



1

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



2



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8

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



9

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



10

Many In the Profession Feel Like This



11

Know the Rules that Govern Healthcare



12



Many Doctors Feel They Are Chasing Moving Target

13

A diagram showing a green circle labeled 'Easy' with an arrow pointing to a red circle labeled 'Difficult'. Below the diagram, the text 'Intermediate to Advanced Topics' is written. To the right, a list of topics is provided: 'Basics will be mentioned, but are not going to be covered in detail', 'Difficult nuances and gray areas to be reviewed', and 'Advanced principles necessary for compliance'.

14



Advanced Billing Compliance

15

Step One: Must Know The Difference | Chiropractic is Different In Medicare

CHIROPRACTIC MEDICARE BENEFITS AND LIMITATIONS	
Recognize the Fundamentals of Medicare Coverage for Chiropractic Services	
Covered and Payable	Active Treatment (AT) Spinal Chiropractic Manipulative TX (CMT) CPT Codes 98940, 98941, 98942
Covered but Not Payable <small>*ABN form must be provided to the patient prior to rendering Covered but Not Payable services.</small>	Spinal CMT codes are deemed Covered but Not Payable when performed for: <ul style="list-style-type: none">• Chiropractic maintenance treatment• More than one spinal manipulation per day
Statutorily Excluded from Medicare Chiropractic Benefit <small>*ABN is not required for these services. Office Financial Policy is recommended to communicate these limitations of Medicare coverage.</small>	All services/supplies ordered or provided by a chiropractor, other than those defined above, are excluded from the Medicare benefit, and therefore the patient is responsible for payment. This includes but is not limited to: <ul style="list-style-type: none">• Extremity CMT 98943• X-rays• Products/supplies• Therapies• Exams• Alternative treatment protocols

16

Step Two-Enrollment Part B

Things to do:

- ★ Apply for a National Provider Identification number (NPI)
- ★ Every provider must enroll in Medicare to treat a Medicare patient. **There is NO Opt-Out for chiropractors.**
- ★ Providers must enroll their corporate business entity in Medicare and attach individual provider numbers by reassigning benefits.

PART B

The Medicare logo, featuring a red circle with a white caduceus symbol and the word 'Medicare' in red.

17

Types of Medicare Coverage: Part B

- Basic Medicare Part B coverage is what most of the senior population have
- Medicare Part B is optional
- Medicare Part B is usually the primary coverage

A diagram showing the four parts of Medicare: Part A (Hospital Insurance), Part B (Medical Insurance), Part C (Medicare Advantage Plans), and Part D (Medicare Prescription Drug Coverage). Part B is highlighted with a red circle and a red arrow pointing to it. Below the diagram, the text 'Chiropractic Benefits are subject to Medicare Part B' is written.

18

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

Accept and Treat Medicare Part B Patients

NO

Not Enrolled in Medicare Part B

Does not accept Medicare Part B patients for covered or excluded services

YES

Must Be Properly Enrolled with Medicare

Must charge proper fee for excluded services

Must bill active treatment CMT on behalf of patient

Payer specific documentation required

Medical Necessity guidelines apply

Coding is based on documentation

Proper use of billing modifiers required

Non-Participating

Regulated limiting fee charged for CMT

May accept assignment on case-by-case basis for CMT

Participating

Accepts allowed regulated fee for CMT

Always accepts assignment for CMT

● Billing

● Patient Finances

● Documentation

● Compliance

● Coding

19

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

THE FOUR PARTS OF MEDICARE

H
PART A
HOSPITAL INSURANCE

B
PART B
MEDICAL INSURANCE
Original benefit is available without a waiting period

C
PART C
MEDICARE ADVANTAGE PLANS (HMO, PPO, etc.)
Must be enrolled in Part A and B to be eligible for Part C coverage

D
PART D
MEDICARE PRESCRIPTION DRUG COVERAGE

● Billing

● Patient Finances

● Documentation

● Compliance

● Coding

20

Step Three-Enroll in Part C Plans if Desired

PART C
H

★ 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.

● Billing

● Patient Finances

● Documentation

● Compliance

● Coding

21

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

Accepts and Treats Medicare Part C Patients

NO

Not enrolled in any Part C Plan

Does not accept Medicare C patients for covered or non-covered services

YES

Non-Participating with Patient's Plan

Charge same as Part B for active CMT. Submission may be required. See verification.

May elect to treat and bill payer directly. May become "direct" provider

If submitting, must accept fee schedule

Payer specific documentation required

Medical Necessity guidelines apply

Coding is based on documentation

Proper use of billing modifiers required

Participating with Patient's Plan

Limited to the contract for fee-for-payment. Patient may still be responsible for excluded services

Must bill on behalf of patient

Payer specific documentation required

Medical Necessity guidelines apply

Coding is based on documentation

Proper use of billing modifiers required

● Billing

● Patient Finances

● Documentation

● Compliance

● Coding

22

Submits Health Insurance Bills for Patients

NO

Doesn't submit billing

Insured patients are treated in cash

Cash Paying Patient/Not Insured

Charge actual fee or implement a legal and compliant discount

Provide receipt/superbill for payments using proper coding

Follow State minimum and liability documentation requirements

YES

Properly enrolled with payer

Payer specific documentation required

Medical Necessity guidelines apply

Coding is based on documentation

Proper use of billing modifiers required

Non-Participating/ Out of Network with Patient's Plan

Actual fee-charged for all services. Patient may elect to self-pay and pay-CHSAs for documentation

Option to accept assignment at case-by-case basis

Participating / In-Network with Patient's Plan

Accepts contracted fee schedule

Bills to 8-accepts assignment from payer

● Billing

● Patient Finances

● Documentation

● Compliance

● Coding

23

Submits Bills for PI or WC Cases for Patients

NO

Injury patients are treated in cash

Cash Paying Patient/Not Insured

Charge actual fee or implement a legal and compliant discount

Provide receipt/superbill for payments using proper coding

Follow State minimum and liability documentation requirements

YES

Submits bills on behalf of patient

Payer specific documentation required

Medical Necessity guidelines apply

Coding is based on documentation

Proper use of billing modifiers required

Worker's Comp

Charge and collect regular WC rate from proper

Changes and collects actual rate, regulated PIP or No-Fault law according to state regulations

Personal Injury

Charge and collect actual rate, regulated PIP or No-Fault law according to state regulations

● Billing


● Patient Finances

● Documentation

● Compliance

● Coding


24



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

25




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?

