medicare
- Covered Services by Chiropractors
- Medically Necessary Definition
- Non-Covered Services
- Have “The Talk” with Medicare Patients
- Voluntary Advanced Beneficiary Notice (vABN)
- Medicare History For Chiropractors
- Contraindications To Manipulation
- P.A.R.T. Exam
- X-rays
- Diagnosis
- Treatment Plan
- Outcome Assessments
- Subsequent Visits
- Mandatory Advanced Beneficiary Notice (ABN)
- Maintenance Manipulations
- Billing Modifiers
- Signature Requirements
- Appeals
- Medicare Advantage Plans

Do I Need To Be A Medicare Provider?

- One must be a Medicare provider approved by CMS to treat Medicare patients for **covered services**.

- **Section 1848(g)(4)(A)** of the Social Security Act requires a provider of **covered services** to bill Medicare.
    - *"Section 1848(g)(4)(A) of the Social Security Act mandates that all physicians submit claims for services rendered to Medicare beneficiaries. This mandatory filing requirement requires claims to be submitted for **all covered services**, regardless of whether the provider accepts assignment."*

- **Violations and Penalties:** Failure to file can lead to civil monetary penalties of $2,000 for each violation and potential exclusion from the Medicare program.
- **What is covered when performed by a DC?** A manual manipulation of the spine when **medically necessary** is the only service covered by Medicare.
- **Medically necessary** Treatment that increases function. Objective measures, such as outcome assessments, are required to evaluate treatment effectiveness.

Medicare Provider Types

1. Participating Provider (PAR) – "in network"

Must complete for CMS-460. Can change status each year.

Must "accept assignment":

- Bill your standard fee for all covered services. Ex. 9894X AT
- MC will pay 80% of the regional fee schedule for PAR providers.
- Must collect 20% from the patient.
- Must charge standard fees for all other services.
- No free or discounted services, waiving deductibles or co-payments – Anti-Kickback Statute and Stark law violations
- *Example: You bill MC $100. MC will pay $80 and the patient pays $20. (This assumes deductible of $283 has been met)*

2. Non-Participating Provider (Non-PAR) – "out of network"

Can accept **assignment or not accept assignment** on a claim-by-claim basis.

If you **DO** accept assignment, you must:

- Bill Medicare at the non-par fee for the covered services.
- MC will pay 80% of 95% of the Non-PAR fee
- Must collect 20% from the patient
- Must charge normal fees for all other services
- Do not give free or discounted services – Anti-Kickback Statute and Stark law violations.
- *Example: You bill MC $100. MC will pay $76 and the patient pays $19. (This assumes deductible of $283 has been met)*

3. Non-Participating Provider (Non-PAR) – "out of network"

If you **DO NOT** accept assignment:

- Bill Medicare for the covered services
- MC will pay the patient directly
- You can bill the "limiting charge" (115% of 95%)
- MC will pay 80% of the Non-PAR regional fee schedule
- Must collect 20% from the patient
- Must charge exact fee
- Do not give free or discounted services – Stark violation
- *Example: You bill MC $100. MC will pay the patient 80% and the patient pays you the full amount $76 + $19 +. (Medicare allows a 15% upcharge non-assigned claims)*

Noridian Fee Schedule For The State of Arizona

ARIZONA ASSOCIATION OF CHIROPRACTIC

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Opting Out of Medicare

Chiropractors are not allowed to opt out of Medicare. NOTE: Opting out of Medicare is not the same as being as not being a Medicare provider.

Having 'The Talk' With Medicare Patients

Medicare patients do not realize that Medicare does not pay for exams, x-rays, therapies, and other services in a chiropractor's office. Therefore, it is necessary to sit down and explain this with the patient.

NOTE: Have them sign a form stating that they understand. It is not required but will help resolve any issues later in care.

Voluntary Advanced Beneficiary Notice

A voluntary ABN can be administered to the patient to let them know that exams x-rays, therapies and other services are not covered in the office.

This is not to be confused with the mandatory ABN, which is required once the patient achieves maximum improvement for that episode and is placed on maintenance care.

Medical Necessity Requirements

The patient must have a significant health problem in the form of a neuromusculoskeletal condition that needs treatment. The manipulative services must be directly related to the patient's condition and provide reasonable recovery expectations or function improvement. The patient must have a subluxation of the spine as shown by X-ray or physical exam, as described in the Documentation Requirements section.

