Be Brilliant with the Front Office Basics: The Key to Better Reimbursement and Lower Risk

Presented by:

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Please Note!

- The views and opinions expressed in this presentation are solely those of the author, Kathy Mills Chang.
- Kathy and/or KMC University does not set practice standards
- We offer this only to educate and inform
- Medicare information provided today is not new and is available in the public domain

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The Reality of Truth According to KMC

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"We All Have to Decide for Ourselves How Much Sin We Can Live With"

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"We All Have to Decide for Ourselves How Much ~~Sin~~ Risk We Can Live With"

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Know the Rules that Govern Healthcare

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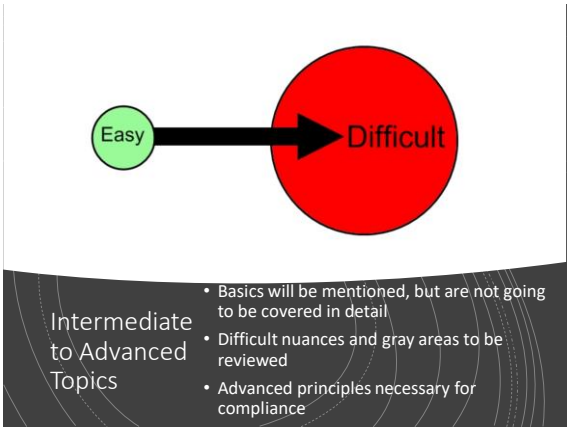

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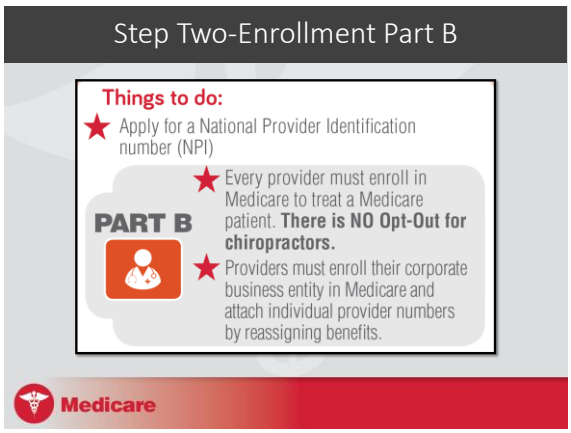

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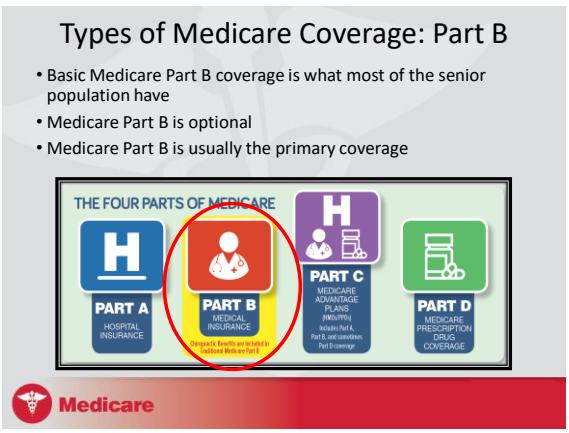

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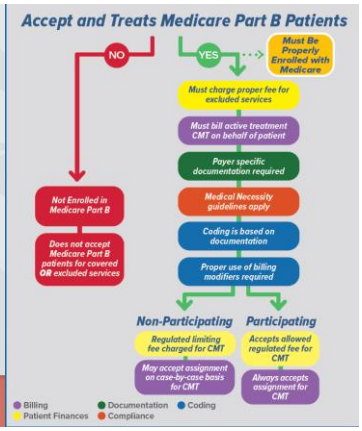
Obligations of DCs When Agreeing to Accept and Treat Medicare Part B Patients



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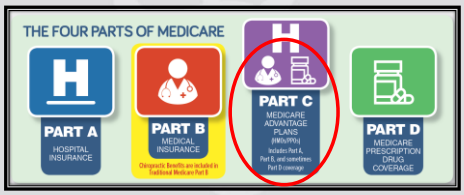
Types of Medicare Coverage: Part C

- Also known as Medicare Advantage Plans or Replacement Plans— "Managed Care Medicare"
- Redirects benefits to a private carrier
- No Part A or B



Medicare

20

Step Three-Enroll in Part C Plans if Desired

PART C

Decide whether to enroll with other Medicare Part C carriers. Some Part C plans may include additional coverage beyond the three covered CMT services. **NOTE:** Patients who are enrolled in a Part C plan in which you do not participate are treated as any other cash paying patient.

Medicare

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Obligations of DCs When Agreeing to Accept and Treat Medicare Part C Patients

Medicare

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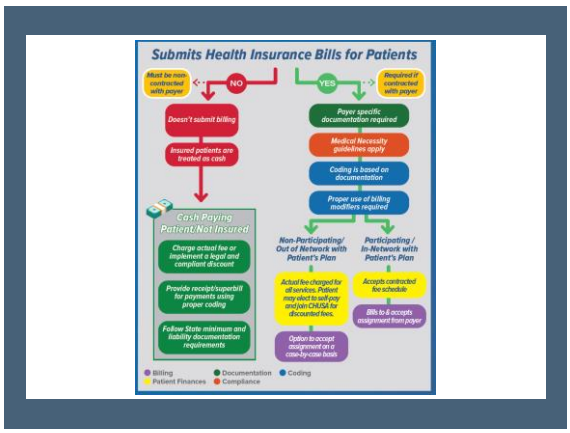

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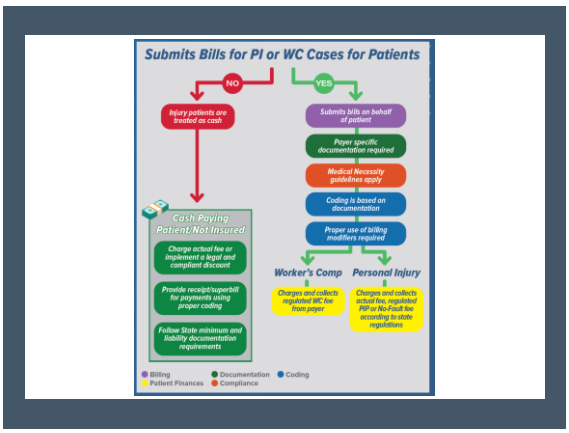

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The Life Cycle of the Patient-Advanced Med Nec

- History
- Treatments performed
- Rationale for therapy
- Release dates from MN care
- Maintenance treatments
- Returns to MN care
- Everything that relates to how their health is managed by your office

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What Medicare Payers Want to See

- Prove Medical Necessity
- Cause and start date
- End date of care
- Diagnosis match patient complaints, does that match billing and coding
- Is patient on/following a treatment plan?

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Your Patient's Flow Under Care

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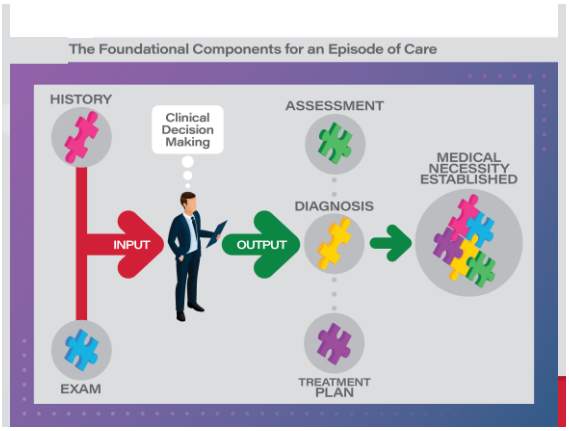

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Medicare Documentation Guidelines in the Absence of Others

Initial Visit
- History
- Description of Present Illness
- Physical Exam
- Diagnosis
- Treatment Plan
- Date of initial treatment

Subsequent Visits
- History
- Review of chief complaint
- Physical Exam
- Document daily treatment
- Progress related to treatment goals/plan

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Understand and Implement Medical Necessity Definitions

The definition of Medical Necessity, per Medicare, is: 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.

Medicare

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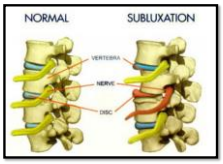
The Opposite of Active Treatment

Maintenance therapy is defined (per Chapter 15, Section 30.5.B. of the Medicare Benefits Policy Manual) as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition.



