Appendix
Answer Key & FAQs (Frequently Asked Questions)

Minnie Medders

Exercise 1

Diagnosis Codes

(M99.03) Seg and somatic dysfunction of lumbar reg

(M54.41) Lumbago w/ sciatica, RT side

(M99.05) Seg and Somatic dysfunction of pelvic reg

(M51.37) Other intervertebral disc degeneration, lumbosacral region

(M62.830) Muscle spasm of back

Compensatory Diagnosis found on exam: (M99.01) Seg and somatic dysfunction of cervical region

Exercise 2

Procedure Codes

99204-25-GY

98940-AT

97035-GY-GP

Exercise 3

Diagnoses in Order

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M9903	B. M5441	C. M9905	D. M5137
E. M62830	F.	G.	H.
I.	J.	K.	L.

Exercise 4

Link Diagnosis to Procedure

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 02 03 2023 QUAL:
15. OTHER DATE QUAL: MM DD YY:
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M9903	B. M5441	C. M9905	D. M5137
E. M62830	F.	G.	H.
I.	J.	K.	L.

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER
02	03	23	02	03	23	11		99204	25	GY			A
02	03	02	02	03	23	11		98940	AT				A
02	03	23	02	03	23	11		97035	GY	GP			C

Exercise 5

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: QUAL:
15. OTHER DATE QUAL: 454 MM DD YY: 03 08 22
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM: MM DD YY TO:
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM: MM DD YY TO:
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $CHARGES:
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M9901	B. M542	C. M9902	D. M5134
E.	F.	G.	H.
I.	J.	K.	L.

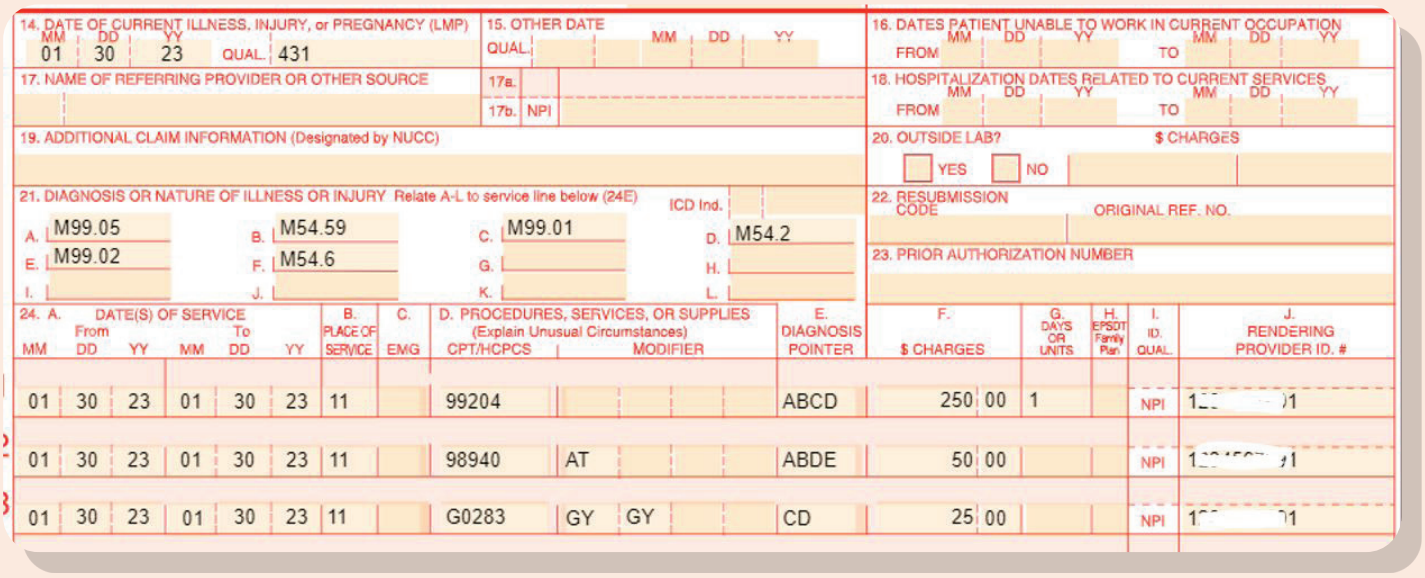
22. RESUBMISSION CODE: ORIGINAL REF. NO.:
23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER			E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
01	04	22	01	04	22	11		98941	AT	GA		ABCD	97.00	1		NPI	1---------6----4
																NPI	

What is wrong with this claim based on Medicare billing guidelines?