Most spinal joint problems fall into these categories:

- **Acute subluxation —** A patient's condition is acute when they're being treated for a new injury as identified by X-ray or physical exam. We expect the chiropractic manipulation to improve or stop the progression of the patient's condition.
- **Chronic subluxation —** A patient's condition is chronic when it's not expected to significantly improve or resolve with further treatment (which happens with an acute condition) but the patient can expect some functional improvement if they continue therapy. Once the clinical status for a given condition has stabilized, without expecting other objective clinical improvements, further manipulative treatment is maintenance therapy, and we don't cover payment.
- **We typically treat patients with an acute exacerbation of a chronic condition in Medicare.**

Excluded Chiropractic Services

A beneficiary is responsible for these services. ***A provider may bill a patient without billing Medicare. (Bill if there is secondary coverage)***

- Maintenance manipulations (you need an ABN signed first)
- Acupuncture
- Counseling/education
- Dietary advice/nutritional supplements
- Lab or other diagnostic tests
- Physical therapies (exercise, ultrasound, traction)
- May bill for denial with GP GY modifiers appended to CPT 97xxx
- Office visits
- Supplies (pillows or vitamins)
- Supportive (bracing, orthopedic)
- X-rays

If using CPT codes, you must bill your normal fee for these services.

Use a non-CPT code for non-injury cases, e.g. M1 for CMT to one area.

Initial Visit Documentation Guidelines

The following apply whether the subluxation is demonstrated by x-ray or by physical examination.

History, which includes:

- Date of onset - This is important, especially for maintenance patients.
- Symptoms causing patient to seek treatment
- Family history, if relevant;
- Past health history

Description of the present illness including:

- Mechanism of trauma;
- Quality and character of symptoms/problem;
- Duration, intensity, frequency, location, and radiation of symptoms;
- Aggravating or relieving factors;
- Prior interventions, treatments, medications, secondary complaints; and

These symptoms must bear a direct relationship to the level of subluxation.

- The subluxation must be causal, i.e., **the symptoms must be related to the level of the subluxation that has been cited**.
- **A statement on a claim that there is "pain" is insufficient**. The location of pain must be described and whether the vertebra listed is capable of producing pain in the area determined.

Contraindications to Care

- Absolute Contraindications
- Relative Contraindications

Absolute Contraindications

(No Manipulation of the affected region)

- **Acute fractures and dislocations:** Or healed fractures with instability.
- **Malignancy:** Tumors involving the vertebral column.
- **Infections:** Acute infections of the spine or joints.
- **Myelopathy:** Signs of spinal cord compression.
- **Cauda Equina Syndrome:** Severe nerve root compression.
- **Vascular issues:** Vertebrobasilar insufficiency syndrome or major artery aneurysms.
- **Inflammatory Arthropathies:** Acute rheumatoid, AS

Relative Contraindications (Document Informed Consent)

- **Severe osteoporosis (demineralization):** Weakened bone structure.
- **Articular hypermobility:** Unstable joints.
- **Bleeding disorders/Anticoagulant therapy:** High risk of bruising or bleeding.
- **Progressive Radiculopathy:** Worsening nerve pain.

P.A.R.T. Exam

P.A.R.T. Exam

This is a palpation exam.

No other exam is required; however, you can perform if necessary.

You must perform for each area of the spine that is treated!

Evaluation of musculoskeletal/nervous system through physical examination or x-ray. Do both.

To determine a subluxation based on physical examination:

- Two (2) of the four (4) criteria of the P.A.R.T. exam are required; One must be:
    - Asymmetry/misalignment
    - Range of motion abnormality

- **Pain/tenderness** - location, quality and intensity;
- **Asymmetry/misalignment** - sectional or segmental level;
- **Range of motion abnormality**;
- **Tissue, tone changes** - characteristics of contiguous or associated soft tissues.

Example: Palpation revealed a fixation at C5 on the right with muscle guarding of the right paraspinal musculature in the mid cervical spine.

A = fixation

T = muscle guarding

Documenting Subluxation With X-Rays

Subluxation Documentation Requirements:

- Documentation of a subluxation must be shown on x-ray or by physical exam.
- A CT scan and or MRI showing subluxation of spine may be used rather than an x-ray.
- 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), 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.

Diagnosis

Diagnosis

Primary diagnosis must be subluxation, including **level of subluxation**, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to condition of spinal joint involved or to direction of position assumed by bone named.

Example: PART exam reveals a PRS subluxation at C5/6.

Secondary diagnosis required to support condition causing primary diagnosis.

Example: DJD at C5/6.

NOTE: You must state that the primary diagnosis of subluxation is capable of producing the secondary diagnosis.

“The subluxation at C5/6 is capable of producing the degenerative joint disease at that level”.