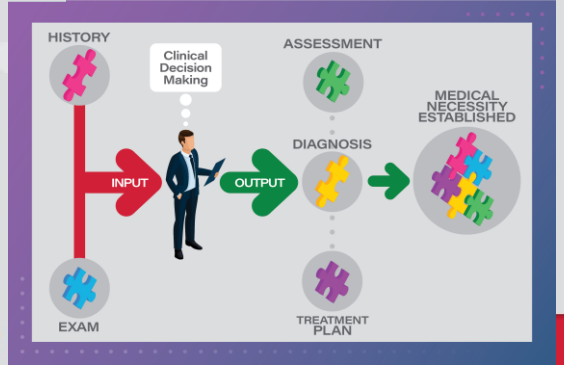
26

Your Patient's Flow Under Care



27

The Foundational Components for an Episode of Care



28

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

29

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.



30



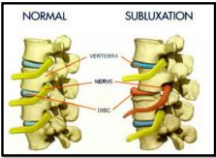
AT = Active Treatment

- By definition meets medical necessity
- Billed and expected to be paid
- Follows MAC screens
- Should not be automatic

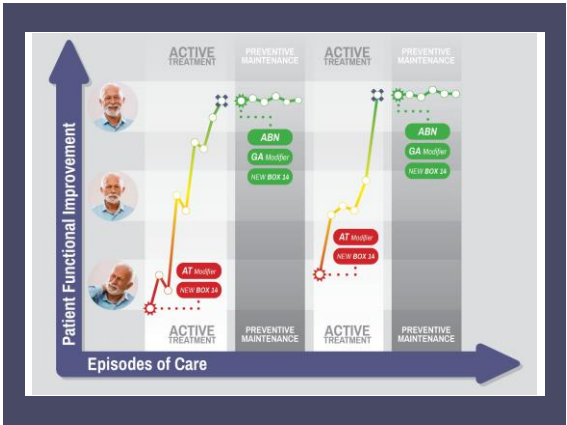
31

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.



32



33

The KMC University's Guide to MEDICARE MODIFIERS

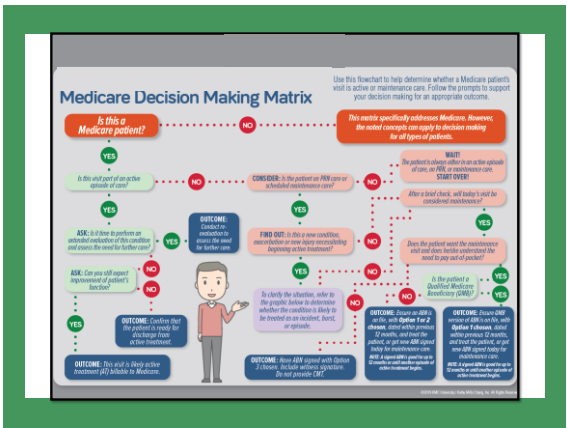
Modifiers Used Only With 98940, 98941, 98942		
Code	Description/Instructions	Effect on Medicare Payment
AT	Reporting Active/Continuous Treatment. Indicates service rendered was medically necessary.	Medicare will consider for payment.
GA	Waiver of Liability ABN on file for mandatory use. Indicates maintenance care or with respect to care chosen.	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 All Statutorily Excluded Services		
Code	Description/Instructions	Effect on Medicare Payment
GY	Indicates statutorily non-covered service/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	Used for certain therapy services as well as equipment treatment plan.	Claim will be denied/patient financially liable. Use with GY modifier on certain therapy services to receive proper denial.

MANDATORY SUBMISSION

VOLUNTARY SUBMISSION

34

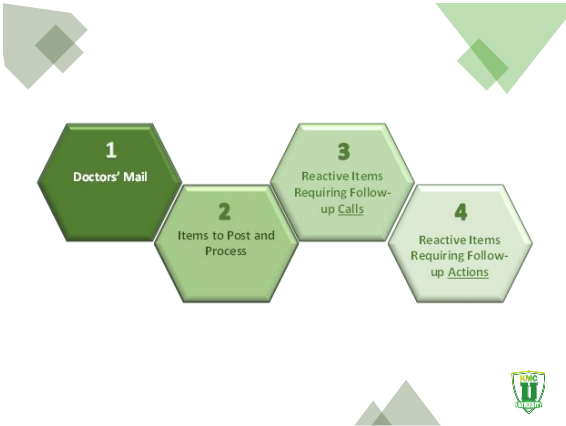


35



Receiving a Response to Your Claim

36



37

The Four Categories for Sorting Mail

1. Doctor's Mail - Items that mail, accounts payable, and other items.

2. Items to post and process system. This may include (also include patient check information.

3. Reactive items that require patient's insurance policy current information.

4. Reactive items that require not require a phone call to be resolved.

or. This may include personal items.

he practice management (of Benefits) printed. It may

letter that states that the patient to obtain

r medical records that does can be resolved.

38

Downloads

1 OFFICE / DOCTOR MAIL

2 ITEMS TO POST

3 REQUIRES A CALL

4 REQUIRES AN ACTION

39

Workshop Exercise

40

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. ____

41

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**

42

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**

43



44

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.

45

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.

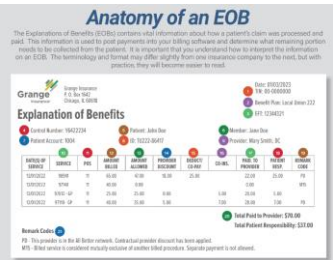
46

Downloads



47

The
Anatomy
of an EOB



48

Workshop
Exercise



49

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

50

Time to Complete



51

Answer Key

8 Patient: John Doe

6 Member: Jane Doe

8 ID: IU222-86417

9 Provider: Mary Smith, DC

12	13	14	15	16	17	18	19
AMOUNT BILLED	AMOUNT ALLOWED	PROVIDER DISCOUNT	DEDUCT/ CO-PAY	CO-INS.	PAID, TO PROVIDER	PATIENT RESP.	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							

52

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 97710 according to the Anatomy of an EOB sample?