1. Missing information in Box 14 and utilizing box 15
2. Diagnosis pointer is pointing to all the diagnoses
3. Modifier AT & GA appended to the same procedure
4. Not enough diagnosis codes to support the 98941
5. Onset date from box 15 is 2 months past when the service was rendered

Exercise 6



14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 30 23 QUAL. 431
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. M99.05 B. M54.59 C. M99.01 D. M54.2
E. M99.02 F. M54.6 G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER			E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
01	30	23	01	30	23	11		99204				ABCD	250 00	1		NPI	1[illegible]1
01	30	23	01	30	23	11		98940	AT			ABDE	50 00			NPI	1[illegible]1
01	30	23	01	30	23	11		G0283	GY	GY		CD	25 00			NPI	1[illegible]1

What is wrong with this claim based on Medicare billing guidelines?

1. Procedure code 99204 is missing required modifiers
2. All services are pointing to more than one diagnosis code.
3. G0283 has duplicate modifiers appended
4. Payer does not require a Qualifier in Box 14

Coding Quiz

1. b
2. d
3. c
4. b
5. c

Medicare FAQs

If a Medicare patient moves from Medical Necessity treatment to Wellness and we have him/her sign an ABN, are we required to continue to bill Medicare with the appropriate modifier or can we convert the patient to cash?

The ABN (Advance Beneficiary Notice) offers three options at the bottom of the form. If the patient selects:

Option 1 - you must bill

Option 2 - you would not bill Medicare

Option 3 – they do not want the service therefore an adjustment is not rendered

You can either elect to charge your patients the allowable/limiting fee set forth by Medicare or you can elect to charge your full office fee. We recommend that you create a policy stating that during maintenance you charge the full fee or the allowable/limiting fee.

Am I required to bill Medicare for statutorily excluded services?

No, not unless the patient requests you to do so. However, if you are in network with the patients' secondary or supplemental plan, then you must determine if those services are covered or non-covered. If the services are covered, you will be required to bill them to Medicare, so that Medicare will cross them over to the patients' secondary or supplemental payer. NOTE: If you are not required

to bill the services, the patient is responsible for your full fee on all statutorily excluded services unless you are part of a medical discount plan such as ChiroHealth USA, or if you are offering a Time-of-Service discount (between 5% and 15%) and the patient is paying in full that day.

How do I bill Medicare for the statutorily excluded services such as exams, therapies and X-rays?

When submitting Medicare claims for statutorily excluded services, each service must have a "GY" modifier. For therapy services, you must include the "GP" modifier (GY GP). The GP modifier is also referred to as the "Always Therapy" modifier. When sending E/M services to Medicare for secondary payer consideration you may want to include the "25" modifier if the E/M service is separate and distinct from the CMT service. E/M services must always have the GY modifier signifying that you realize this is a statutorily excluded service (25 GY).

I am enrolled as a Medicare provider, but I do not accept Medicaid patients. Do the QMB (Qualified Medicare Beneficiary) billing rules still apply to me since it is paid by Medicaid, and I am not enrolled?

Yes, all Medicare providers must abide by the billing protection rules, even providers who DO NOT accept Medicaid. You must refrain from billing the Medicare cost sharing for Parts A and B covered services. Note most states have a special enrollment process for providers who are not in network but must be enrolled in order to file a claim for a QMB patient. Contact your state Medicaid for more details.

Henry Humes

Exercise 7

Locate the type of Medicare Advantage Plan. Once located please select all the statements below that could apply to Henry's plan type.

- ☐ If the provider is out of network with the Medicare Advantage Plan, they would charge the patient their self-pay fee.
- ■ If the provider is out of network and the patient has asked them to file a claim on their behalf the provider would have to abide by the payer's fee schedule and policy requirements.
- ■ If the provider is out of network, and the provider does not want to accept the terms and fee schedule of the insurance payer, they must refer the patient to another provider or encourage the patient to seek care with an in-network provider.
- ☐ Based on this plan type, the provider should have the patient sign an Advance Notice of Non-Coverage and bill them their self-pay fee.
- ☐ If the provider is in network with this payer, the provider can assume that they are in network with all the plan types of that particular payer.
- ■ If the provider is in network, they must abide by the fee schedule outlined by the payer for this particular plan type.

Exercise 8

Diagnosis Hierarchy

(M99.01) Seg and somatic dysfunction of cervical reg

(M50.321) Other cervical disc degeneration C4/5

(M99.03) Seg and somatic dysfunction of lumbar reg

(M51.36) Other intervertebral disc degeneration, lumbar region

(M99.04) Seg and somatic dysfunction of sacral reg

(M47.897) Other spondylosis, lumbosacral region

(M47.892) Other spondylosis, cervical region

(M53.82) Cervical dorsopathy

(M53.86) Lumbar dorsopathy

(M62.830) muscle spasms of the back

Can you locate the Compensatory Diagnosis: (M99.02) Seg and somatic dysfunction of thoracic region

Sample of ChiroTouch EHR (Electronic Health Records)

Today's Treatment:

- **Chiropractic Spinal Adjustments:** Diversified to the left C3, left C4, right C5, L3, L4, right L5, right Sacrum, and right Pelvis spinal level(s).
- **Compensatory Adjustments:** to the T5 and T6 spinal level(s).