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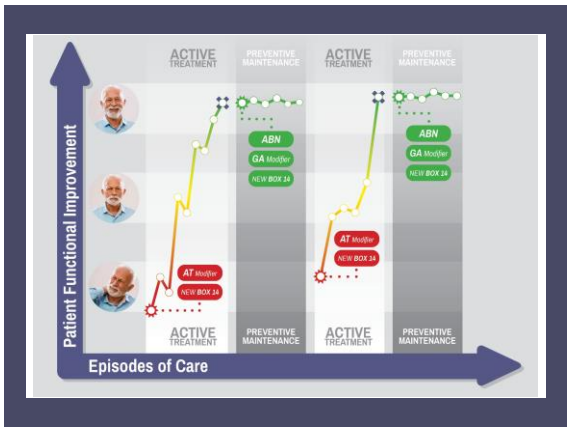

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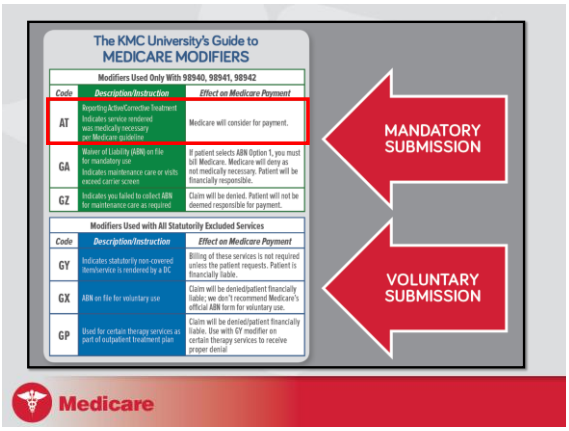

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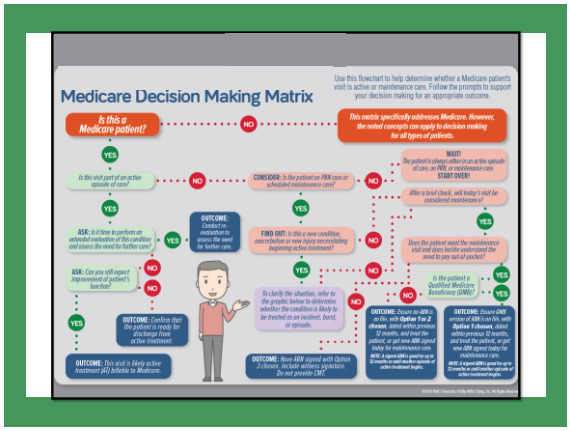

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Receiving a Response to Your Claim

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The Four Categories for Sorting Mail

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Downloads

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Workshop Exercise

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Workbook Exercise #1

Exercise 1

Sort the Mail. Please select the number that best describes each of the mail items below. Place the corresponding number in the space provided next to each statement.

1. Doctors Mail 2. Items to post or process 3. Reactive/Follow-Up Call 4. Reactive/Follow-Up Action

a. A Blue Cross and Blue Shield letter saying that the patient is not a covered beneficiary. ____

b. An EOB (Explanation of Benefits) from Aetna with a list of claims paid. ____

c. Medicare letter saying that the MBI (Medicare Beneficiary Identifier) does not match the patient's name on the claim form.____

d. Workers' Compensation carrier letter requesting office notes for select days of service. ____

e. A credit card bill addressed to the doctor. ____

f. A request for records from Geico Insurance for a personal injury claim. ____

g. An envelope addressed to the doctor with the word personal on the outside. ____

h. Remittance Advice from State Farm Insurance for a personal injury claim. ____

i. A written request from a patient for a copy of their entire medical record. ____

j. A letter from the Chiropractic Board addressed to the doctor. ____

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Exercise 1 Answer Key

a. A Blue Cross and Blue Shield letter saying that the patient is not a covered beneficiary. 3

b. An EOB (Explanation of Benefits) from Aetna with a list of claims paid. 2

c. Medicare letter saying that the MBI (Medicare Beneficiary Identifier) does not match the patient's name on the claim form. 4

d. Workers' Compensation carrier letter requesting office notes for select days of service. 4

e. A credit card bill addressed to the doctor. 1

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Exercise 1 Answer Key

f. A request for records from Geico Insurance for a personal injury claim. 4

g. An envelope addressed to the doctor with the word personal on the outside. 1

h. Remittance Advice from State Farm Insurance for a personal injury claim. 2

i. A written request from a patient for a copy of their entire medical record. 4

j. A letter from the Chiropractic Board addressed to the doctor. 1

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Three More Folders to Create

Start with Mail Sorting Folders

Create Three Follow-Up Folders (utilized after you start the posting process)

Make sure all the reactive items from the initial sorting process have been handled. If not, these will find a new home in the after posting folders.

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Follow Up After Posting

1. **Reactive items that require a follow-up call** - A call item can be something that requires a call back for clarification or resolution. These might be able to be carried out via the payer's portal. This could be an unjustified denial, an underpayment or other claim item that may need reconsideration by the payer. Transfer the date-stamped item that requires a call-back to the appropriate folder or bin. Always place the latest items in the back of the folder or the bottom of the bin to maintain a fair and efficient queue. That allows you to resolve issues in the order they are received.
2. **Reactive items that require further action** - An action item can be something that requires you to gather supporting documentation, fax notes, or print a claim. This could be a records request, a form to be filled out, or an authorization form. These items are usually emptied each day. If there are items left over from previous days, always place any new items in the back of the folders, or the bottom of the bins.
3. **Pending Items** - The pending items folder or bin is used to house paper notes and copies of EOBs for easy follow up access (e.g., notes for pending EOBs are stored in this folder/bin until you resolve the issue). We like to call them the 'problem children' cases. Remember, in most cases you have already carried out a call or action for these, now you are waiting to follow up.

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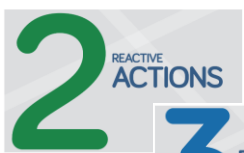
Downloads



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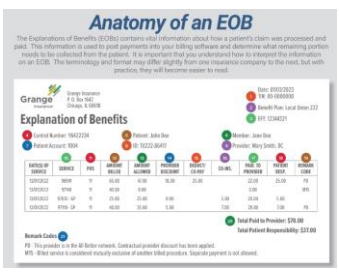
The Anatomy of an EOB



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Workshop Exercise

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Exercise 2

Which of the following statements is true about the Anatomy of an EOB sample? Circle your answer.

A) The patient is responsible for $15.00

B) The patient is responsible for $22.00

C) The patient is responsible for $37.00

D) The patient is responsible for $12.00

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Time to Complete

51

Answer Key

5 Patient: John Doe
8 ID: TU222-86417
6 Member: Jane Doe
9 Provider: Mary Smith, DC

12 AMOUNT BILLED	13 AMOUNT ALLOWED	14 PROVIDER DISCOUNT	15 DEDUCT/ CO-PAY	16 CO-INS.	17 PAID. TO PROVIDER	18 PATIENT RESP.	19 REMARK CODE
65.00	47.00	18.00	25.00		22.00	25.00	PD
40.00	0.00				0.00		M15
25.00	25.00	0.00		5.00	20.00	5.00	
40.00	35.00	5.00		7.00	28.00	7.00	PD

20 Total Paid to Provider: $70.00

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Exercise 3

a. What is the contractual write-off for procedure code 98941 according to the Anatomy of an EOB sample?

$_____._____

b. What is the amount allowed by the insurer for procedure code 97110 according to the Anatomy of an EOB sample?

$_____._____

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Exercise 3

a. What is the contractual write-off for procedure code 98941 according to the Anatomy of an EOB sample?

$ 18.00

10 DATE(S) OF SERVICE	SERVICE	11 POS	12 AMOUNT BILLED	13 AMOUNT ALLOWED	14 PROVIDER DISCOUNT	15 DEDUCT/ CO-PAY	16 CO-INS.	17 PAID. TO PROVIDER	18 PATIENT RESP.	19 REMARK CODE
12/01/2022	98941	11	65.00	47.00	18.00	25.00		22.00	25.00	PD
12/01/2022	97140	11	40.00	0.00				0.00		M15
12/01/2022	97012 - GP	11	25.00	25.00	0.00		5.00	20.00	5.00	
12/01/2022	97110 - GP	11	40.00	35.00	5.00		7.00	28.00	7.00	PD

Amount Billed – Amount Allowed = Contractual Write Off

Answer Key

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Exercise 3

a. What is the contractual write-off for procedure code 98941 according to the Anatomy of an EOB sample?

$ 18.00

b. What is the amount allowed by the insurer for procedure code 97110 according to the Anatomy of an EOB sample?

$ 35.00

4 Control Number: Y6422234 | 6 Patient: John Doe | 5 Member: Jane Doe
7 Patient Account: 1004 | 8 ID: TI2222-86417 | 9 Provider: Mary Smith, DC

10 DATE(S) OF SERVICE	11 SERVICE	12 POS	13 AMOUNT BILLED	14 AMOUNT ALLOWED	15 PROVIDER DISCOUNT	16 DEDUCT/ CO-PAY	17 CO-INS.	18 PAID. TO PROVIDER	19 PATIENT RESP.	20 REMARK CODE
12/01/2022	98941	11	65.00	47.00	18.00	25.00		22.00	25.00	PD
12/01/2022	97140	11	40.00	0.00				0.00		M15
12/01/2022	97012 - GP	11	25.00	25.00	0.00		5.00	20.00	5.00	
12/01/2022	97110 - GP	11	40.00	35.00	5.00		7.00	28.00	7.00	PD

Amount Billed – Contractual Write Off = Amount Allowed

Answer Key

55

10 DATE(S) OF SERVICE	11 SERVICE	12 POS	13 AMOUNT BILLED	14 AMOUNT ALLOWED	15 PROVIDER DISCOUNT	16 DEDUCT/ CO-PAY	17 CO-INS.	18 PAID. TO PROVIDER	19 PATIENT RESP.	20 REMARK CODE
12/01/2022	98941	11	65.00	47.00	18.00	25.00		22.00	25.00	PD
12/01/2022	97140	11	40.00	0.00				0.00		M15
12/01/2022	97012 - GP	11	25.00	25.00	0.00		5.00	20.00	5.00	
12/01/2022	97110 - GP	11	40.00	35.00	5.00		7.00	28.00	7.00	PD

The Zero Pay Line Item

- 97140 has 0.00 in the amount allowed column and 0.00 in the Paid to Provider Column
- Locate the Remark Code for this line item for a better understanding as to why the claim was not paid

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Remark Code- What does it tell us?