\$ _____

53

Exercise 3

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

\$ 18.00

10	11	12	13	14	15	16	17	18	19
DATES) OF SERVICE	SERVICE	POS	AMOUNT BILLED	AMOUNT ALLOWED	PROVIDER DISCOUNT	DEDUCT/ CO-PAY	CO-INS.	PAID, TO PROVIDER	PATIENT RESP.
12/01/2022	98941	11	65.00	47.00	18.00	25.00		22.00	25.00
12/01/2022	97740	11	40.00	0.00				0.00	
12/01/2022	97712- GP	11	25.00	25.00	0.00		5.00	20.00	5.00
12/01/2022	97710- GP	11	40.00	35.00	5.00		7.00	28.00	7.00

Amount Billed – Amount Allowed = Contractual Write Off

Answer Key

54

Exercise 3

- a. What is the contractual write-off for procedure code 96941 according to the Anatomy of an EOB sample?
\$ 18.00
- b. What is the amount allowed by the insurer for procedure code 97101 according to the Anatomy of an EOB sample?
\$ 35.00

Control Number: 15422234
Patient Account: 1004
Patient: John Doe
Member: Jane Doe
Provider: Mary Smith, DC

DATE(S) OF SERVICE	SERVICE	POS	AMOUNT BILLED	AMOUNT ALLOWED	PROVIDER DISCOUNT	DEDUCT/ CO-PAY	CO-INS.	PAID TO PROVIDER	PATIENT RESP.	REMARK CODE
12/01/2022	96941	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		MTS
12/01/2022	97012 - GP	11	25.00	25.00	0.00		5.00	20.00	5.00	
12/01/2022	97101 - GP	11	40.00	35.00	5.00		7.00	28.00	7.00	PD

DATE(S) OF SERVICE	SERVICE	POS	AMOUNT BILLED	AMOUNT ALLOWED	PROVIDER DISCOUNT	DEDUCT/ CO-PAY	CO-INS.	PAID TO PROVIDER	PATIENT RESP.	REMARK CODE
12/01/2022	96941	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		MTS
12/01/2022	97012 - GP	11	25.00	25.00	0.00		5.00	20.00	5.00	
12/01/2022	97101 - GP	11	40.00	35.00	5.00		7.00	28.00	7.00	PD

Amount Billed – Contractual Write Off = Amount Allowed

Answer Key



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

Remark Code- What does it tell us?

DATE(S) OF SERVICE	SERVICE	POS	AMOUNT BILLED	AMOUNT ALLOWED	PROVIDER DISCOUNT	DEDUCT/ CO-PAY	CO-INS.	PAID TO PROVIDER	PATIENT RESP.	REMARK CODE
12/01/2022	96941	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		MTS
12/01/2022	97012 - GP	11	25.00	25.00	0.00		5.00	20.00	5.00	
12/01/2022	97101 - GP	11	40.00	35.00	5.00		7.00	28.00	7.00	PD

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

Remark Codes

PD - This provider is in the All Better network. Contractual provider discount has been applied.
MTS - Billed service is considered mutually exclusive of another billed procedure. Separate payment is not allowed.

Workshop Exercise



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.



The CPT Manual defines "Distinct Procedure" as a procedure or service performed on the same patient that is not normally performed together and must support a different diagnosis.

ALL RAPID SOLUTIONS

Mastering Coding Edits

Tracking Down Code Edits

How to Use the Medicare National Correct Coding Initiative (NCCI) Tools

To indicate that a (Management) service is other than EM services, use Documentation in your system, separate

either in all situations or in most cases (CCM) of "O" don't report the codes when code of service (CDS) is eligible for payment and Medicare together only in limited circumstances by

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 97140. 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.



61

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



62



Exercise Your Posting Skills

63



EOBs & Remittance Advice Vary Between Payer Classes



64

Meet Your Patients

- Minnie Medders
- Henry Humes
- Kathleen Blue



65



66

67

Local Coverage Determinations **Medical Policy Articles**

Medical Policy Articles

Article Title	Article #	Related CPT/HCPCS Codes
Chiropractic Services - Medical Policy Article Revised term substitution, manipulation	Article	98940, 98941, 98942

1 to 1 of 1 records (Filtered from 36 total entries)

1


- LCDs
- Medical Policy Articles

68

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

69




Documentation Drives Coding

What was first, the chicken or the egg?
When it comes to chiropractic, the answer is simple:
documentation ALWAYS drives coding.




The patient starts with the doctor as consultation. A history and physical exam is performed. The health record is updated. This is the vital link and the foundation for the update of case.



By reviewing the **pastur** visit documentation, the correct **Evaluation and Management (E/M)** code is assigned. Treatment rendered on a given visit is coded according to the procedures performed (adjustment, EMG, exercise)

70

 The Anatomy of an Initial New Patient Visit Note

Date of Service: 2/3/2023

HISTORY:

Chief Complaint: Minnie reports an acute complaint in the lumbar, right sacralic and right/tibial/radial regions.

- **Mechanism of Injury:** Patient states she **sent over to pick up a case of water on 2/2/2023** and left a pull in her low back.
- **Frequency/Duration:** Frequency is 70% but ~ 50% of the time discomfort described as burning, "shock like" and aching.
- **Reduction of Symptoms:** Currently radiating down right leg to mid-calf.
- **Change in Complaint:** WAS: Complaint has stayed the same since the onset and the pain levels is generally called 10/10 (on being most lowered).
- **Modifying Factors:** Relieved by stretching and aggravated by changing positions, grasping and twisting, getting in or out of car, getting out of bed, getting up from sitting and household chores.
- **Previous Episodes or Care:** Patient states this happened a few years ago and she went for a chiropractor and had a month of care which failed the problem. (Chiropractor: [redacted])

● **Mechanism of injury/sustained** is clearly indicated

● **Components of History of Present Illness are well-defined**


No additional concerns related by patient.

Systems Review: Minnie reports status of conditions below which may relate to complaints:

