Medicare Diagnosis

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Diagnosis

- The diagnosis is one of two codes that you place on the CMS 1500 form when you submit a claim.
- The diagnosis communicates the patient's condition to the computer that reads the claim.
- The computer is programmed to read the diagnosis and make certain decisions, including whether or not you get paid.
- The more accurately that you diagnose the patient, the better you can manage the case and the better you will get paid and the less likely you are to be reviewed.
- "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 particular bone named."[1]
- The spine is divided into 5 areas:[2]

Area of Spine	*Names of Vertebrae*	*Number of Vertebrae*	*Short Form or Other Name*	Subluxation ICD-9 code
Neck	*Occiput* *Cervical* *Atlas* *Axis*	*7*	*Occ, CO* *C1-C7* *C1* *C2*	739.0 739.1
Back	*Dorsal or Thoracic Costovertebral Costotransverse*	*12*	**D1-D12** *T1-T12* *R1-R12* *R1-R12*	739.2
Low Back	*Lumbar*	*5*	*L1-L5*	739.3
Pelvis	*Ilii r and l*		*I, Si*	739.5
Sacral	*Sacrum, Coccyx*		*S, SC*	739.4

Which Diagnosis Code to Use

- There are currently three groups of codes that are used by chiropractors to identify the subluxation:
  - The ICD-9 code 739.x
  - The ICD-9 code 839.x

[1] Medicare Benefit Policy Manual Chapter 15, Section 240.1.3(A)
[2] Local Carrier Determination L10881

- And the HCPCS code S8990**HCPCS Code S8990**
- There are three reasons for not using S8990 for Medicare billing.
- The Health Care Procedure Coding System (HCPCS) is developed and maintained by CMS and consist of a letter followed by a series of numbers.
- The codes are categorized by the letter prefixes.
- The "S" codes are Private Payer Codes.
- Quoting from the HCPCS Manual:
- "HCPCS "S" codes are temporary national codes established by the private payers for private payer use. Prior to using "S" codes on insurance claims to private payers, you should consult with the payer to confirm that the "S" codes are acceptable. **"S" codes are not valid for Medicare use."** S8990 is defined as "physical or manipulative therapy performed for maintenance rather than restoration".
- Maintenance care is not a covered service for Medicare beneficiaries.
- As such, we are not required to bill Medicare for maintenance care and would not require a specific code for that purpose.Not a single Medicare Administrative Contractor lists code S8990 in a Local Coverage determination.
- If this code is not listed in the LCD then it is not acceptable to use when billing chiropractic services. Reason 1 is sufficient to explain why code S8990 is not to be used to bill maintenance CMT to Medicare.
- However, if this code were allowed to be used for Medicare billing, then reasons 2 and 3 would come into play. **ICD-9 code 839.X**
- Defined as "other, multiple, and ill defined dislocations."
- The 830-839 series of diagnoses are for dislocations and subluxations.
- The subluxations referenced here are medical subluxations.Taber's Cylopedic Medical Dictionary defines subluxation as: A partial or incomplete dislocation.
- This section provides individual codes for open dislocations and closed dislocations.
- Open dislocations include:
    - Compound,
    - Infected, or
    - With foreign body
- Closed dislocations include:
    - Complete,
    - Dislocation NOS,
    - Partial,
    - Simple, or
    - Uncomplicated
- Clearly, the 839.X series of codes is not for use by chiropractors.

- **The 739.X series of codes.**
    - These are defined as: Nonallopathic lesions not elsewhere classified.
    - They include:

- Segmental Dysfunction
- Somatic Dysfunction
- This is the code that was designed for use by chiropractors.
- This is the code that we should use for diagnosis of the subluxation.
- This code is listed in every state's Local Coverage Determination and thus is required by every carrier or MAC.

Area of the Spine	Name of Vertebra	ICD-9 Code
Neck	Occiput	739.0
	Cervical	739.1
Back	Thoracic	739.2
Low Back	Lumbar	739.3
Pelvis	ILLII R & L	739.5
Sacral	Sacrum, Coccyx	739.4

Local Coverage Determination The following is taken from the LCD for Illinois. There is similar language in almost every other LCD.