Claim:

1. M99.01 Segmental Dysfunction, Cervical Spine

2. M50.3 Disc Degeneration, Cervical Spine

Treatment Plan

Treatment Plan: The treatment plan needs to include the following:

- Recommended level of care (duration and frequency of visits);
- Specific treatment goals; and
- Objective measures to evaluate treatment effectiveness
    - Need to use outcome assessments
- Date of the initial treatment

Cannot say: “See 3 times a week for 4 weeks”

Example:

“Beginning on May 4th, 2026, the patient will receive a manipulation to the cervical spine, 3 times a week for approximately 4 to 6 weeks. The goal of treatment is to increase joint mobility and decrease muscle guarding in the cervical region. A Neck Disability Index will be administered every two weeks to evaluate treatment effectiveness.”

Subsequent Visits

Subsequent Visits

The following apply whether the subluxation is demonstrated by x-ray or by physical examination for subsequent visits.

Visit

- Review of chief complaint
- Changes since last visit - just stating increased or decreased pain is not sufficient
- System review, if relevant
- Physical exam (PART)
- Assessment of change in patient condition since last visit
- Evaluation of treatment effectiveness
- Documentation of treatment given on day of visit

Fraud Alert

Software Generated Documentation: On subject of computerized documentation, CMS states, "Documentation should detail the specific elements of the chiropractic service for this particular patient on this day of service. It should be clear from the documentation why the service was necessary that day. **Services supported by repetitive entries lacking encounter specific information will be denied.**"

Documentation must demonstrate vertebrae affected, to what degree and if the vertebra can produce pain that patient came in with. If billing for more than one level, all levels must reflect this.

CMS-1500 Claim Form

&

Electronic Claims

CMS-1500

Item 21 on CMS-1500 claim form or its electronic equivalent allows space for four (4) diagnoses for each claim; however, each treatment region requires two diagnoses, a primary and a secondary.

When billing for two treated regions, enter the two most clinically significant primary and corresponding secondary diagnoses on claim form

- If billing for 3-5 regions of subluxation, **documentation** must support **both primary and secondary codes** for each region individually. When billing for three to five regions, the two most clinically pertinent diagnosis pairs are placed in Item 21 on CMS-1500 claim form and remaining three to five primary and secondary code pairs must be present in documentation
- The primary and secondary diagnosis codes for each level billed must be reflected in the documentation. Medical review checks diagnosis codes for correlation in the documentation.

For Medicare purposes, a chiropractor MUST append an AT modifier on a claim when providing active/corrective therapy 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

- Claims without AT modifier will be considered maintenance therapy and will be denied.
- Use of AT modifier and GA modifier together on a claim is never appropriate

Detail specific date of service elements:

- Clarify which services necessary
- Documentation must support each level billed
- Be careful with software generated documentation as some include identical entries for different patients/ different dates of service
- Be careful with check-off sheets: they can be difficult to read, lack findings, be too generic, and lack enough space to list specific required information
- Be careful including non-encounter specific repetitive entries that do not contain policy required components, denied upon review
- Whichever documentation style is used, it must include required elements to support medical necessity for service(s) rendered
- Physicians/NPPs should not add late signatures to medical records, other than a short delay that occurs during transcription process. Use signature authentication process. Retroactive orders are not acceptable

CMS Internet Only Manual (IOM), Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Sections 30.5 and 240

CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 220

CMS IOM, Publication 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4

CMS Medicare Learning Network (MLN) Matters (MM) 6698

Title XVIII of the Social Security Act, Section 1862(a)(7)

Title XVIII of the Social Security Act, Section 1862(a)(1)(A)

CMS Signature Requirements

CMS requires that all medical services, orders, and documentation be authenticated by the author via handwritten or electronic signature. Signatures must be legible or accompanied by a signature log/attestation if not. Stamped signatures are disallowed except for specific, documented physical disabilities. Key requirements include: [1, 2, 3]

- **Acceptable Signatures:** Handwritten, electronic (with date/time stamp, "electronically signed by," or "verified/reviewed by"), or digital signatures.
- **Missing Signatures:** If a signature is missing, a signature log or attestation statement must be provided.
- **Illegible Signatures:** If a signature is illegible, a log, attestation, or printed name indicating the signer must be provided.
- **Scribes:** A scribe does not sign. The provider must sign, date, and time the note to affirm the care provided.
- **Electronic Records:** Must have secure, password-protected systems to ensure only the user has access.

Unacceptable Signatures:

- Signature stamps (without approved disability exception).
- Initials not linked to a printed/typed signature log.
- Unsigned, typed notes containing only the provider's printed name.

Part C (Medicare Advantage)

Part C (Medicare Advantage)

54% of Medicare recipients have a Medicare Advantage Plan.

64% of Medicare recipients will be MAP by 2034.