● **Relevant systems related to the chief complaint are noted and reviewed**

Minnie Medders' Initial Exam Office Visit

71

		0001 Insurance: CLAIM FORM 0002 Insurance: CLAIM FORM 0003 Insurance: CLAIM FORM		0004 Insurance: CLAIM FORM 0005 Insurance: CLAIM FORM 0006 Insurance: CLAIM FORM	
01 POLICY NUMBER, CLAIM NUMBER OR FREQUENTLY USED 02 03 2023		04 CLAIM TYPE 05 CLAIM TYPE 06 CLAIM TYPE		07 CLAIM TYPE 08 CLAIM TYPE 09 CLAIM TYPE	
10 DATE OF LOSS 11 02 03 2023		12 DATE OF LOSS 13 02 03 2023		14 DATE OF LOSS 15 02 03 2023	
16 DATE OF LOSS 17 02 03 2023		18 DATE OF LOSS 19 02 03 2023		20 DATE OF LOSS 21 02 03 2023	
22 DATE OF LOSS 23 02 03 2023		24 DATE OF LOSS 25 02 03 2023		26 DATE OF LOSS 27 02 03 2023	
28 DATE OF LOSS 29 02 03 2023		30 DATE OF LOSS 31 02 03 2023		32 DATE OF LOSS 33 02 03 2023	
34 DATE OF LOSS 35 02 03 2023		36 DATE OF LOSS 37 02 03 2023		38 DATE OF LOSS 39 02 03 2023	
40 DATE OF LOSS 41 02 03 2023		42 DATE OF LOSS 43 02 03 2023		44 DATE OF LOSS 45 02 03 2023	
46 DATE OF LOSS 47 02 03 2023		48 DATE OF LOSS 49 02 03 2023		50 DATE OF LOSS 51 02 03 2023	
52 DATE OF LOSS 53 02 03 2023		54 DATE OF LOSS 55 02 03 2023		56 DATE OF LOSS 57 02 03 2023	
58 DATE OF LOSS 59 02 03 2023		60 DATE OF LOSS 61 02 03 2023		62 DATE OF LOSS 63 02 03 2023	
64 DATE OF LOSS 65 02 03 2023		66 DATE OF LOSS 67 02 03 2023		68 DATE OF LOSS 69 02 03 2023	
70 DATE OF LOSS 71 02 03 2023		72 DATE OF LOSS 73 02 03 2023		74 DATE OF LOSS 75 02 03 2023	
76 DATE OF LOSS 77 02 03 2023		78 DATE OF LOSS 79 02 03 2023		80 DATE OF LOSS 81 02 03 2023	
82 DATE OF LOSS 83 02 03 2023		84 DATE OF LOSS 85 02 03 2023		86 DATE OF LOSS 87 02 03 2023	
88 DATE OF LOSS 89 02 03 2023		90 DATE OF LOSS 91 02 03 2023		92 DATE OF LOSS 93 02 03 2023	
94 DATE OF LOSS 95 02 03 2023		96 DATE OF LOSS 97 02 03 2023		98 DATE OF LOSS 99 02 03 2023	
100 DATE OF LOSS 101 02 03 2023		102 DATE OF LOSS 103 02 03 2023		104 DATE OF LOSS 105 02 03 2023	
106 DATE OF LOSS 107 02 03 2023		108 DATE OF LOSS 109 02 03 2023		110 DATE OF LOSS 111 02 03 2023	
112 DATE OF LOSS 113 02 03 2023		114 DATE OF LOSS 115 02 03 2023		116 DATE OF LOSS 117 02 03 2023	
118 DATE OF LOSS 119 02 03 2023		120 DATE OF LOSS 121 02 03 2023		122 DATE OF LOSS 123 02 03 2023	
124 DATE OF LOSS 125 02 03 2023		126 DATE OF LOSS 127 02 03 2023		128 DATE OF LOSS 129 02 03 2023	
130 DATE OF LOSS 131 02 03 2023		132 DATE OF LOSS 133 02 03 2023		134 DATE OF LOSS 135 02 03 2023	
136 DATE OF LOSS 137 02 03 2023		138 DATE OF LOSS 139 02 03 2023		140 DATE OF LOSS 141 02 03 2023	
142 DATE OF LOSS 143 02 03 2023		144 DATE OF LOSS 145 02 03 2023		146 DATE OF LOSS 147 02 03 2023	
148 DATE OF LOSS 149 02 03 2023		150 DATE OF LOSS 151 02 03 2023		152 DATE OF LOSS 153 02 03 2023	
154 DATE OF LOSS 155 02 03 2023		156 DATE OF LOSS 157 02 03 2023		158 DATE OF LOSS 159 02 03 2023	
160 DATE OF LOSS 161 02 03 2023		162 DATE OF LOSS 163 02 03 2023		164 DATE OF LOSS 165 02 03 2023	
166 DATE OF LOSS 167 02 03 2023		168 DATE OF LOSS 169 02 03 2023		170 DATE OF LOSS 171 02 03 2023	
172 DATE OF LOSS 173 02 03 2023		174 DATE OF LOSS 175 02 03 2023		176 DATE OF LOSS 177 02 03 2023	
178 DATE OF LOSS 179 02 03 2023		180 DATE OF LOSS 181 02 03 2023		182 DATE OF LOSS 183 02 03 2023	
184 DATE OF LOSS 185 02 03 2023		186 DATE OF LOSS 187 02 03 2023		188 DATE OF LOSS 189 02 03 2023	

72

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	1	99204 25, GY		250.00	0.00	0.00	0.00	PR	0.00	96, N425
020323	020323	1234567890	11	1	1	98940 AT		40.00	27.46	27.46	0.00	CO 45	0.00	
020323	020323	1234567890	11	1	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)													



73

Workshop Exercise



74

Line Item Posting

Exercise 5
Let us put your line item posting skills to work. You are now looking at Minnie's EOB from MedCare. Please answer the questions listed below.

Medders, Minnie

Begin Service Date	End Service Date	Rendering NPI	POS	Units	Procedure Code	Modifiers	Billed Amount	Allowed Amount	Deductible	Copay	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)

a. Are all the dates of service and procedure codes accounted for? Compare the claim to the EOB. Circle the answer.
Yes No

b. Which services are considered statutorily excluded?
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.

e. What is the contractual write-off amount for procedure code 98940?
\$ 27.46

f. What is the total out of pocket cost for this patient according to this EOB?
\$ 27.46



75

Time to Complete



76

Answer Key

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

Remark Code
96, N425
96, N425

77

Answer Key

Modifier	Description/Restriction	Effect on Medicare Payment
AT	Reporting of a service rendered into medically necessary per Medicare guidelines	Medicare will consider for payment.
GA	Waiver of liability (ABN) on file for mandatory visit	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.
Modifier	Description/Restriction	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 responsible.
GX	ABN on file for voluntary visit	Claim will be denied/patient financially liable; we don't recommend Medicare's official ABN form for voluntary visit.
GP	Services delivered under an outpatient physical therapy plan of care	Use on PT modalities and procedures, along with GY to receive proper denial.