- The neuromusculoskeletal condition necessitating the treatment must be listed as the secondary diagnosis. Local Coverage Determinations are issued by Medicare Administrative Contractors to clarify policy regarding specific services.
- All but six states and Railroad Medicare have LCDs specific for chiropractic.
- Connecticut, New York, North Carolina, South Carolina, Virginia, and West Virginia do not have LCDs specific for chiropractic.
- At the top of each LCD is a section marked "Document Information".
- In that section will be a "Revision Effective Date".
- This date will tell you how current the information is that is in this document.
- You should have a copy of your state's LCD for reference.
- You can find the chiropractic LCD on the Mac's website.
- Or you can find them on my website, www.chiromedicare.net under the resources tab.
- Most LCDs contain the information provided in the Medicare Benefits Policy Manual, Chapter 15, section 240 that is specific to the documentation requirements for chiropractors.
- Some will also contain utilization guidelines for chiropracticThe following is an example from the Illinois LCD:
- Once the maximum therapeutic benefit has been achieved for a given condition, ongoing maintenance therapy is not considered to be medically

necessary under the Medicare program.Other information, such as this on documentation requirements, will be present:

- Documentation supporting the medical necessity of this item, such as ICD-9 codes, must be submitted with each claim. Claims submitted without ICD-9 codes will be denied as being not medically necessary. Documentation in the form of progress notes need not be submitted with each claim but be available upon request.Remember that these are samples from the Illinois LCD.
- Yours may be different.
- This is why you should have a printed copy on hand for your office.Most LCDs contain a list of diagnoses that are to be used for secondary diagnoses.
- These are the only diagnoses to be used for this MAC.
- The list below is from the Illinois LCD.
- Some LCDs break them into sections like this and some do not.
- The Local Carrier Determination (LCD) for a specific state or jurisdiction will list the ICD-9 codes that support medical necessity
- Note: conditions must be coded to the ICD-9 code of highest specificity
- "The precise level of the subluxation must be specified by the chiropractor 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"[3]
- "There are two ways in which the level of the subluxation may be specified in patient's record.
  - The exact bones may be listed, for example: C 5, 6, 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)"[4]

Diagnosis

- Each area of the spine that is adjusted must have a primary and secondary diagnosis to support medical necessity for the adjustment
- The primary diagnosis is derived from the table above
- The secondary diagnosis is derived from the lists below
- The lists are divided into groups that support low, medium, and high levels of care
- Only those diagnoses listed are accepted as support of medical necessity for the adjustment.

[3] Local Carrier Determination L10881
[4] Local Carrier Determination L10881

- **Conditions that generally require short term treatment (**less than 10 treatments**)**[5]

ICD-9 CM Symptom/Condition Codes (Secondary Diagnosis)	Code Description
307.81	Tension Headache
346.00	Classical migraine, without mention of intractable migraine
346.01	Classical migraine, with intractable migraine, so stated
346.10	Common migraine, without mention of intractable migraine
346.11	Common migraine, with intractable migraine, so stated
346.20	Variants of migraine, without mention of intractable migraine
346.21	Variants of migraine, with intractable migraine, so stated
346.80	Other forms of migraine, without mention of intractable migraine
346.81	Other forms of migraine, with intractable migraine, so stated
346.90	Migraine, unspecified, without mention of intractable migraine
346.91	Migraine, unspecified, with intractable migraine, so stated
355.1	Meralgia Paresthetica
721.0	Cervical Spondylosis without myelopathy
721.2	Thoracic Spondylosis without myelopathy
721.3	Lumbosacral spondylosis without myelopathy
721.90	Spondylosis of unspecified site without myelopathy
723.1	Cervicalgia
724.1	Pain in the thoracic spine
724.2	Lumbago
724.5	Backache, unspecified
728.85	Muscle spasm
784.0	Headache

[5] Local Carrier Determination L10881

- **Conditions that generally require moderate term treatment (**20 - 30 treatments)[6]

ICD 9 CM Symptom/Condition Codes (Secondary Diagnosis)	Code Description
353.0	Brachial plexus lesions
353.1	Lumbosacral plexus lesions
353.2	Cervical root lesions
353.3	Thoracic root lesions
353.4	Lumbosacral root lesions
353.8	Other nerve root and plexus disorders
355.0	Lesion of the sciatic nerve

ICD 9 CM Symptom/Condition Codes (Secondary Diagnosis)	Code Description
355.2	Other lesions of femoral nerve
355.8	Mononeuritis of lower limb, unspecified
*719.01-719.09	Effusion of joint
*719.11-719.19	Hemarthrosis
*719.21-719.29	Villonodular synovitis
*719.31-719.39	Palindromic rheumatism
*719.41-719.49	Pain in joint
*719.51-719.59	Stiffness of joint, not elsewhere classified
*719.61-719.69	Other symptoms referable to joint
*719.7	Difficulty Walking
*719.81-719.89	Other specified disorders of joint
720.1	Spinal enthesopathy
722.91	Other and unspecified disc disorder, cervical region
722.92	Other and unspecified disc disorder, thoracic region
722.93	Other and unspecified disc disorder, lumbar region
723.2	Cervicocranial syndrome
723.3	Cervicobrachial syndrome
723.4	Brachial neuritis or radiculitis
723.5	Torticollis, unspecified
724.4	Thoracic or lumbosacral neuritis or radiculitis
724.6	Disorders of sacrum, ankylosis
724.79	Coccygodynia (disorder of coccyx)
724.8	Other symptoms referable to back, facet syndrome
729.1	Myalgia and myositis, unspecified
729.4	Fascitis, unspecified
738.4	Acquired spondylolisthesis
756.11	Spondylosis, lumbosacral region
846.0	Sprains and strains of lumbosacral (joint) (ligament)
846.1	Sprains and strains of sacroiliac ligament
846.2	Sprains and strains of sacrospinatus (ligament)
846.3	Sprains and strains of sacrotuberus (ligament)
846.8	Sprains and strains of sacroiliac region, other specified sites of sacroiliac region
847.0	Sprains and strains of neck
847.1	Sprains and strains of thoracic
847.2	Sprains and strains of lumbar
847.3	Sprains and strains of sacrum
847.4	Sprains and strains of coccyx