10 DATE(S) OF SERVICE	11 SERVICE	12 POS	13 AMOUNT BILLED	14 AMOUNT ALLOWED	15 PROVIDER DISCOUNT	16 DEDUCT/ CO-PAY	17 CO-INS.	18 PAID. TO PROVIDER	19 PATIENT RESP.	20 REMARK CODE
12/01/2022	98941	11	65.00	47.00	18.00	25.00		22.00	25.00	PD
12/01/2022	97140	11	40.00	0.00				0.00		M15
12/01/2022	97012 - GP	11	25.00	25.00	0.00		5.00	20.00	5.00	
12/01/2022	97110 - GP	11	40.00	35.00	5.00		7.00	28.00	7.00	PD

21 Remark Codes

PD - This provider is in the All Better network. Contractual provider discount has been applied.

M15 - Billed service is considered mutually exclusive of another billed procedure. Separate payment is not allowed.

20 Total Paid to Provider: $70.00
Total Patient Responsibility: $37.00

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Workshop Exercise

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Exercise 4

Why do you think the procedure code 97140 was not paid on this EOB? Please state the reason and provide your opinion as to what that remark code means. This is where you put on your detective hat to find out why it was denied.

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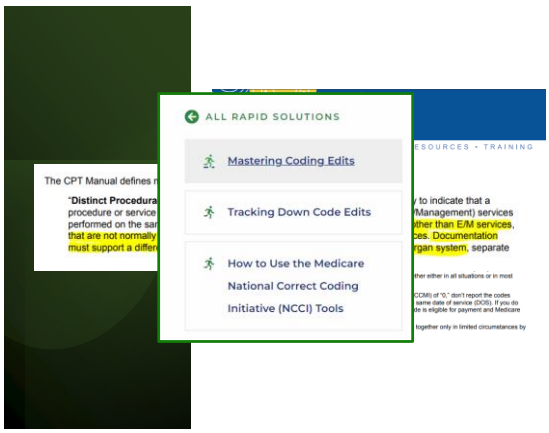

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Answer Key

Coding 97140 QuickTip: When billing code 97140 in addition to CMT on the same visit, the two services must have been performed on separate anatomic sites. Use modifier 59 with code 97140 to indicate that this was a separate and distinct procedure from the CMT. Check with each non-Medicare carrier to determine whether they require the new subset modifiers XE, XS, XP, and XU. (See Modifiers Section.)

in the code description. Also, it appears the provider performed 98941. Since the manual therapy must be in a separate organ/structure or body region it is unlikely that there are many regions left in order to perform manual therapy. Granted it could have been performed in an extraspinal region, but audits have shown that a majority of doctors perform and document manual therapy and CMT in the same region when billed this way. Even with the modifier, this claim would probably result in a request for supporting documentation since the payer cannot see the written documentation at this point. The modifiers and procedure codes are what tells the story on the initial submission.

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Follow-Up Task

Documentation that Supports 97140

- Include the reason for performing 97140 (the need)
- Document treatment goals associated with the manual therapy services
- Include objective and measurable goals
- Document progression toward treatment goals
- Clearly identify the region(s) treated with manual therapy

2 REACTIVE ACTIONS

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Exercise Your Posting Skills

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EOBs & Remittance Advice Vary Between Payer Classes

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Meet Your Patients

- Minnie Medders
- Henry Humes
- Kathleen Blue

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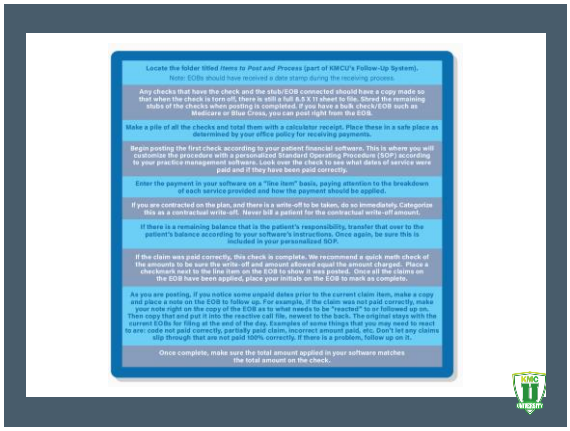

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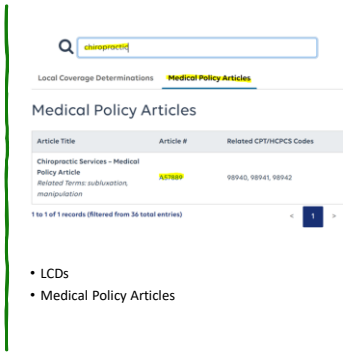
Finding the Coverage Documents



- LCDs
- Medical Policy Articles

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Minnie Medders' Data Gathering

- Traditional Part B Medicare
- Eligibility Check completed
- Located MAC Portal and confirmed the following:
  - Medicare Primary Status (MSP)
  - QMB Status
  - Not a Medicare Advantage Plan
- Located the Local Coverage Article for this beneficiary

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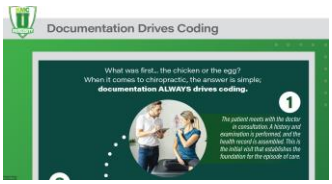
Document FIRST then Code **The Compliant Way**



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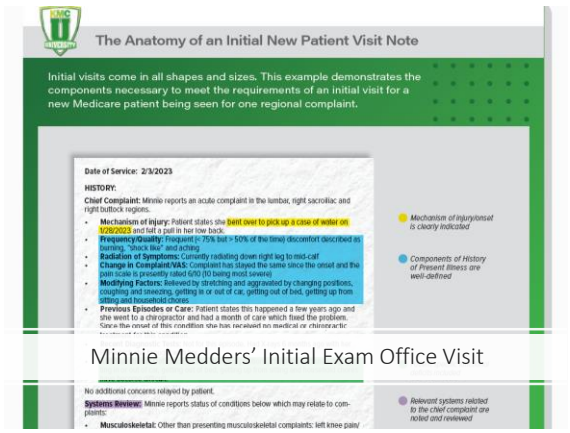

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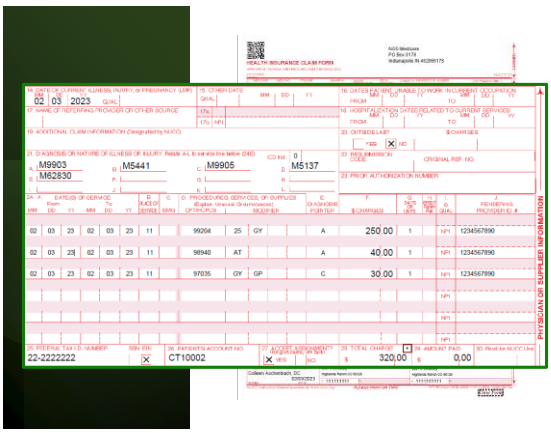

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The Collections Stage

Medders, Minnie

Begin Service Date	End Service Date	Rendering NPI	POS	Units	Procedure Code	Modifiers	Billed Amount	Allowed Amount	Deductible	Copay Coinsurance	Adjust Codes	Paid to Provider	Remark Code
020323	020323	1234567890	11	1	99204	25, GY	250.00	0.00	0.00	0.00	PR	0.00	96, N425
020323	020323	1234567890	11	1	98940	AT	40.00	27.46	27.46	0.00	CO 45	0.00	
020323	020323	1234567890	11	1	97035	GY, GP	30.00	0.00	0.00	0.00	PR	0.00	96 , N425

CO	Contractual Obligation
PR	Patient Responsibility
45	Charge exceeds fee schedule/ maximum allowable
96	non-covered charges
N425	Statutorily Excluded service(s)

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Workshop Exercise

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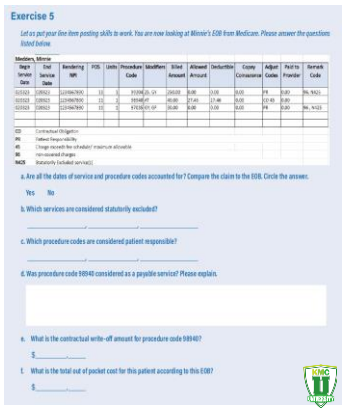
Line Item Posting



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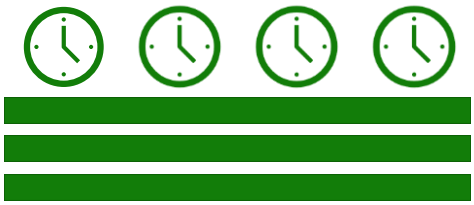
Time to Complete



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Answer Key

a. Are all the dates of service and procedure codes accounted for? Compare the claim to the EOB. Ci… r.