78

Foundations
of the Billing
& Collection
Process

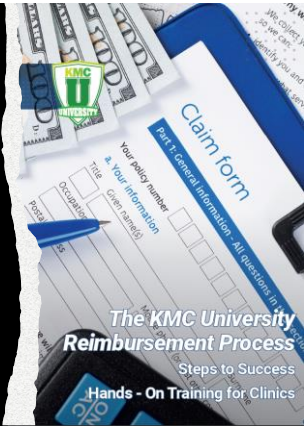
Part 2



79

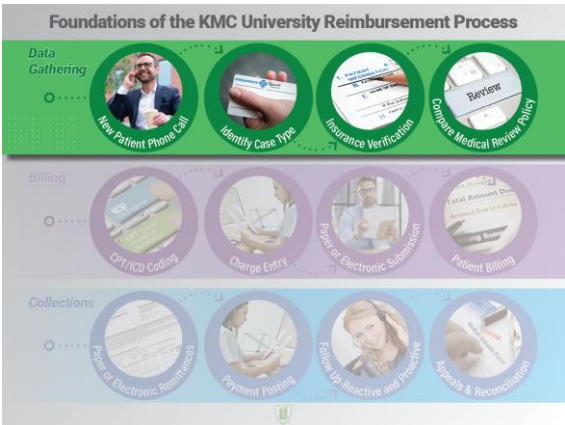
The KMC
University
Reimbursement
Process

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



80

Foundations of the KMC University Reimbursement Process



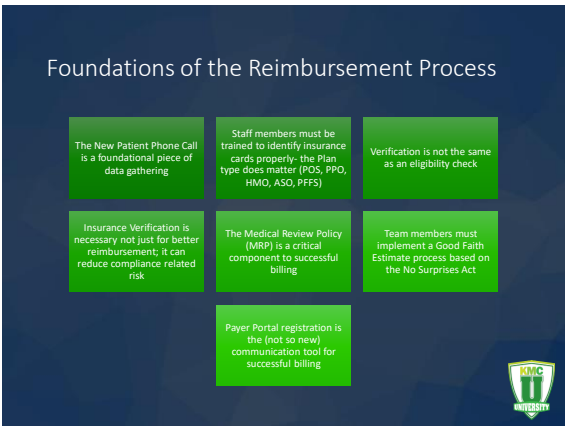
81

A Recap of Part 1



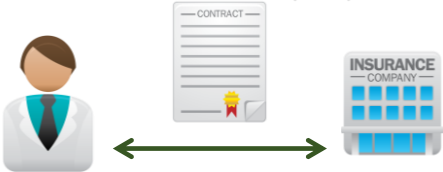
82

Foundations of the Reimbursement Process



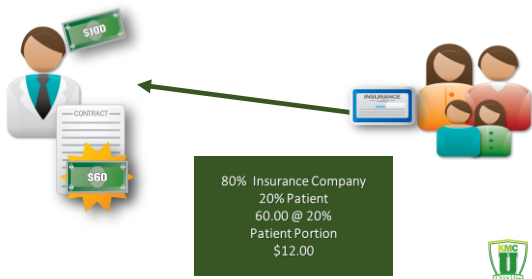
83

Doctor
Insurance Company



84

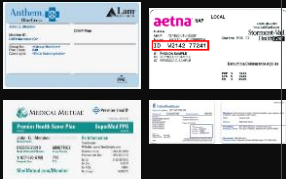
Patient & Doctor



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

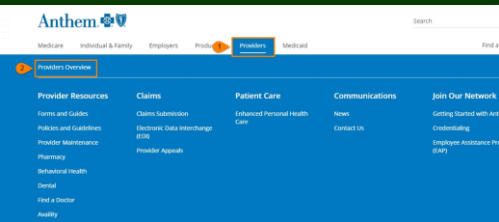


86



Payer Relationships

87

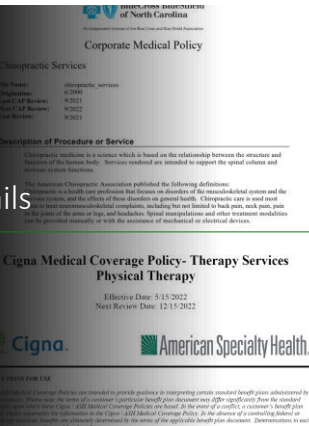


Provider Resources

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

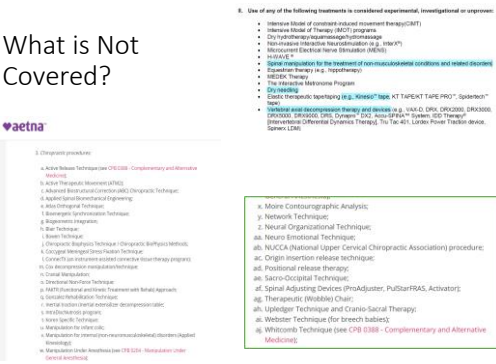
88

Coverage Details



89

What is Not Covered?



90



91

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 progress is individualized and there is documentation outlining quantifiable, attainable, functional goals.
 - Improvement is evidenced by successive objective measurements.
 - The services are supervised 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 Ohio) are necessary to safely and effectively furnish a recognized therapy service due to the complexity and/or repetition of the type of care and the medical condition of the individual, with the goal of improvement of an impairment or functional limitation.

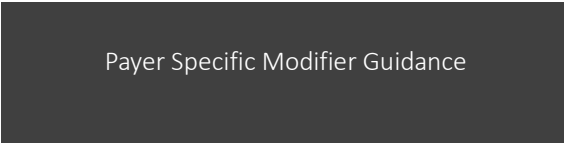


97140 services will be denied as integral or incidental to 98940-98943 services unless submitted with a -59 modifier, indicating a distinct procedural service.

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.



92



93



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



RESOURCES - PROVIDERS

If you are a contracted provider, [log in](#) or [activate your account](#) to access additional resources.



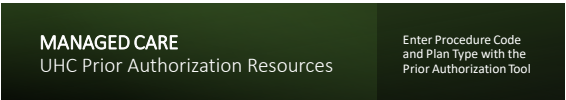
**ACUPUNCTURE AND ORIENTAL
MEDICINE**



CHIROPRACTIC



95



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-Placed 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




How to Subscribe to the MLN Matters® Electronic Mailing List

MLN Matters Articles explain national Medicare policy in an easy-to-understand format.

To subscribe to the free MLN Matters electronic mailing list:

- Go to <https://list.nih.gov/cgi-bin/va.exe?A0=mlnmatters>. On the right side of the page, under the "Options" tab, select "Subscribe or Unsubscribe".
- Set up an account and get an email when we release new and revised MLN Matters articles. It's that easy!



97

Original Medicare

- Original Medicare includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- You can join a separate Medicare drug plan to get Medicare drug coverage (Part D).
- You can use any doctor or hospital that takes Medicare, anywhere in the U.S.
- To help pay your out-of-pocket costs in Original Medicare (like your 20% coinsurance), you can also shop for and buy supplemental coverage.

☒ Part A

☒ Part B

☐ You can add Part D

☐ You can also add Supplemental coverage

This includes Medicare Supplement Insurance (Medigap). Or, you can use coverage from a former employer or union, or Medicaid.