- **As per treatment plan - *Hot pack:*** hot moist pack applied to posterior cervical (neck) and lumbar region(s) for 8 minutes.
- **As per treatment plan - *Ultrasound:*** ultrasound with contact medium performed to posterior cervical (neck) region(s) for 10 minutes at a setting of continuous 100% and at 1.0 W/cm2.
- **As per treatment plan - *EMS Unattended:*** interferential EMS applied to lumbar, left and right sacroiliac region(s) for 8 minutes.

Exercise 9

List the procedure codes for this patient case.

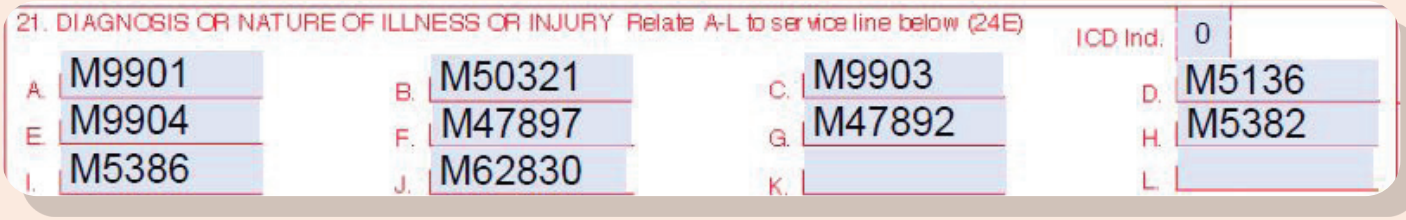
98941-AT

97035-GY-GP

G0283-GY-GP

Exercise 10

Take a closer look at the documentation and fill out the diagnosis as it would appear if entered correctly into the practice management software for Henry.