Yes No

b. Which services are considered statutorily excluded?

99204, 97035

Remark Code
96, N425
96 , N425

c. Which procedure codes are considered patient responsible?

99204, 98940, 97035

d. Was procedure code 98940 considered as a payable service? Please explain.

Yes, per the AT modifier and the fact that it was applied to the patient's deductible.

Procedure Code	Modifiers	Billed Amount	Allowed Amount	Deductible	Copay Coinsurance	Adjust Codes	Paid to Provider	Remark Code
99204	25, GY	250.00	0.00	0.00	0.00	PR	0.00	96, N425
98940	AT	40.00	27.46	27.46	0.00	CO 45	0.00	
97035	GY, GP	30.00	0.00	0.00	0.00	PR	0.00	96 , N425

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Answer Key

e. What is th… 98940?

$ 12.5…

MEDICARE MODIFIERS

Modifiers Used Only With 98940, 98941, 98942

Modifier	Description/Instruction	Effect on Medicare Payment
AT	Reporting Active/Corrective Treatment Indicates service rendered was medically necessary per Medicare guideline	Medicare will consider for payment.
GA	Waiver of Liability (ABN) on file for mandatory use Indicates maintenance care or visits exceed carrier screen	If patient selects ABN Option 1, you must bill Medicare. Medicare will deny as not medically necessary. Patient will be financially responsible.
GZ	Indicates you failed to collect ABN for maintenance care as required	Claim will be denied. Patient will not be deemed responsible for payment.

Modifiers Used with Statutorily Excluded Services

Modifier	Description/Instruction	Effect on Medicare Payment
GY	Indicates statutorily non-covered item/service is rendered by a DC	Billing of these services is not required unless the patient requests. Patient is financially liable.
GX	ABN on file for voluntary use	Claim will be denied/patient financially liable; we don't recommend Medicare's official ABN form for voluntary use.
GP	Services delivered under an outpatient physical therapy plan of care	Use on PT modalities and procedures, along with GY to receive proper denial.

Medders, Minnie

Begin Service Date	End Service Date	Rendering NPI	PC…	…djust Codes	Paid to Provider	Remark Code
020323	020323	1234567890			0.00	96, N425
020323	020323	1234567890		2 45	0.00	
020323	020323	1234567890			0.00	96 , N425

CO	Contractual Obligation
PR	Patient Responsibility
45	Charge exceeds fee schedule/ m…
96	non-covered charges
N425	Statutorily Excluded service(s)

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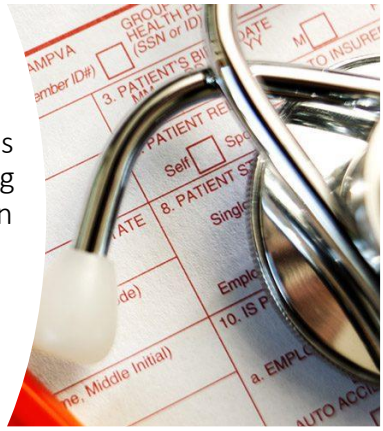
Foundations of the Billing & Collection Process

Part 2



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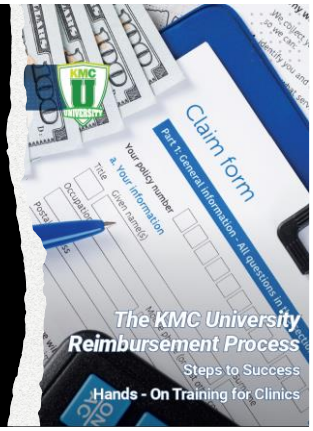
The KMC University Reimbursement Process

- Workbook contains an overview of key topics
- Includes several exercises that will be completed during the workshop
- Answers & additional references are in the Appendix



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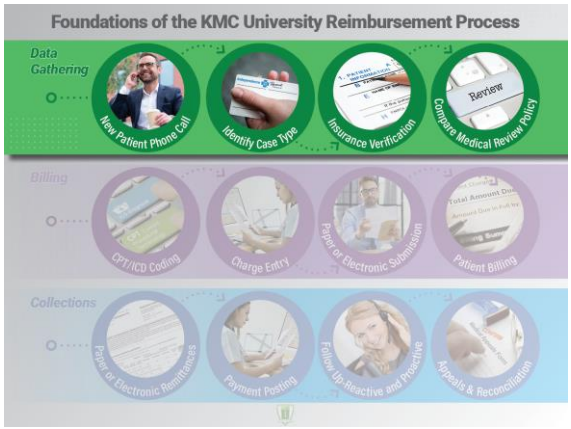


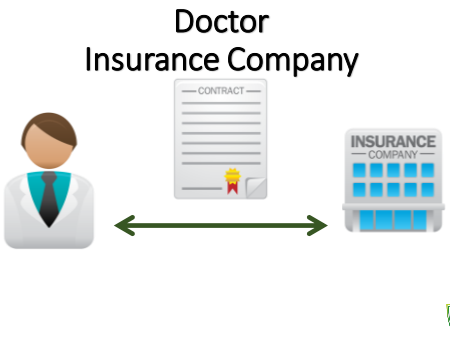
81

82

Foundations of the Reimbursement Process

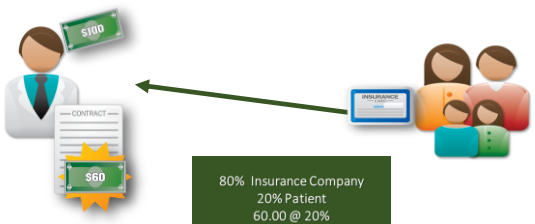
- The New Patient Phone Call is a foundational piece of data gathering
- Staff members must be trained to identify insurance cards properly- the Plan type does matter (POS, PPO, HMO, ASO, PFFS)
- Verification is not the same as an eligibility check
- Insurance Verification is necessary not just for better reimbursement; it can reduce compliance related risk
- The Medical Review Policy (MRP) is a critical component to successful billing
- Team members must implement a Good Faith Estimate process based on the No Surprises Act
- Payer Portal registration is the (not so new) communication tool for successful billing

83



84

Patient & Doctor

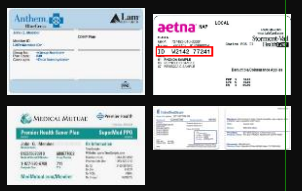


80% Insurance Company
20% Patient
60.00 @ 20%
Patient Portion
$12.00

85

The Patient's Insurance Card

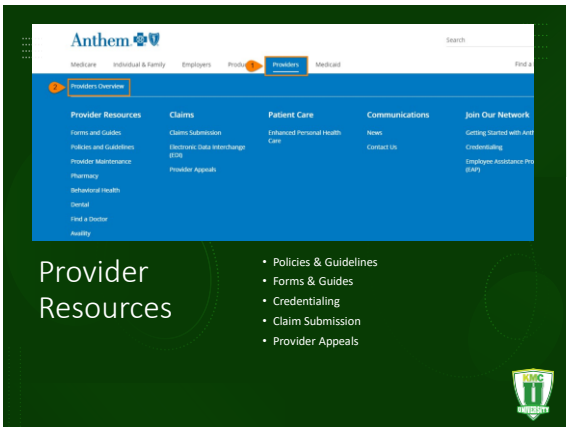
- Identify Type of Plan
- Provider's Network Status
- Confirm address for claim submission
- Confirm patient is eligible and active
- Fill out a Verification Form for the Verification Process



86

Payer Relationships

87



Provider Resources

- Policies & Guidelines
- Forms & Guides
- Credentialing
- Claim Submission
- Provider Appeals

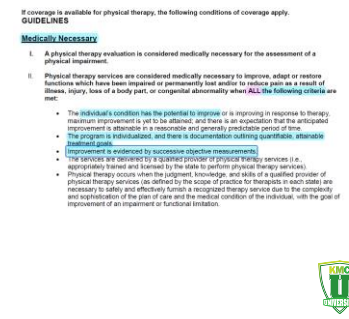
88

Coverage Details

89

90

Medical Necessity Requirements


If coverage is available for physical therapy, the following conditions of coverage apply.
GUIDELINES

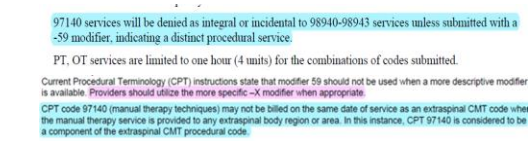
Medically Necessary

I. A physical therapy evaluation is considered medically necessary for the assessment of a physical impairment.

II. Physical therapy services are considered medically necessary to improve, adapt or restore functions which have been impaired or permanently lost and/or to reduce pain as a result of illness, injury, loss of a body part, or congenital abnormality when ALL the following criteria are met:

- The individual's condition has the potential to improve or is improving in response to therapy, maximum improvement is yet to be attained, and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.
- Improvement is evidenced by successive objective measurements.
- The services are delivered by a qualified provider of physical therapy services (i.e., appropriately trained and licensed by the state to perform physical therapy services).
- Physical therapy occurs when the judgment, knowledge, and skills of a qualified provider of physical therapy services (as defined by the scope of practice for therapists in each state) are necessary to safely and effectively furnish a recognized therapy service due to the complexity and sophistication of the plan of care and the medical condition of the individual, with the goal of improvement of an impairment or functional limitation.