Medicare Advantage (also known as Part C)

- Medicare Advantage is a Medicare approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These "bundled" plans include Part A, Part B, and usually Part D.
- In most cases, you can only use doctors who are in the plan's network.
- In many cases, you may need to get approval from your plan before it covers certain drugs or services.
- Plans may have lower out-of-pocket costs than Original Medicare.
- Plans may offer some extra benefits that Original Medicare doesn't cover—like vision, hearing, and dental services.

☒ Part A


☒ Part B

☒ Part D

☒ Some extra benefits

Some plans also include:

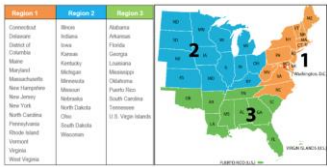
☐ Lower out-of-pocket costs



98

VA Optum Regions

99



Region 1	Region 2	Region 3
Connecticut Delaware District of Columbia Florida Georgia Hawaii Illinois Indiana Iowa Kansas Kentucky Louisiana Maine Maryland Massachusetts Michigan Minnesota Mississippi Missouri Montana Nebraska Nevada New Hampshire New Jersey New Mexico New York North Carolina North Dakota Ohio Oklahoma Oregon Pennsylvania Rhode Island South Carolina South Dakota Tennessee Texas Utah Vermont Virginia Washington West Virginia Wisconsin Wyoming	Alabama Alaska Arizona Arkansas California Colorado Connecticut Delaware Florida Georgia Hawaii Idaho Illinois Indiana Iowa Kansas Kentucky Louisiana Maine Maryland Massachusetts Michigan Minnesota Mississippi Missouri Montana Nebraska Nevada New Hampshire New Jersey New Mexico New York North Carolina North Dakota Ohio Oklahoma Oregon Pennsylvania Rhode Island South Carolina South Dakota Tennessee Texas Utah Vermont Virginia Washington West Virginia Wisconsin Wyoming	Alabama Alaska Arizona Arkansas California Colorado Connecticut Delaware Florida Georgia Hawaii Idaho Illinois Indiana Iowa Kansas Kentucky Louisiana Maine Maryland Massachusetts Michigan Minnesota Mississippi Missouri Montana Nebraska Nevada New Hampshire New Jersey New Mexico New York North Carolina North Dakota Ohio Oklahoma Oregon Pennsylvania Rhode Island South Carolina South Dakota Tennessee Texas Utah Vermont Virginia Washington West Virginia Wisconsin Wyoming

Follow the Rules

Chiropractic and Acupuncture Services


Quick Reference Guide – All Regions

- Included.
- If VA is appointing, submit the Request for Services (RFS) directly to the authorizing VA Medical Center (VAMC). VA will review the included clinical documentation supporting your request. If approved, you will be notified.
- No payment will be made for services rendered without a prior authorization.
 - Chiropractors should follow the same appointing and authorization process as other Community Care providers. Refer to the Appointment Scheduling Quick Reference Guide for more information.


100

Keep an Eye Out for Medicaid Cards


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

**UnitedHealthcare** | Community Plan
Health Plan (HMO) 911-877-26-04
Member ID: 999999999
Subscriber: M BROWN SR
MMIS: 999999999999
PCP Name: DR. PROVIDER BROWN
PCP Phone: (999) 999-9999

MyCareOhio
Community Health Plan
Member ID: 87726
Subscriber: M BROWN SR
MMIS: 999999999999
PCP Name: DR. PROVIDER BROWN
PCP Phone: (999) 999-9999

**MOLINA**
Healthcare
Member ID: 87726
Subscriber: M BROWN SR
MMIS: 999999999999
PCP Name: DR. PROVIDER BROWN
PCP Phone: (999) 999-9999


Molina Medicaid
Member ID: 87726
Subscriber: M BROWN SR
MMIS: 999999999999
PCP Name: DR. PROVIDER BROWN
PCP Phone: (999) 999-9999



101

Find Your State Medicaid Status

102

**KFF Medicaid Chiropractic Coverage**

Medicaid Benefits: Chiropractor Services

Find out if your state covers chiropractic services under Medicaid. Search by state or filter by state.

Search by state:

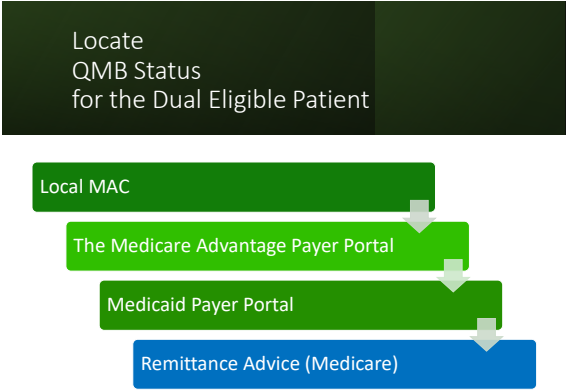
Filter by state:

Results: 10 states

State	Coverage	Notes
Alabama	Covered	
Alaska	Covered	
Arizona	Covered	
Arkansas	Covered	
California	Covered	
Colorado	Covered	
Connecticut	Covered	
Delaware	Covered	
Florida	Covered	
Georgia	Covered	
Hawaii	Covered	
Idaho	Covered	
Illinois	Covered	
Indiana	Covered	
Iowa	Covered	
Kansas	Covered	
Kentucky	Covered	
Louisiana	Covered	
Maine	Covered	
Maryland	Covered	
Massachusetts	Covered	
Michigan	Covered	
Minnesota	Covered	
Mississippi	Covered	
Missouri	Covered	
Montana	Covered	
Nebraska	Covered	
Nevada	Covered	
New Hampshire	Covered	
New Jersey	Covered	
New Mexico	Covered	
New York	Covered	
North Carolina	Covered	
North Dakota	Covered	
Ohio	Covered	
Oklahoma	Covered	
Oregon	Covered	
Pennsylvania	Covered	
Rhode Island	Covered	
South Carolina	Covered	
South Dakota	Covered	
Tennessee	Covered	
Texas	Covered	
Utah	Covered	
Vermont	Covered	
Virginia	Covered	
Washington	Covered	
West Virginia	Covered	
Wisconsin	Covered	
Wyoming	Covered	

(855) 832-6562

17



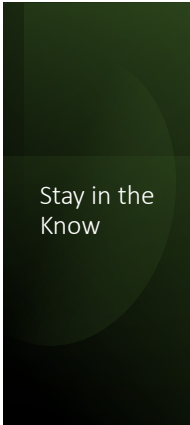
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104