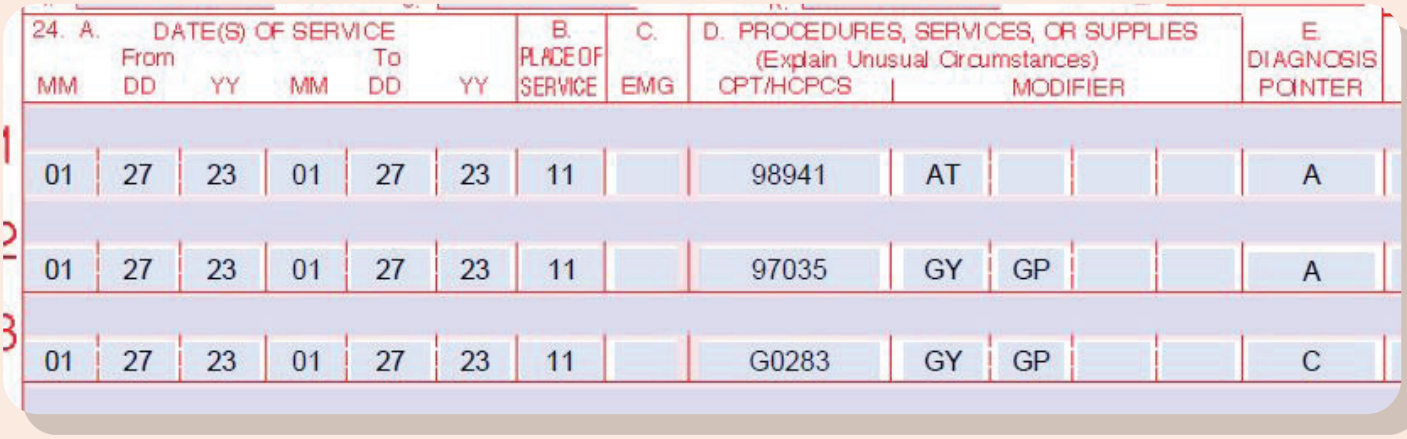


21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 0

A. M9901	B. M50321	C. M9903	D. M5136
E. M9904	F. M47897	G. M47892	H. M5382
I. M5386	J. M62830	K.	L.

Exercise 11

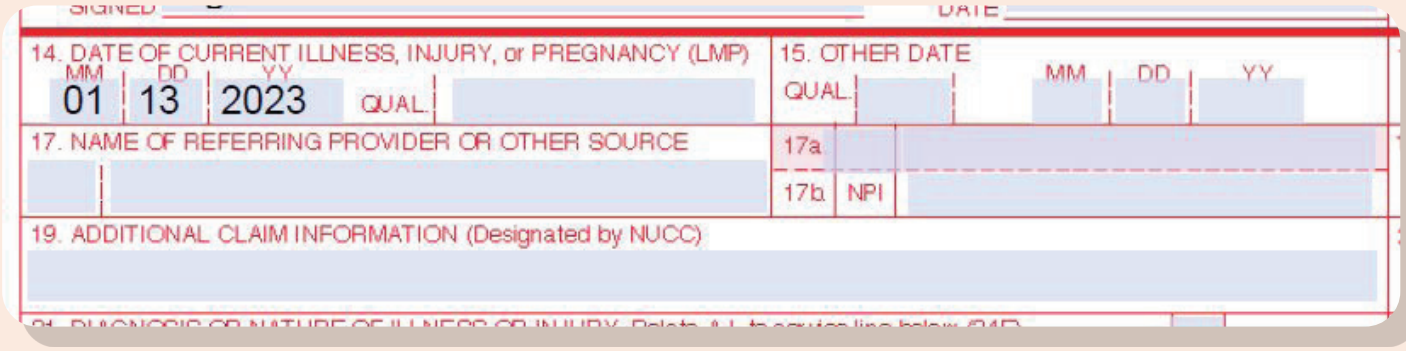
Now it is time to link the diagnosis to the procedure. Enter the letters for each procedure in column E.



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER
01	27	23	01	27	23	11		98941	AT				A
01	27	23	01	27	23	11		97035	GY	GP			A
01	27	23	01	27	23	11		G0283	GY	GP			C

Exercise 12

Based on the documentation, what date should be in Box 14 of the claim form?



SIGNED DATE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 01 DD 13 YY 2023 QUAL

15. OTHER DATE QUAL MM DD YY

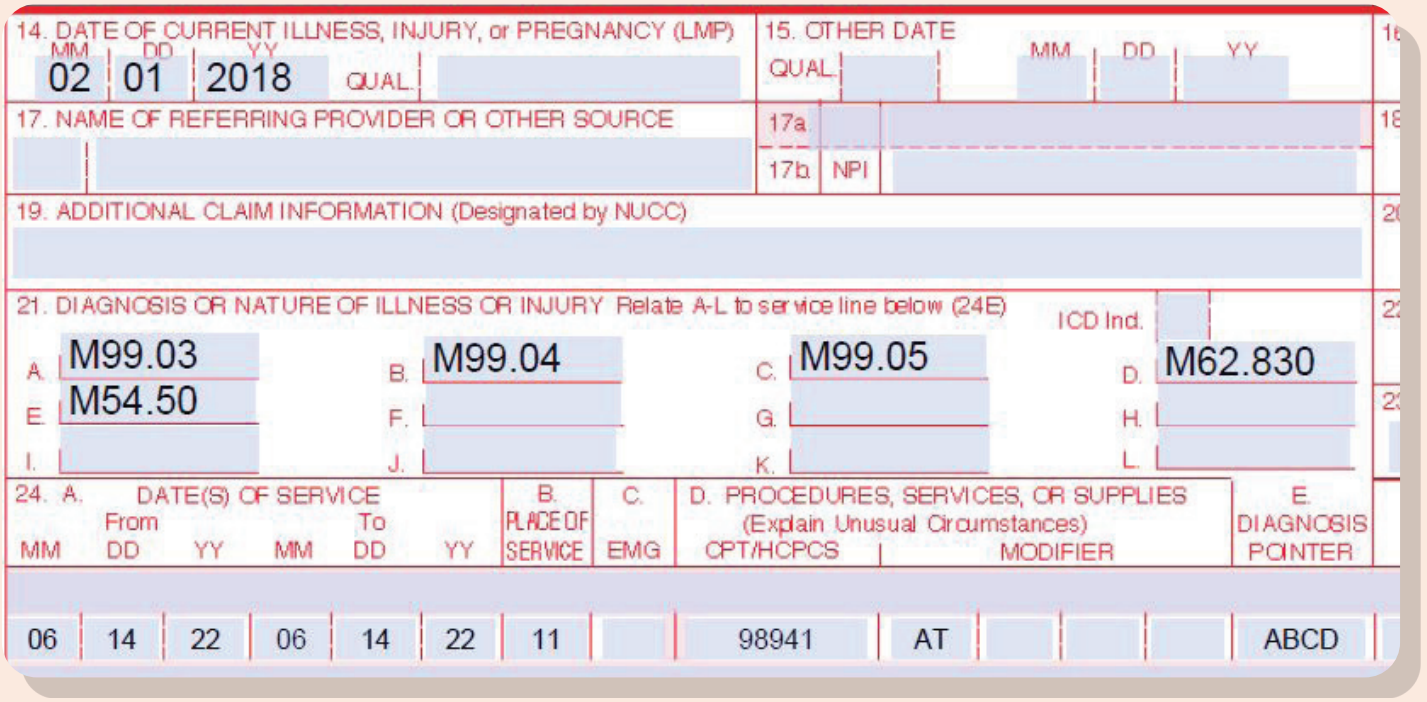
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b NPI