91


97140 services will be denied as integral or incidental to 98940-98943 services unless submitted with a -59 modifier, indicating a distinct procedural service.

PT, OT services are limited to one hour (4 units) for the combinations of codes submitted.

Current Procedural Terminology (CPT) instructions state that modifier 59 should not be used when a more descriptive modifier is available. Providers should utilize the more specific –X modifier when appropriate.

CPT code 97140 (manual therapy techniques) may not be billed on the same date of service as an extraspinal CMT code when the manual therapy service is provided to any extraspinal body region or area. In this instance, CPT 97140 is considered to be a component of the extraspinal CMT procedural code.

Payer Specific Modifier Guidance

92

One Stop Shopping Resources

93

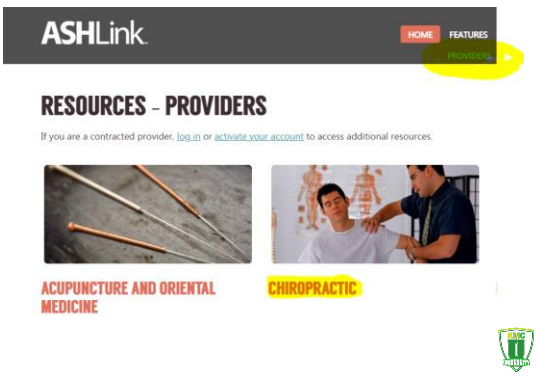
Availity

Availity is where healthcare connects
Payer-provider collaboration starts here!

One stop log in to access a variety of payer portals

Payer Collaboration Sites

94


ASHLink

HOME FEATURES PROVIDERS

RESOURCES - PROVIDERS

If you are a contracted provider, log in or activate your account to access additional resources.

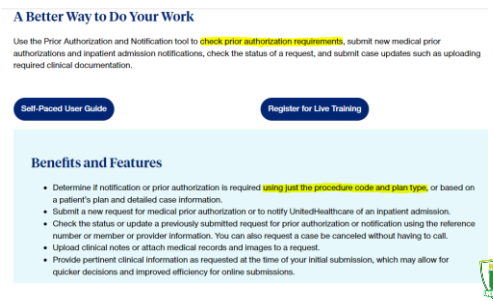
ACUPUNCTURE AND ORIENTAL MEDICINE

CHIROPRACTIC

95

MANAGED CARE
UHC Prior Authorization Resources

Enter Procedure Code and Plan Type with the Prior Authorization Tool


A Better Way to Do Your Work

Use the Prior Authorization and Notification tool to check prior authorization requirements, submit new medical prior authorizations and inpatient admission notifications, check the status of a request, and submit case updates such as uploading required clinical documentation.

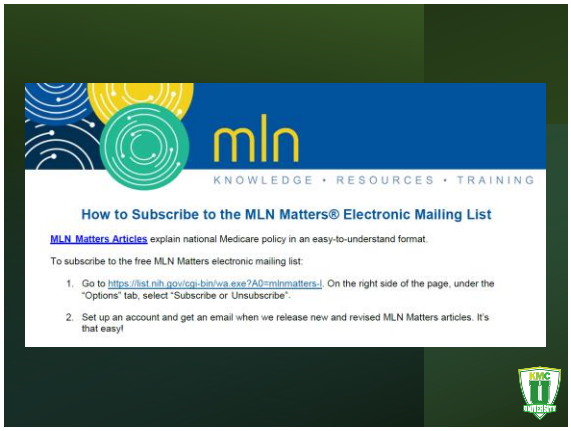
Self-Paced User Guide

Register for Live Training

Benefits and Features

- Determine if notification or prior authorization is required using just the procedure code and plan type, or based on a patient's plan and detailed case information.
- Submit a new request for medical prior authorization or to notify UnitedHealthcare of an inpatient admission.
- Check the status or update a previously submitted request for prior authorization or notification using the reference number or member or provider information. You can also request a case be canceled without having to call.
- Upload clinical notes or attach medical records and images to a request.
- Provide pertinent clinical information as requested at the time of your initial submission, which may allow for quicker decisions and improved efficiency for online submissions.

96



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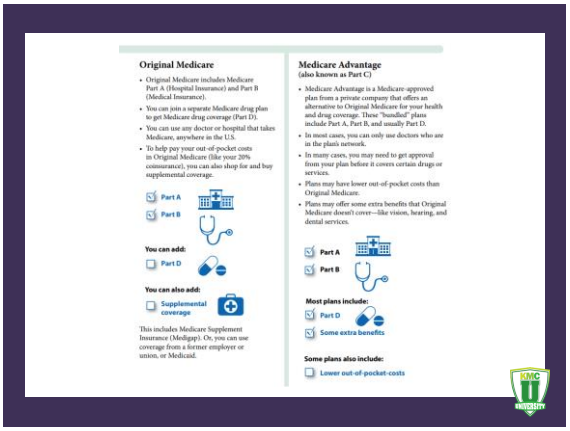
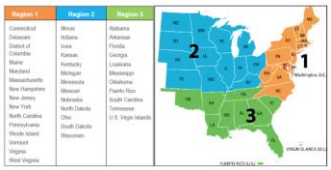


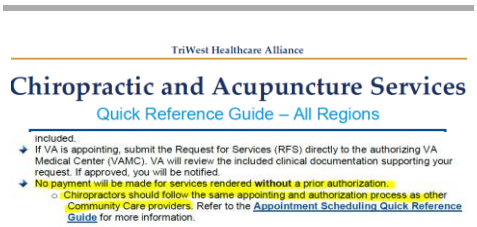
98

VA Optum Regions



99

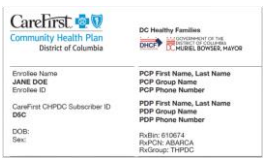
Follow the Rules

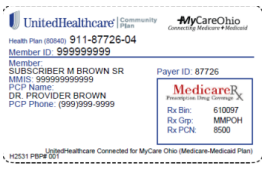


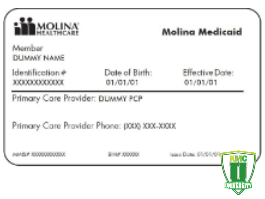
100

Keep an Eye Out for Medicaid Cards

Look for words : Community Plan; Community Health; Home State Health; Department of Social Services







101

Find Your State Medicaid Status

102

Locate
QMB Status
for the Dual Eligible Patient

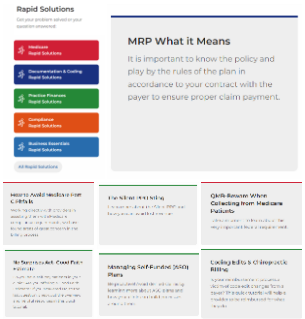
- Local MAC
- The Medicare Advantage Payer Portal
- Medicaid Payer Portal
- Remittance Advice (Medicare)

103

Library
Member
Resources

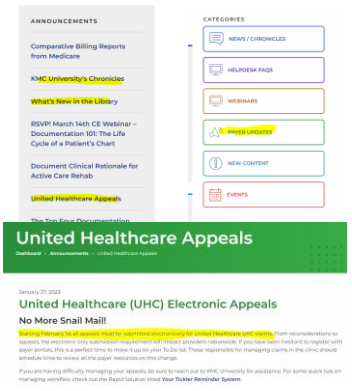
104

Resources



105

Stay in the
Know



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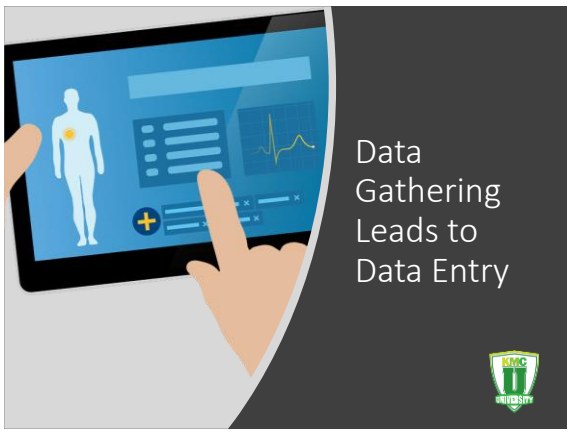
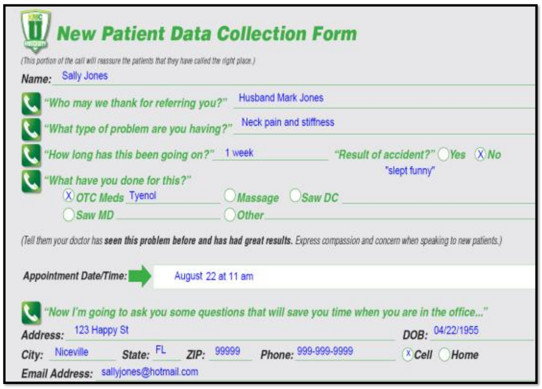