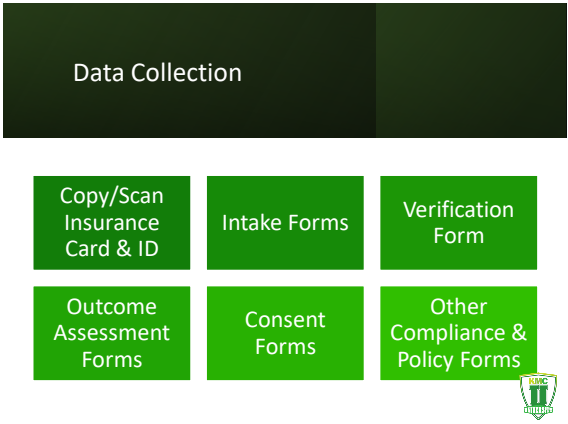
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106

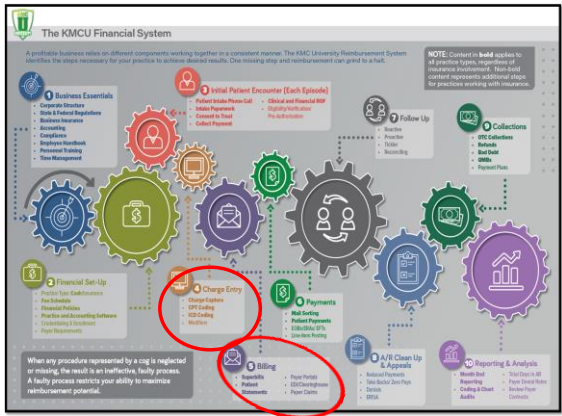


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108

19



115



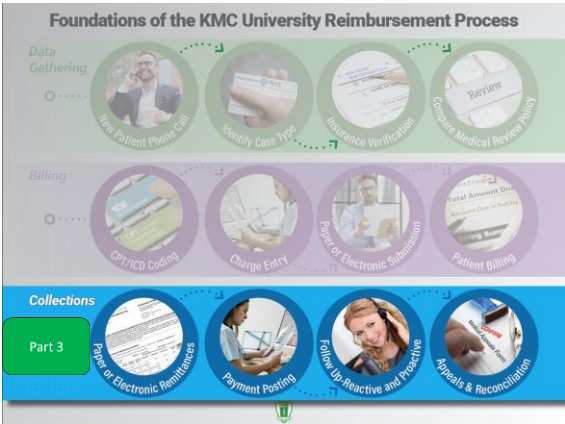
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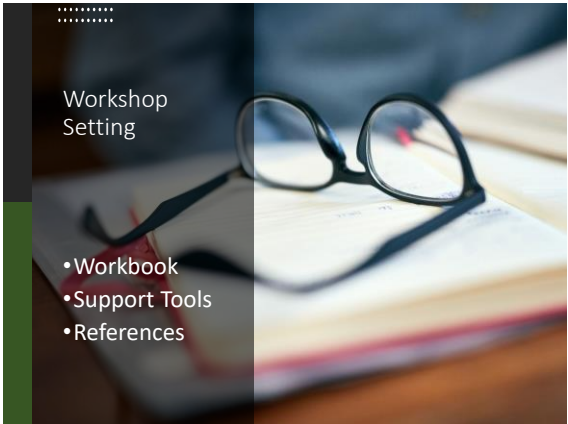
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118




119



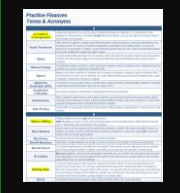
120

The Language of Practice Finances

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







Practice Finance Terms & Acronyms



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



Minnie Medders

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

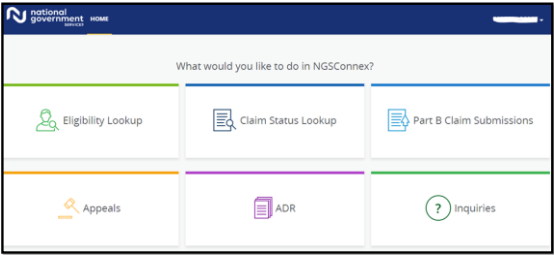
Demographics

Overview	Clinical	Documents	Billing	Insurance (1)	Ledger	Claims Worklist	Cases (1)
Profile Appointments Insurance							
Demographics							
Basic Information		Medical Record Number		Alerts & Notes			
Medders, Minnie		C71002		Type Message			
Female		Status		There are no Alerts or Notes for this patient.			
01/01/1954 69 years old		Active					
Additional Information		Employment Status		Insurance (1)			
Social Security Number: 035-66-7634		Retired		Set as Payer Plan Name Insured ID			
Relationship Status: Widowed		Preferred Location		Primary Medicare Medicare SKG880747			
Preferred Provider: Auchenbach, Colleen		Kathy Mills Chang, Inc.					
Contact Information		Email		Active Guarantors (1)			
Address: Grateful Wy, Woodport, MO 64095		minnie1954@gmail.com		Name Relation Balance			
Phone Number: (207) 219-7841 (home)				Medders, Minnie Self \$0.00			

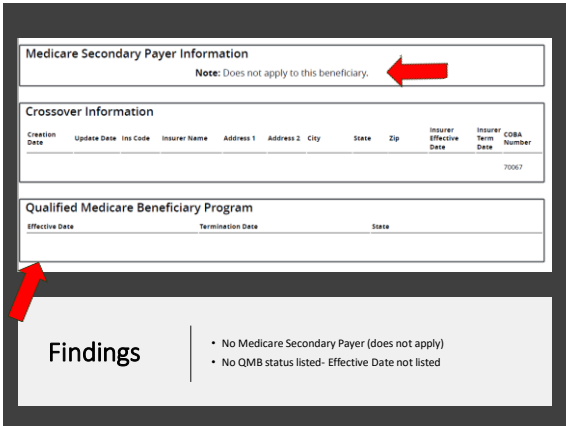
126

MAC Portal

- Eligibility Look Up Tool



127



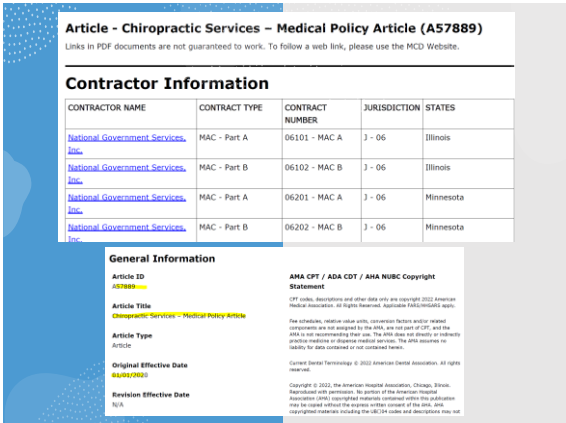
128

Finding the Coverage Documents



- LCDs
- Medical Policy Articles

129

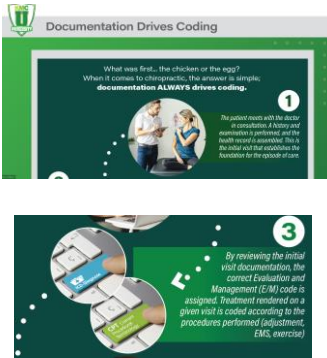


130

Let's Find Novitas Louisiana

131

Document FIRST then Code The Compliant Way




132

POLL

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

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, Spondylosithesis, 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, Headaches, and 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.