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Exercise 13



14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	QUAL.	15. OTHER DATE QUAL.	MM DD YY
02 01 2018			

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	
	17b. NPI	

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

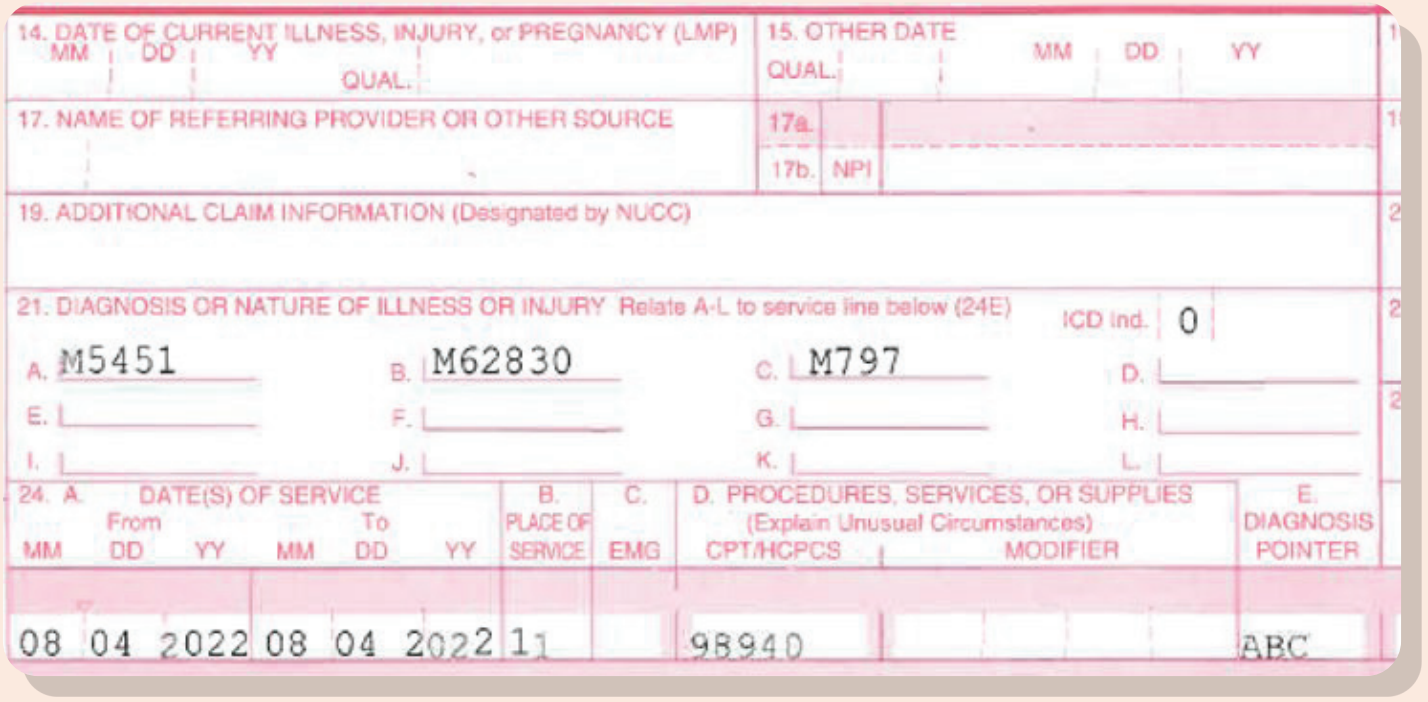
A. M99.03	B. M99.04	C. M99.05	D. M62.830
E. M54.50	F.	G.	H.
I.	J.	K.	L.

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER
06	14	22	06	14	22	11		98941	AT	ABCD

What is wrong with this claim based on Medicare billing guidelines? List below some of the errors you have identified.

1. Diagnosis coupling is wrong
2. Diagnosis pointer is ABCD rather than just A
3. Box 14 is dated 2018 (first time patient was seen in clinic rather than episode)
4. Decimals are utilized in the diagnosis codes

Exercise 14



14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	QUAL.	15. OTHER DATE QUAL.	MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	
	17b. NPI	

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M5451	B. M62830	C. M797	D.
E.	F.	G.	H.
I.	J.	K.	L.

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER
08	04	2022	08	04	2022	11		98940		ABC

What is wrong with this claim based on Medicare billing guidelines? List below some of the errors you have identified.

