

Federal Employees

Federal Workers' Compensation

One of the most confusing claim types handled by doctors of chiropractic is the Federal Workers' Compensation claim. Although the Federal Workers' Compensation Act (FECA) authorizes medical services for treatment of any condition causally related to factors of Federal employment, many doctors of chiropractic have found difficulty in getting their chiropractic claims paid. The reasons for this difficulty are varied. Sometimes doctors of chiropractic assume the Federal Workers' Compensation program is the same as Medicare. This leads to incorrect billing, frustration, and, in some cases, perpetual denials. Sometimes, Federal agencies are not aware of the coverage of chiropractic under the FECA, and inadvertently direct claimants away from the doctor of chiropractic. In this section you will find answers to the questions most doctors of chiropractic wrestle with, as well as guidance in how to ensure your patients' Federal Workers' Compensation claims are handled properly.

Entitlement

Federal employees are entitled to all services, appliances, and supplies prescribed or recommended by qualified physicians which, in the opinion of the Office of Workers' Compensation Programs (OWCP), are likely to cure, give relief, reduce the degree or period of disability, or aid in lessening the amount of monthly compensation. Medical care, under this statute, includes examination, treatment, and related services such as medications and hospitalization, as well as transportation needed to secure these services. Preventive care is not authorized.

Definition of Physician

The term "physician" includes surgeons, osteopathic practitioners, podiatrists, dentists, clinical psychologists, optometrists, and chiropractors within the scope of their practice as defined by state law.

Chiropractic Services

Under the FECA, the services of chiropractors may be reimbursed only for treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist. The term "subluxation" is defined as an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae anatomically which must be demonstrable on any x-ray film to individuals trained in the reading of x-rays. Chiropractors may interpret their own x-rays, and if a subluxation is diagnosed, OWCP will accept the chiropractor's assessment of any disability caused by it. Because doctors of chiropractic are considered physicians under the FECA, it is permissible for a patient to choose a doctor of chiropractic as his/her treating physician.

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Covered Chiropractic Services

Under the FECA, chiropractic services are covered according to medical necessity. The following conditions must apply:

- Three CPT codes are available for use to describe your manipulative services: Chiropractic manipulative treatment (CMT) codes, **98940**, **98941**, and **98942**. CMT code **98940** describes CMT, spinal, one to two regions; **98941** describes CMT, spinal, three to four regions; **98942** describes CMT, spinal, five regions. For a complete description of the proper use of CMT codes, see page 11. Code **98943** is not permitted for use, as this code describes treatment to extraspinal regions, where a subluxation cannot be documented.
- An x-ray must be taken to demonstrate the subluxation. Unlike Medicare, the P.A.R.T. process (see page 211) is **not allowed** in lieu of the x-ray.
- The diagnosis must be subluxation. It is the only diagnosis required on the CMS-1500 billing form. All other related diagnoses should be recorded in your clinical records. The 839.XX series of diagnosis codes are required.

Note: The 739.XX series of diagnosis codes sometimes used with other Federal programs, such as Medicare, are not permissible.

- Radiology and Evaluation and Management (E/M) services are reimbursable for a chiropractor under the FECA. X-rays of the spine are covered provided the diagnosis is subluxation and the subluxation is demonstrable on x-ray. E/M services are covered provided these services are medically necessary. For a description of when it is appropriate to bill an E/M code on the same date as a CMT code, see pages 259.

Authorization to Treat

A claimant has total choice of physician under the Federal Workers' Compensation Act. Since a doctor of chiropractic is designated as a physician under the act, a claimant may choose him/her as the treating physician.

Generally, the first physician a claimant sees will be recorded as the doctor of record for the case. Certain federal agencies may have on-site health clinics where employees may be required to report after an injury for an evaluation and/or treatment. It should be noted that this does not mean the on-site doctor is the doctor of record and retains control of the case. It is still the claimant's choice who he/she will see for treatment of the injury.

If a patient has been seeing another physician, and wants to change to a doctor of chiropractic, proper procedure must be followed. In order to change active treating physicians, a claimant must do the following:

- 1) The claimant must request, in writing, to the claims examiner a change of physicians.
- 2) In the request, they must indicate the reason for the change, which doctor they want to change from, and the name of the doctor they want to change to.
- 3) They must wait for the authorization to be final before seeking treatment from the new doctor. There is no guarantee that any coverage will be provided for the new physician prior to the date of the authorization to change doctors.

The Office of Workers' Compensation Programs indicates that the claims examiner will take all factors into consideration when deciding on a change of doctor request. Keeping in touch with the claims examiner is of the utmost importance. Unfortunately, some claimants will "shop" for doctors who will unnecessarily keep a disability claim open, so claims adjusters carefully scrutinize all change requests.

Proper Reporting

When a claimant is injured, it is mandatory that form CA-1 is filled out by the employee and signed by the supervisor. This form is the first report of injury that is entered into the system to initiate a claim. A claimant has 30 days from the date of injury to file this form.