[6] Local Carrier Determination L10881

- **Conditions that generally require long term treatment (**more than 30 treatments**)**[7]

ICD 9 CM Symptom/Condition Codes (Secondary Diagnosis	Code Description
721.7	Traumatic Spondylopathy
722.0	Displacement of cervical intervertebral disc without myelopathy
722.10	Displacement of lumbar intervertebral disc without myelopathy
722.11	Displacement of thoracic intervertebral disc without myelopathy
722.4	Degeneration of cervical intervertebral disc
722.51	Degeneration of thoracolumbar intervertebral disc
722.52	Degeneration of lumbosacral intervertebral disc
722.81	Postlaminectomy syndrome, cervical region
722.82	Postlaminectomy syndrome, thoracic region
722.83	Postlaminectomy syndrome, lumbar region
723.0	Spinal stenosis in cervical region
724.01	Spinal stenosis, thoracic region
724.02	Spinal stenosis, lumbar region
724.3	Sciatica
756.12	Spondylolisthesis

- Those states with articles do not have a list of secondary diagnoses to use.
- I have prepared a "Universal Medicare Diagnosis List" that you can download for free at my website www.chiromedicare.net.
- It is in the forms section.

Hierarchy of Diagnosis

- Neurological Diagnosis
  - 724.3 Sciatica
- Structural Descriptor Diagnosis
  - 722.52 Degeneration of Lumbosacral Intervertebral Disc
- Functional Diagnosis
  - 719.7 Difficulty Walking
- Soft Tissue, Extremity, Complicating Factors
  - 847.0 Sprains and Strains of the Neck
- The condition must be coded to the highest level of specificity.
- If the highest level of specificity is "soft tissue" then that is what you code.

[7] Local Carrier Determination L10881

Diagnosis

- 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.
- In other words, the area(s) of chief complaint must be consistent with the area(s) of examination.
- Which must be consistent with the area(s) of adjustment.
- Which must be consistent with the area(s) billed.
- The diagnosis must reflect this.The diagnosis must be consistent with the orthopedic and neurological test findings.
- For example: If you have a diagnosis of Sciatica then you should have a compliant of low back pain with radiation down the leg and positive Laseque's and Braggard's tests.You must have imaging reports to confirm certain diagnoses.
- For example: If you have a diagnosis of Degenerative Disk Disease you should have an x-ray report on file that lists disk thinning and spurring on the vertebral margins.Your diagnosis can be changed as new information becomes available.
- For example: A patient has both low back and cervical diagnoses. At the first re-exam the cervical problem has resolved. It is appropriate to remove the cervical diagnosis from the claim form for services after the re-exam.The diagnosis is part of the Assessment portion of the SOAP notes.
- It is your opinion of what is wrong with the patient.
- The better that you communicate this information to third party payers, the better you will be paid.

Non-Medicare Diagnosis

- Medicare diagnoses usually require that each spinal region have a primary subluxation diagnosis and a secondary neuromusculoskeletal diagnosis (Florida is the exception).
- All other third party payers do not want the subluxation diagnosis as the primary diagnosis. List the appropriate diagnoses in the order of the hierarchy of diagnosis.
- For most third-party payers you are not restricted to a list of diagnoses.
- You can use the appropriate diagnosis from the ICD-9 book.
- Just like with Medicare, you are communicating the patient's condition to the insurance companies computer.
- The more accurately and thoroughly that you diagnose the better that you will be paid and the fewer problems that you will have.

ICD-10

- The implementation deadline for ICD-10 has been changed.
- It is now October 1, 2014.
- The ICD-10 coding system is completely different from the ICD-9 system.
- The ICD-10 codes consist of letter and number combinations up to 10 places.The ICD-10 codes are much more specific than the ICD-9 codes.
- The ICD-10 codes will also serve as both diagnosis codes and procedure codes.
- You need to start familiarizing yourself with the ICD-10 codes now.

Summary

- Medicare is very clear that the doctor is responsible for communicating the patient's condition to them.
- Understanding the diagnosis process and choosing the most accurate and specific diagnoses for that patient will convey the most accurate information to Medicare.Medicare is legally obligated to pay for care that is medically necessary.
- Clear and accurate diagnoses are an important part of proving medical necessity.