107

Data Collection

- Copy/Scan Insurance Card & ID
- Intake Forms
- Verification Form
- Outcome Assessment Forms
- Consent Forms
- Other Compliance & Policy Forms

108



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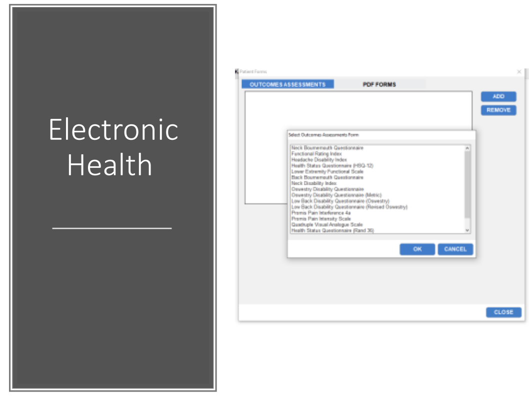

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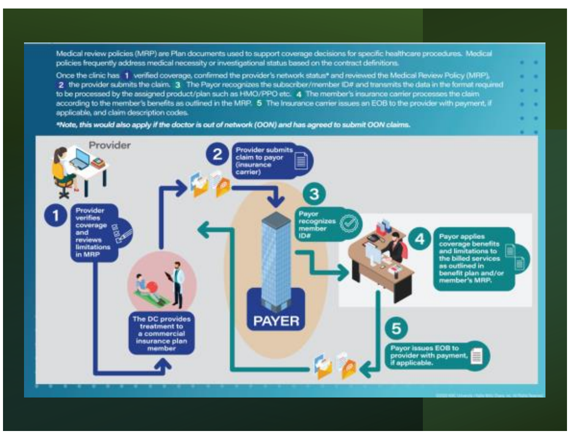

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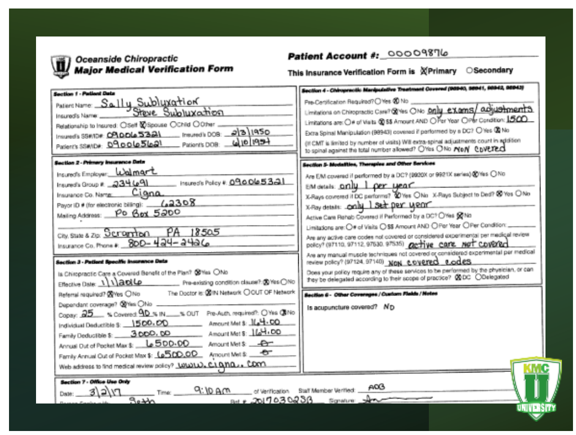

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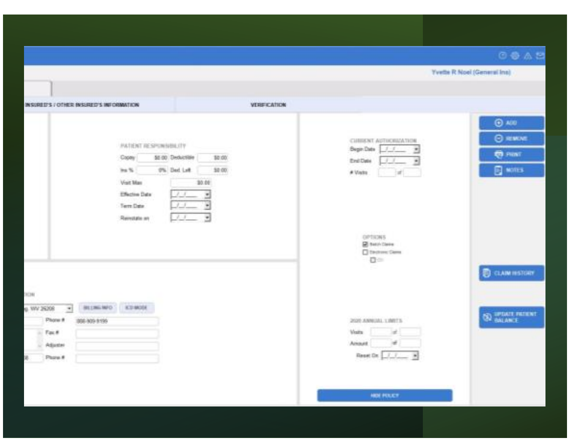

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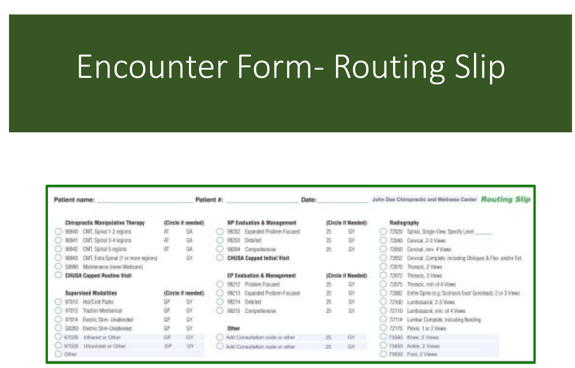

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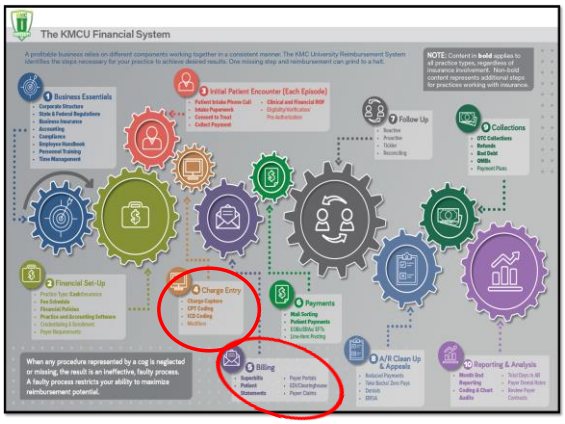

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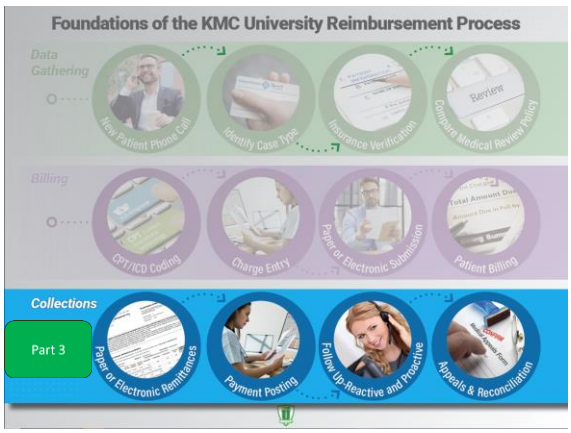

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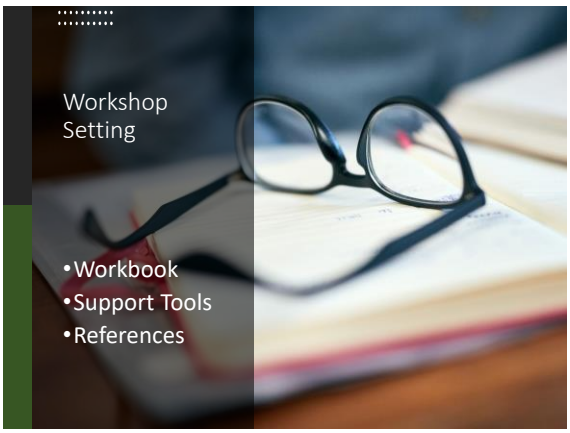


120

The Language of Practice Finances

- Know the terms and definitions
- Policy and Procedures
- Staff Training
- Keep in mind the 'definitions' of specific payers

121

Meet Your Patients

- Minnie Medders
- Henry Humes
- Kathleen Blue
- Sam Simple

122

Scenarios

- Medicare – Initial Exam Office Visit
- Medicare Advantage- Routine Office Visit
- Commercial Insurance –Re-exam Office Visit
- Self-Pay

123

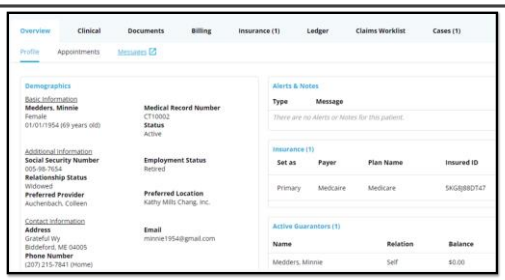
124

Minnie Medders' Data Gathering

- Traditional Part B Medicare
- Eligibility Check completed
- Located MAC Portal and confirmed the following:
  - Medicare Primary Status (MSP)
  - QMB Status
  - Not a Medicare Advantage Plan
- Located the Local Coverage Article for this beneficiary