After reporting the claim, the supervisor should fill out form CA-16, an authorization to treat the claimant. This is the form the claimant brings with him/her to the doctor and the claims office information will be printed on the top.

When a claimant is reporting an occupational disease, such as would occur over time, as opposed to a specific incident, form CA-2 should be filled out. This is most common with repetitive motion type injuries or longer-term disabilities such as black lung disease.

Proper Billing

All bills must be submitted on a CMS-1500 form. There is no Federal guideline given for how frequently you may send billings. However, you must submit all bills within one year of the date of service. **Never, under any circumstances, send the bills to the agency or employer.** Despite what they may say, they have no reason to review the claims. All claims should be forwarded only to the claims examiner at the regional office handling the claim.

Each CMS-1500 form should be filled out completely with all pertinent information filled in each block. Most important is the claim number. This number can be obtained after the claim has been set up, by contacting the regional claims office for your area. The regional claims offices, are listed below.

Each CMS-1500 form should be accompanied by a report of the patient's condition for those dates of service you are billing for. You may submit a written report, or you may submit your clinical notes

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for those dates of service. With the initial claim, include the plan of treatment, exam and x-ray findings, etc. This will give the claims examiner the best possible picture of your assessment of the injury and your findings and plan of treatment. It is vitally important that you include the claimant's name and claim number on every piece of paper submitted. **The CMS-1500 forms are separated from the supporting documentation when they arrive at the claims office. They must have this information on the top, or they will be lost.**

A "clean claim," meaning a claim with no errors, notes attached, and nothing else the claims examiner needs to process it, should be processed within 30 days of the date it was received.

Listed below are the regional claims offices and the states they support.

Employment Standards Administration Office of Workers' Compensation Programs Division of Federal Employees' Compensation

District Office 1—Boston

(Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont)

U. S. Dept. of Labor, OWCP

JFK Federal Building, Room E-260

Boston, MA 02203

617-565-2137

617-565-1931 - Interactive Voice Response System

District Office 2—New York

(New Jersey, New York, Puerto Rico, and the Virgin Islands)

U. S. Dept. of Labor, OWCP

201 Varick Street, Room 740

New York, NY 10014

212-337-2075*

District Office 3—Philadelphia

(Delaware, Pennsylvania, and West Virginia)

U. S. Dept. of Labor, OWCP

Curtis Center, Suite 715 East

170 South Independence Mall West

Philadelphia, PA 19106-3308

215-861-5481, 5482

Fax: 215-861-5453

District Office 6—Jacksonville

(Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee)

U. S. Dept. of Labor, OWCP
214 North Hogan Street, Suite 1006
Jacksonville, FL 32202
904-357-4777
904-357-4778 - Interactive Voice Response System

District Office 9—Cleveland

(Indiana, Michigan, and Ohio)

U. S. Dept. of Labor, OWCP
1240 East Ninth Street, Room 851
Cleveland, OH 44199
216-522-3800
216-522-2867 - Interactive Voice Response System

District Office 10—Chicago

(Illinois, Minnesota, and Wisconsin)

U. S. Dept. of Labor, OWCP
230 South Dearborn Street, Eighth Floor
Chicago, IL 60604
312-353-5656*

District Office 11—Kansas City

(Iowa, Kansas, Missouri, and Nebraska; all employees of the Department of Labor, except Job Corps enrollees, and their relatives)

U. S. Dept. of Labor, OWCP
City Center Square
1100 Main Street, Suite 750
Kansas City, MO 64105
816-426-2195*

District Office 12—Denver

(Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming)

U. S. Dept. of Labor, OWCP
1801 California Street, Suite 915
Denver, CO 80202-2614
303-844-1310*

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District Office 13—San Francisco

(Arizona, California, Hawaii, and Nevada)

U. S. Dept. of Labor, OWCP
71 Stevenson Street
San Francisco, CA 94105
or write to:
P.O. Box 3769
San Francisco, CA 94119-3769
415-975-4090*

District Office 14—Seattle

(Alaska, Idaho, Oregon, and Washington)

U. S. Dept. of Labor, OWCP
1111 Third Avenue, Suite 615
Seattle, WA 98101-3212
206-553-5508*

District Office 16—Dallas

(Arkansas, Louisiana, New Mexico, Oklahoma, and Texas)

U. S. Dept. of Labor, OWCP
525 Griffin Street, Room 100
Dallas, TX 75202
214-767-4707
214-767-4360 - Interactive Voice Response System

District Office 25—Washington, D. C.

(District of Columbia, Maryland, and Virginia; all areas outside the U.S., its possessions, territories, and trust territories; and all special claims)

U. S. Dept. of Labor, OWCP
800 North Capitol Street, N.W., Room 800
Washington, D.C. 20211
202-565-9770* (D.C., Maryland and Virginia)
202-565-6990* (Overseas cases, cases prefixed by two letters)

**The Interactive Voice Response System can also be accessed from this number.*