1. Missing AT modifier
2. Diagnosis is not a subluxation (dysfunction) code
3. Box 14 data missing
4. Diagnosis pointer is more than one letter
5. Missing GY GP modifiers on the 97124 code

Exercise 15

Reviewing the Patient's Coverage – Beneficiary Eligibility Report

1.Does the patient have traditional Medicare or Medicare Advantage for the year 2023? **Medicare Advantage**

2.What is the name of the patient's insurance for the calendar year 2022? **Wellcare Dual Access Open**

3.What is the name of the patient's insurance for the calendar year 2023? **Anthem Maine Health Advantage Dual Plus**

4.Does the patient have a deductible? **No**

5.Does the Medicare Secondary Payer apply? **No**

6.Is there another payer involved for crossover claims? **Yes, Medicaid, Maincare.**

7.Is the patient a QMB? If yes, what is the effective date? Is there a termination date? **Yes, effective date 5/1/2019 and no termination date.**

8.Where should claims be submitted to in 2023? **Medicare Advantage plan**

Medicare Advantage FAQs

Do QMB billing requirements apply to beneficiaries enrolled in all Medicare Advantage plans?

Yes. The QMB billing restrictions apply to all QMB, including those enrolled in Medicare Advantage plans and original Medicare.

Should I use the Medicare Mandatory ABN for Medicare Advantage Plans?

Medicare Advantage plans do not accept traditional Medicare's ABN form. According to CMS, "You should not use the Medicare (CMS) advance written notice of non-coverage for items and services you furnish under the Medicare Advantage Program (Part C). See MLN (Medicare Learning Network®) Matters for additional information: ***https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf***
We advise you to check your contracted MA (Medicare Advantage) plans for further direction on how to handle any required forms for maintenance care or non-covered services.

Kathleen Blue

Exercise 16

Review the sample documentation for Kathleen Blue and list below the procedure codes that best represent the services rendered. Be sure to include any required modifiers. The information you gathered in the intake and verification process should be referenced during this process. Pay close attention to the payer's limitations and documentation requirements when rendering E/M services on the same day as CMT.

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER
02	09	23	02	09	23	11		99213	25
02	09	23	02	09	23	11		98941	
02	09	23	02	09	23	11		97110	GP

Exercise 17

Link the diagnosis to the procedure. Enter the letters for each procedure in column E.

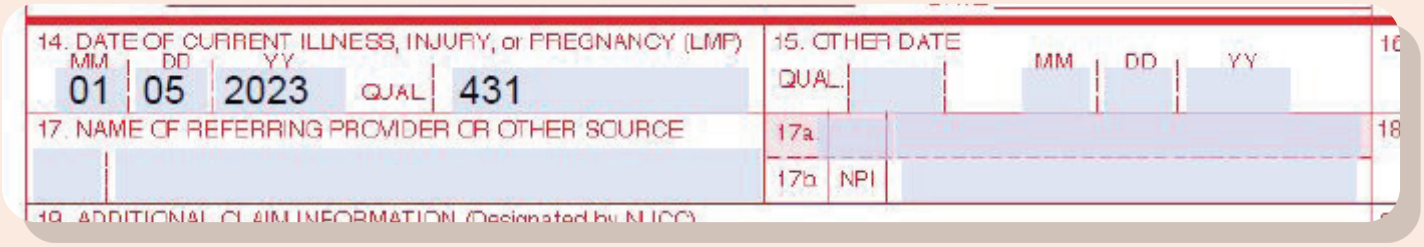
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A.	M50321	B.	M5136	C.	M47892	D.	M47896
E.	M5382	F.	M5386	G.	M9901	H.	M9903
I.	M9904	J.	M62830	K.		L.	

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER
02	09	23	02	09	23	11		99213	25	ABCD
02	09	23	02	09	23	11		98941		GHI
02	09	23	02	09	23	11		97110	GP	ABD

Exercise 18

Based on the documentation, what date should be in Box 14 of the claim form?



Exercise 19

Identify the information in the FAQ (Frequently Asked Questions) & MRP (Medical Review Policy) provided by Kansas BCBS (Blue Cross Blue Shield) that may impact payment from the payer for the Evaluation procedure. Look for anything else that may cause you to edit the claim based on the payer's requirement. Snippets are provided below. Full copies are included with downloads.