125

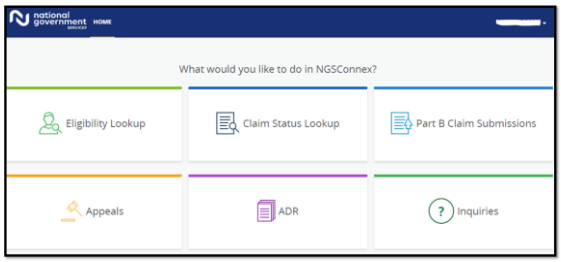
Demographics



126

MAC Portal

- Eligibility Look Up Tool



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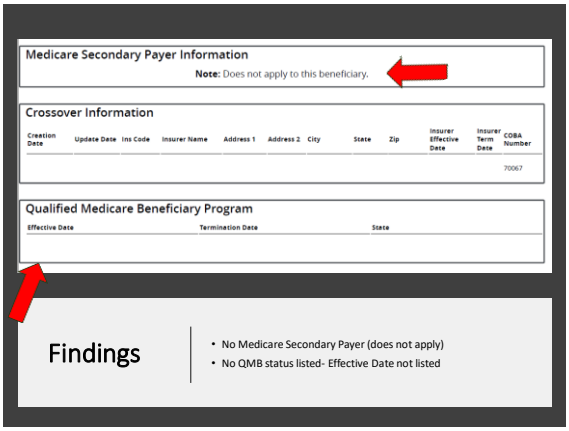


128

Finding the Coverage Documents

- LCDs
- Medical Policy Articles

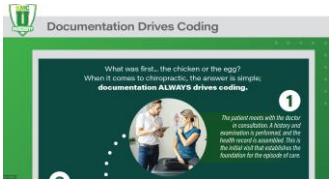
129

130

Let's Find Novitas Louisiana

131

Document FIRST then Code **The Compliant Way**



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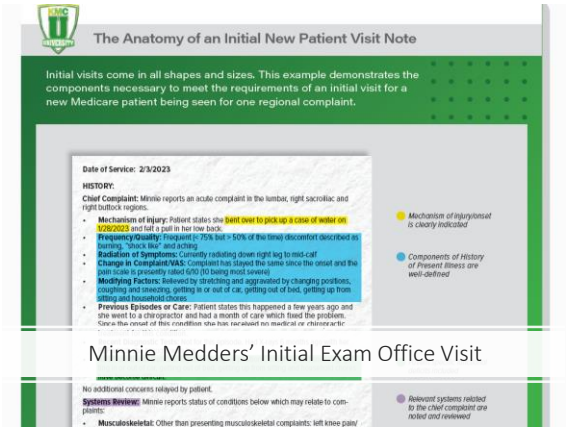


133

POLL

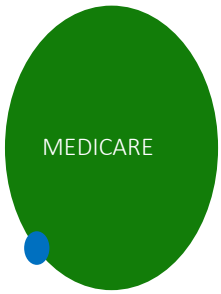
- Do you know the rules for reporting diagnosis codes on the claim form?

134

Diagnosis Hierarchy

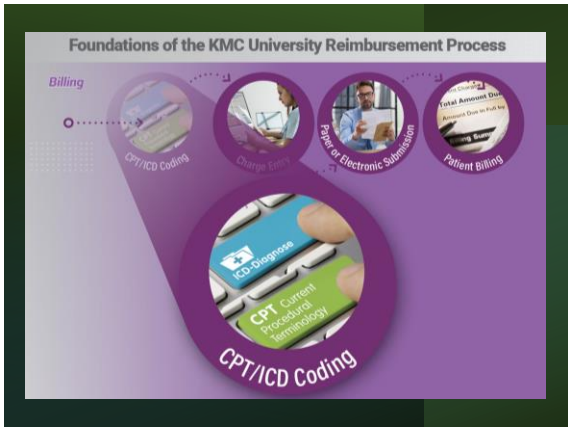
- **Position 1:** Neurological/Injury: Examples of neurological diagnoses include Radiculitis and Sciatic Neuritis.
- **Position 2:** Structural/Subluxation: Examples of structural diagnoses for the spine include Degenerative Joint Disease, Spondylolisthesis, Scoliosis, etc.
- **Position 3:** Functional: Examples include Restricted Range of Motion, Deconditioning Syndrome, and muscle wasting.
- **Position 4:** Soft Tissue/Extraspinal/Other: Fibromyalgia, myofascitis, and myalgia are excellent diagnoses to support manual therapy. Examples of extraspinal diagnoses include Frozen Shoulder, Carpal Tunnel Syndrome, Headache or Pain Syndromes.
- **Position 5:** Complicating Factors: Examples include obesity, high blood pressure, diabetes, cancer, and other forms of co-morbidities.
- **Position 6:** External cause, Activity, and Location Codes: Examples are related to mechanisms of injury, like slips, trips, falls and accidents, and activity codes show what the patient was doing when injured. These are not required, but helpful, and if reported are only reported on the first claim.

135



The preferred order is the same but use the **required coupling of the primary segmental dysfunction diagnosis first**, and the secondary neuromusculoskeletal diagnosis listed second in the pair. Then move on to the next condition and repeat that coupling for the next condition.

136



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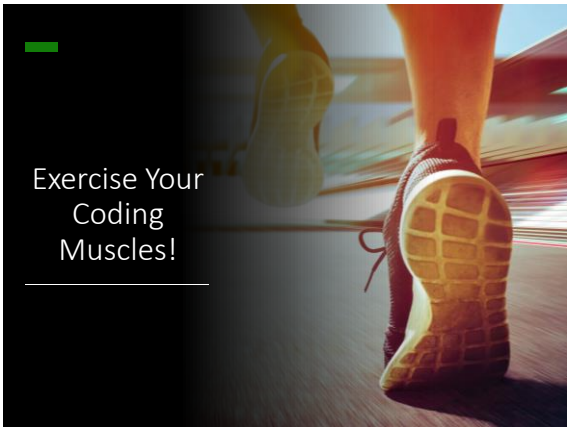


138

Exercise 1a

Place the following diagnosis in the correct order according to Medicare guidelines. The information you gathered in the intake and verification process should be referenced during this process.

(M99.05)	Segmental and Somatic dysfunction of pelvic region
(M62.830)	Muscle spasm of back
(M99.03)	Segmental and somatic dysfunction of lumbar region
(M54.41)	Lumbago w/ sciatica, RT side
(M51.37)	Other intervertebral disc degeneration, lumbosacral region

1. _____
2. _____
3. _____
4. _____
5. _____

139

Answer

(M99.03) Segmental and somatic dysfunction of lumbar region

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

(M99.05) Segmental and Somatic dysfunction of pelvic region

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

(M62.830) Muscle spasm of back

140

Exercise 1b- Locate the Compensatory Subluxation/Dysfunction Diagnosis

These are the spinal or extra-spinal regions where the patient does not report any pain or functional deficit, but where subluxations are found by the doctor during the examination process. Although the doctor feels they must be treated to help stabilize the patient's primary subluxations, they are **NOT billable** because they are not associated with a complaint. Compensatory subluxations must also be evaluated and documented.

141

Answer

Compensatory Diagnosis found on exam:

(M99.01) Segmental and somatic dysfunction of cervical region

142

The Charge Entry Process

- Creating an individual account for the patient; assigning an account number
- Entering demographics
- Assigning the account to a specific insurance payer or designating self-pay
- Entering ICD-10 diagnosis codes (pointing the codes to the related procedure)
- Entering the procedure performed (CPT codes assigned by the provider)
- Applying modifiers to the CPT codes based on documentation & CPT requirements
- Assigning the relevant charges or fee schedules to these procedures

143

Exercise 2 Procedure Code

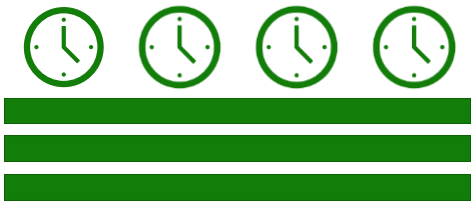
Selecting the Procedure Codes

Review the sample documentation for Minnie Medders 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. The verification process helps staff members address payer restrictions, requirements, and expectations.

1. _____ Modifier _____ Modifier _____
2. _____ Modifier _____ Modifier _____
3. _____ Modifier _____ Modifier _____

144

Time to Complete



145

Answer

99204-25-GY
98940-AT
97035-GY-GP

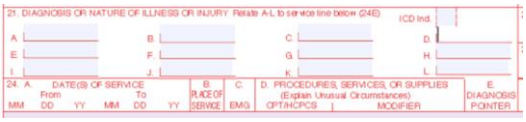
TODAY'S TREATMENT:

- **Primary Treatment (1-2 regions):** Diversified, Drop Table and Activator - Chiropractic Manipulative Treatment (CMT) to the right pelvis and right L5 spinal level.
- **Compensatory adjustment(s) at level(s):** right C2-Activator
- **Supportive Therapy** to optimize treatment effectiveness the following therapy(s) were performed today:
  - Ultrasound with contact medium performed to right lumbar and right buttock region(s) for 8 minutes at a setting of continuous 100% and at 1.6 W/cm2.