Key Aspects of Medicare Advantage for Chiropractic Care:

- **Coverage Extent:** While Part B limits coverage to spinal manipulation, MA plans often include coverage for examinations, therapies, and maintenance care.
- **Provider Network:** Many plans require patients to use in-network chiropractors.
- **Billing & Modifiers:** Chiropractors must use the "AT" (Active Treatment) modifier for Medicare to consider the treatment medically necessary.
- **Authorization:** Some plans, particularly HMOs, may require prior authorization for visits.

Coverage varies by specific Medicare Advantage plan and carrier (e.g., Aetna, UnitedHealthcare, Humana, BC/BS).

Medicare Appeals

The 5 Levels of Medicare Appeals

Level 1: Redetermination

- **Action**: A second review of your claim by Noridian personnel who were not involved in the original decision.
- **Deadline**: File within **120 days** of receiving your initial claim determination (typically the date on your Medicare Summary Notice).
- **Processing Time**: Noridian generally completes this within **60 days**.

Level 2: Reconsideration

- **Action**: An independent review conducted by a Qualified Independent Contractor (QIC).
- **Deadline**: File within **180 days** of the Level 1 decision notice.

Level 3: Administrative Law Judge (ALJ) Hearing

- **Action**: A hearing before an ALJ within the Office of Medicare Hearings and Appeals (OMHA).
- **Threshold**: For 2025, the amount in controversy must be at least **$190**.

Level 4: Medicare Appeals Council Review

- **Action**: A review by the Departmental Appeals Board (DAB) if you disagree with the ALJ's decision.
- **Deadline**: File within **60 days** of receiving the ALJ's decision.

Level 5: Judicial Review in Federal District Court

- **Action**: The final level of appeal, involving a lawsuit in federal court.
- **Threshold**: For 2025, the amount in controversy must be at least **$1,900**.

Advance Beneficiary Notice

For chiropractors, an **Advance Beneficiary Notice of Non-coverage (ABN)** is used to inform Medicare patients when a manual manipulation of the spine is likely to be denied as **maintenance therapy** rather than active treatment.

When an ABN is Required

- **Maintenance Care**: The patient has reached maximum clinical improvement, and further care is supportive rather than corrective.
- **Exceeded Limits**: You believe the frequency of services exceeds Medicare's medical necessity guidelines for a specific diagnosis.

Current Form Status

The Centers for Medicare & Medicaid Services (CMS) recently updated the ABN form (**CMS-R-131**).

Expiration: The updated form is now effective and expires **March 31, 2029**.

ABN Billing Modifiers

Using the correct modifier on your claim tells Noridian whether an ABN is on file:

- **AT Modifier**: Used for **Active Treatment**. No ABN is required. This indicates the care is medically necessary.
- **GA Modifier**: Used when a **valid ABN is on file**. This indicates you expect a denial for maintenance care, allowing you to bill the patient directly after Medicare denies the claim.
- **GZ Modifier**: Used when you expect a denial but **do not** have a signed ABN. You cannot bill the patient in this scenario.
- **GY Modifier**: Used for **statutorily excluded services** (like x-rays) to trigger a formal denial, which is often needed for secondary insurance.

Documentation Tips

- Provide complete and legible documentation
- Clearly identify medical necessity
- Use standard abbreviations
- Include plan of treatment
- Computerized documentation may not provide individualized information
    - Detail specific date of service elements
    - Clarify which services necessary
    - Documentation must support each level billed
- Be careful with software generated documentation as some include identical entries for different patients/ different dates of service
- Be careful with check-off sheets: they can be difficult to read, lack findings, be too generic, and lack enough space to list specific required information
- Be careful including non-encounter specific repetitive entries that do not contain policy required components, denied upon review
- Whichever documentation style is used, it must include required elements to support medical necessity for service(s) rendered
- Physicians should not add late signatures to medical records, other than a short delay that occurs during transcription process. Use signature authentication process.

Mistakes Made in Medicare By Chiropractors

#1. Chiropractors do not read the documentation requirements for Medicare

#2. Chiropractors do not think that the documentation requirements are…*required*!

#3. DC’s do not document the required Medicare history

#4. DC's do not document informed consent for relative contraindications for care

#5. DC’s do not document and avoid treating absolute contraindications

#6. DC's do not document the required PART exam for each spinal region treated

#7. DC’s do not document the required two (2) diagnosis for each spinal region treated

8. DC’s do not document the required treatment plan for type, frequency and duration

9. DC’s do not document the required subsequent visit

10. DC’s do not document the ABN when mandated

11. DC’s do not use outcome assessments to evaluate treatment effectiveness