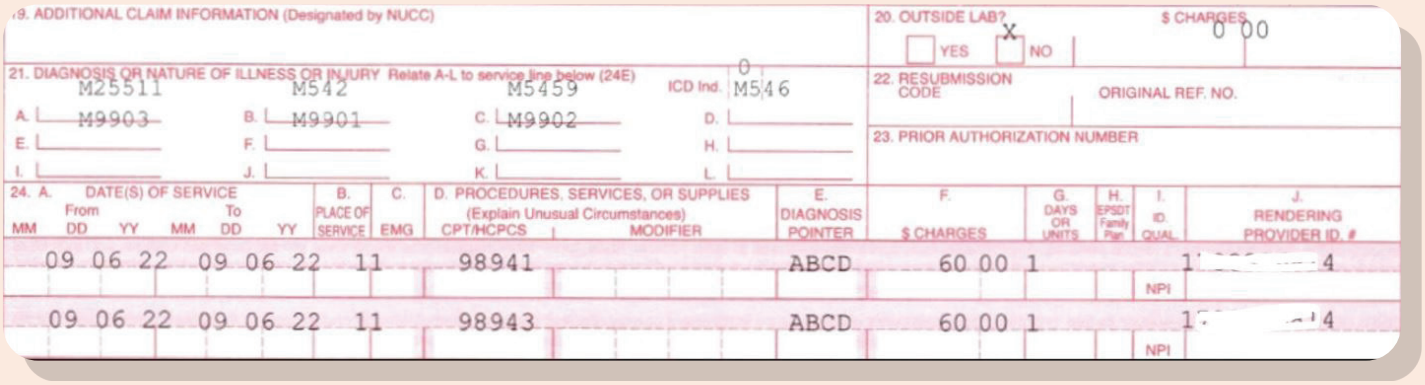
Findings

- Per Appendix B... E/M codes should not be billed in conjunction with any manipulations. With respect to re-exams every 30 days, the medical necessity for a re-exam depends on the patient's condition and response to treatment.
- MRP- E & M s are part of manipulation.
- Physical Medicine Guidelines- Established patient E&M codes should not be billed in conjunction with manipulation. If an established patient E&M is billed in conjunction with the manipulation on the same date of service, the E&M will deny content of service to the manipulation. Use of modifier 25 will not allow the established patient E&M service to pay.
- E&M services can be reported separately on the same date of service as a manipulation if it is for an initial exam of a new patient. Modifier 25 on the E&M is not necessary. The routine use of E&M codes without sufficient documentation is not an appropriate billing practice.

Summary of Actions

1. 99213 will not be covered per the policy. Need to obtain Advance Notice of Non-Coverage or similar signed acknowledgement from the patient.
2. Total time for 97110 must be in the documentation.

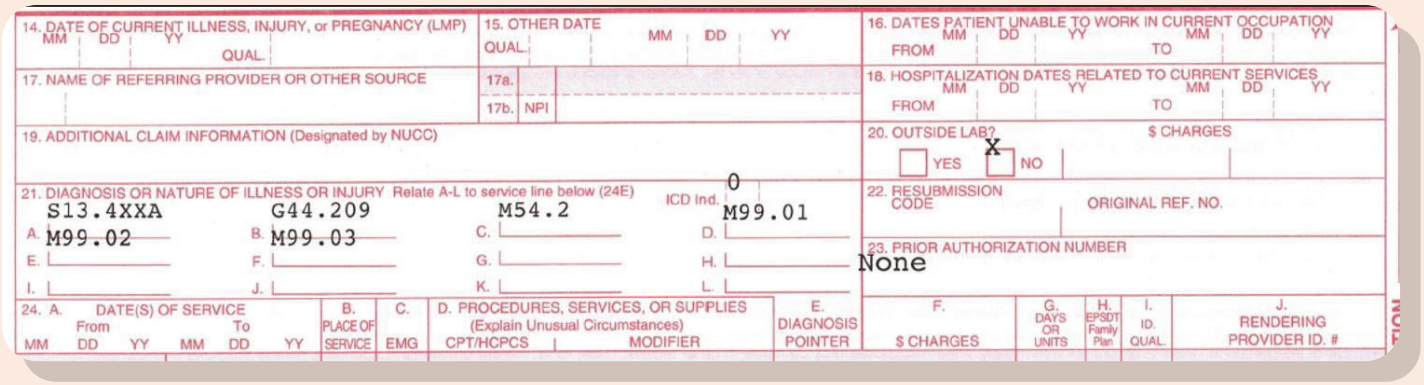
Exercise 20



What is wrong with this commercial claim? List the areas of concern or items that may impact reimbursement.

1. Alignment is off which can impact the payer's ability to process the claim.
2. Procedure code 98943 points to spinal CMT codes. Spinal CMT code points to shoulder pain code.
3. Primary diagnosis is a pain diagnosis. This is a symptom of a condition/dysfunction. Condition should be reported first.

Exercise 21


14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
S13.4XXA G44.209 M54.2 M99.01
A. M99.02 B. M99.03 C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER None
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #

What is wrong with this commercial claim? List the areas of concern or items that may impact reimbursement.

1. Alignment is off which can impact the payer's ability to process the claim.
2. Procedure code 97140 requires 59 modifier or X modifier as well as a GP modifier.
3. Procedure code 97140 points to the same diagnosis as the CMT.
4. Box 14 is empty.

Commercial Insurance FAQs

What does it mean when the insurance says, "PCP referral required"?

Primary care physicians (PCPs) are the gatekeepers of patients' health care within an HMO and a POS (if the patient is using the HMO part of the POS) type of plan. In some instances, a referral from a primary care physician may be required before a patient can seek care from a specialist. Primary care physicians may only refer to specialists in the network.