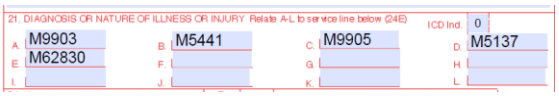
Examination and treatment rendered without incident

146

Exercise -3 The Diagnosis Order



147



Answer

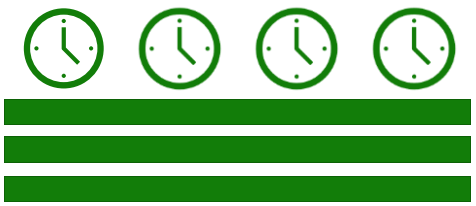
148

Exercise 4- Diagnosis Pointing

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER
99204	25	GY			
98940	AT				
97035	GY	GP			

149

Time to Complete



150

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

Answer

151

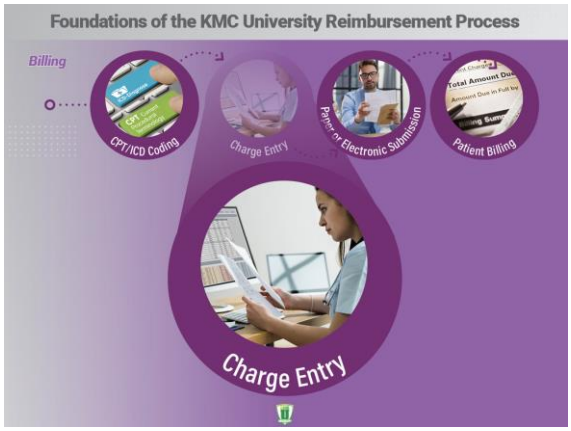
MAC Reporting Requirements

- Point to the Primary Diagnosis only

24E	Diagnosis code	2400	SV101-6	Procedure modifier 4	the claim notes (N1 to) item 19.
			SV107-1	Diagnosis code pointer	

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
			SV107-2	Diagnosis code pointer	Enter the diagnosis code reference letter shown in Item 21 to relate the date of service and the procedures performed to the primary diagnosis. A submitter must point to the primary diagnosis for each service line. Use the remaining diagnosis pointers in declining level of importance to service line.
			SV107-3	Diagnosis code pointer	
			SV107-4	Diagnosis code pointer	

152



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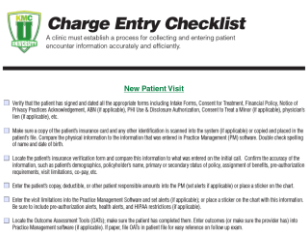
Support Tool



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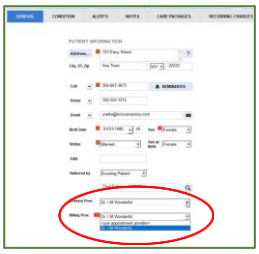
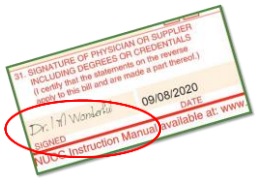
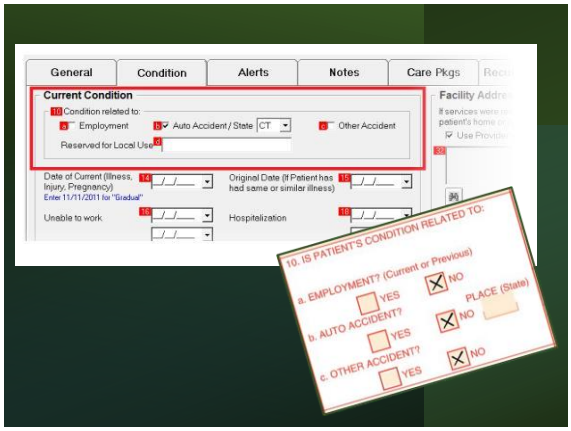
Mapping Charge Entry Data

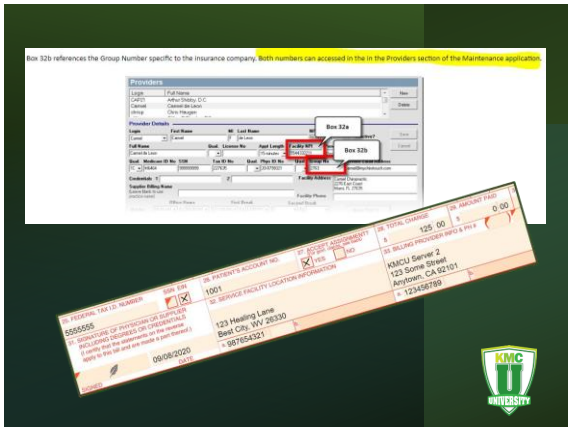




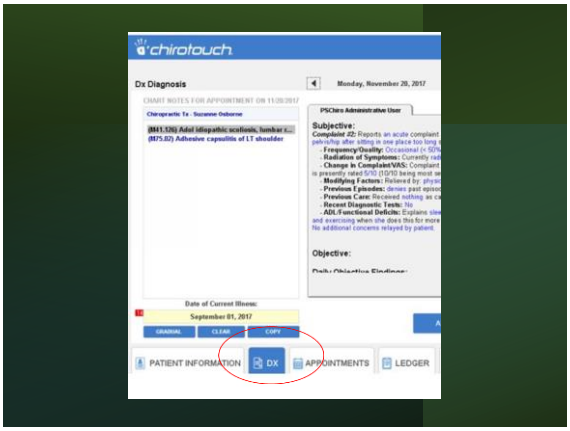
155



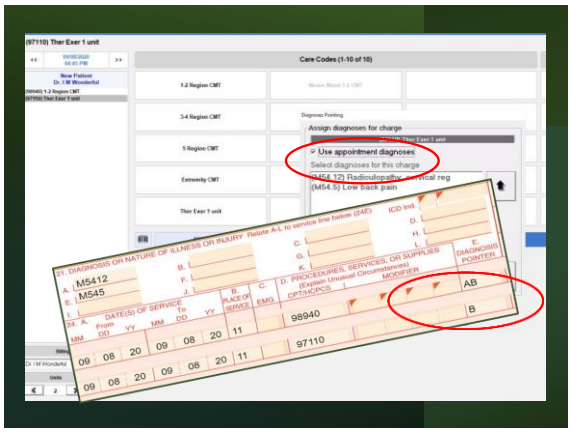
156



157



158



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Invest In Your Charge Entry Process

Customize	Each field should be clearly defined in your software
Map	Track data from software field to claim field
Update	Update data fields quarterly based on payer & coding changes
Train	Charge Entry staff NEED to know the outcome of each entry point

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161

Exercise 5 – What is Wrong With This Claim?

162

Answer

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

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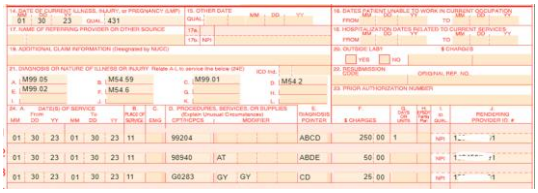
Exercise 6 – What is Wrong With This Claim?



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY				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.	

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
01	30	23	01	30	23	11		98940	AT	ABDE	50 00			NPI	1
01	30	23	01	30	23	11		G0283	GY	GY	CD	25 00			NPI	1

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Answer

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

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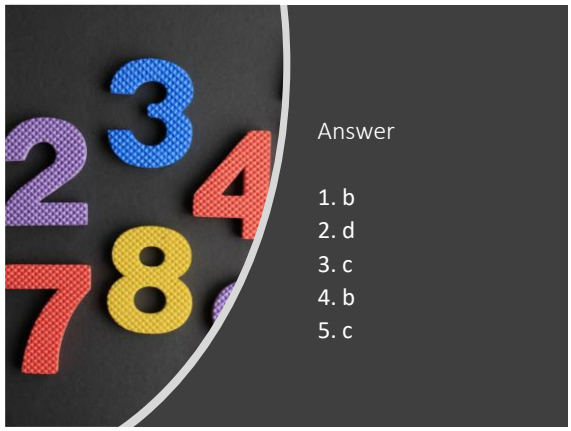
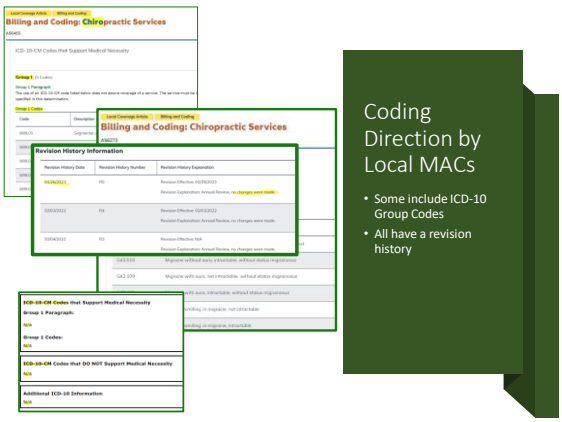


166



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Minnie's Clean Claim

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