The insurance said that pre-treatment authorization is necessary. What does that mean?

Pre-treatment authorization (PTA) refers to the insurance plan requirement in which future treatment must be pre-authorized by the insurance company or third-party administrator. This can be done via a phone call to utilization review, via fax on a specific form, or online through the carrier's portal. The requirements for PTA's vary from plan to plan but include the provider's information, the patient's demographics, historical information, examination findings, therapeutic goals, outcome assessments, diagnosis for the request, and the specific treatment plan being requested. Often the carrier requires you to access specific forms for submitting this information.

The doctor asked me if a TPA (Third Party Administrators) managed this patient's insurance plan. What is that?

Most major insurance carriers' contract with Third-Party Administrators (TPA) for Pre-Treatment Authorization (PTA). Third-Party Administrators are agencies that process claims and perform other administrative services in accordance with a service contract for an insurance carrier. Two of the most common TPA's are American Specialty Health (ASH) and OPTUM Health. ASH contracts chiropractic, acupuncture, and physical therapy services for most major carriers.

When a patient has maxed out on their insurance benefits, do I keep submitting to insurance companies and just keep getting the denials, or should I sit down with the patient and switch them to cash?

If you completed a verification of benefits when the patient began treating, you could confirm that the patient was maxed out on benefits. Hopefully during your verification process you were able to confirm the benefit level and set an alert in your practice management software. If you received an EOB (Explanation of Benefits) that indicated that the patient maximum visit limit has been met, it is recommended that you contact the payer to confirm. Once you have confirmed that the benefits have maxed out, you will need to have a conversation with the patient to inform them that the insurance will no longer pay. Should they continue care, they will be fully responsible for all charges after the maxed-out date. Continued billing of the charges depends on two things: the carrier contract and the patient's choice. If your carrier contract states that you must bill for non-covered services, you would need to continue to bill. Also, if the patient has secondary insurance, you will need to submit the claim to the primary insurance in order for the secondary to be able to process it.

When billing BCBS for a Therapeutic Procedure CPT (Current Procedural Terminology) code that starts with a 97, what modifier do I use?

It is our understanding that any Therapeutic procedure Code that starts with a 97 will need to have a GP modifier on it to bill BCBS, please refer to the Medical Review Policy of that BCBS.

I noticed a field on the KMC University Routing Slip that says, "Diagnosis Pointer Instructions." What is that?

This field allows the doctor to alert the persons assigned to entering charges to link a certain procedure with a particular diagnosis (e.g., if a CMT (98940) is rendered along with 97140, the doctor must report the minutes, the location, and the diagnosis for 97140 in order to properly bill the procedure as separate and distinct from the region the CMT was rendered.) On a 1500 claim form this information is placed in Box 24 E, Diagnosis Pointer. The letter listed in this field should match the diagnosis assigned in box 21, Diagnosis.

Self-Pay FAQs

If you have a 100% cash practice, are you legally bound to give superbills or copies of routing slips to patients? I do have an agreement with ChiroHealthUSA, but it's my understanding that patients can still request superbills to submit on their own. Is that correct?

Patients can request copies of their account ledgers and records at any time. This would replace a superbill. There truly is no work around for giving patients something they can submit for reimbursement.

If you charge patients the same amount for all services but do not make them pay the full amount, is that legal? In other words, their insurance runs out and you charge them on the books $122.00 but only make them pay $65.00.

No, this is considered a dual fee schedule. If you are stating that your fees for these services are $122, then you must account for the patient paying the total $122. The only exceptions to this are any contracted fee schedules you have in place, like In Network Participation with an insurance carrier or enrollment in a Discount Medical Plan Organization like ChiroHealthUSA.

We tend to down-code examinations for my cash patients, but I am beginning to see more and more of them. Do I have any issues doing this?

Yes! You should always code what you do with the most appropriate CPT code that describes the procedure. Down-coding is just as big a red flag as many other poor coding techniques. It's more appropriate to set your fee schedule in a way that is legal and fair, code properly, and get reimbursed fairly for the work you are doing. There are ways to do this right. Maybe you need to use a Discount Medical Plan Organization (DMPO), like ChiroHealthUSA, to set an appropriate fee schedule for uninsured and under-insured patients. The best way to restructure and investigate your fees is by starting with your actual fees, getting those right, then working toward your contracted fees, your discounted fees, and then your hardship policy. You can do this legally and compliantly, and practice with ease while coding correctly!

Is it legal if I offer care plans with discounts based on how many visits the patient purchases that may eventually provide the equivalent of a free visit?

According to the Office of Inspector General (OIG), care plans that incentivize the patient to purchase more visits are an inducement violation. A modest Time of Service discount of 5-15% (or state limit if different) can be offered to patients for services not covered by insurance that are paid when the services are rendered.