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.

Foundations of the KMC University Reimbursement Process

Billing

CPT/ICD Coding

Charge Entry

Upload of Electronic Submission

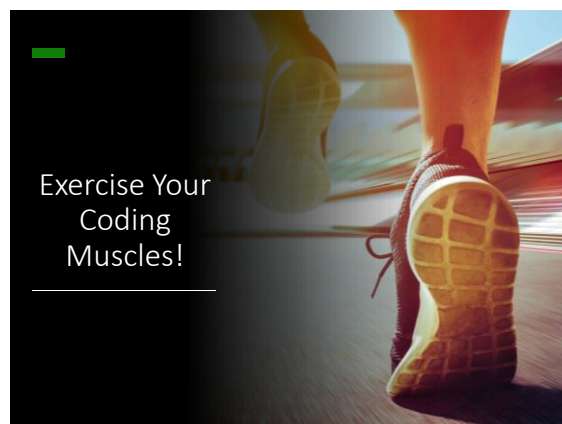
Patient Billing

Total Amount Due
Amount Due in Full

ICD Diagnosis

CPT Current Procedure Terminology

CPT/ICD Coding



Exercise Your
Coding
Muscles!

23

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



- (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.



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

141

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

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 _____

143

144

Time to Complete



145

Exercise -3 The Diagnosis Order

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Relate A-L to service line below (24E)										ICD Ind.
A			B			C			D	
E			F			G			H	
I			J			K			L	
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE		C.	D. PROCEDURES, SERVICES, OR SUPPLIES			E. DIAGNOSIS	
From To			YY MM DD YY		SEVICE	EMS	(Explain Unusual Circumstances)			MODIFIER
MM DD YY MM DD							CPT/HCPCS			POINTER

147

Exercise 4- Diagnosis Pointing

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

149

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

Answer



148

Time to Complete



150

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below G4E

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. PROCEDURE, SERVICE, OR SUPPLY (Explain Unusual Circumstances) D. 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

MAC Reporting Requirements

- Point to the Primary Diagnosis only

		SV101-6	Procedure modifier 4	the claim notes (N11) item 11.
24	Diagnosis code	2400	SV101-1	Diagnosis code pointer

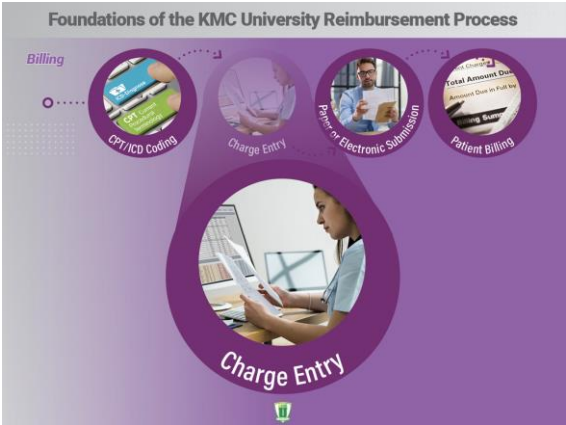
Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
			SV101-2	Diagnosis code pointer	Enter the diagnosis code reference letter shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. At patient level point to the primary diagnosis for each service line. Use the remaining diagnosis pointers in declining level of importance to service line.
			SV101-3	Diagnosis code pointer	
			SV101-4	Diagnosis code pointer	

Answer



151

152



153

Support Tool

Charge Entry Checklist

A checklist must be completed in process for submitting and entering patient encounter information accurately and efficiently.

New Patient Visit

- Verify that the patient has signed and dated all of the appropriate forms including: Consent to Treatment, Financial Policy, Notice of Privacy Practices Acknowledgment, ABN (if applicable), PHN (if applicable), Consent to Treat (if applicable), physician's form (if applicable), etc.
- Make sure a copy of the patient's insurance card and any other identification is scanned into the system (if applicable) or copied and placed in the patient file. Compare the physical information to the information that was entered in Practice Management (PM) software. Double-check spelling of names and other details.
- Locate the patient's insurance verification form and compare this information to what was entered on the initial visit. Confirm the accuracy of the information, such as patient demographic, policyholder's name, primary or secondary status of policy, assignment of benefits, pre-authorization requirements, and limitations, co-pay, etc.
- Enter the patient's name, date of birth, or other patient response accurately into the PM (not what is applicable) or place a sticker on the chart.
- Enter the visit diagnosis into the Practice Management software and all other information, or place a sticker on the chart with this information. Be sure to include pre-authorization status, health status, and other conditions (if applicable).
- Locate the Insurance Reimbursement form (IAR), make sure the patient has completed form. Enter columns for make sure the provider has filled into Practice Management software (if applicable). Explain the IAR to patient for any questions or follow-up.

154

Mapping Charge Entry Data

Software interface showing patient information and a red circle around the 'Charge Entry' button.

Signature of physician or supplier including degrees or credentials. Includes a date stamp: 09/08/2020.

155

Software interface showing 'Current Condition' and 'Facility Address' tabs. Includes a red box around the 'Current Condition' section and a red box around the 'Facility Address' section.

156

The screenshot displays the ChiroTouch software interface. At the top, the 'chirotouch' logo is visible. The main header area shows the date 'Monday, November 20, 2017' and a navigation bar with buttons for 'PATIENT INFORMATION', 'DX', 'APPOINTMENTS', and 'LEGDER'. The 'DX' button is highlighted with a red circle. Below the header, the 'Diagnosis' section is active, displaying a list of diagnoses: 'Chiropractic Tx', 'Increase Outcome', 'IBS (10)', 'Acute suprapubic pain, tender LLQ (20)', and 'Adhesive capsule of L1 shoulder'. The 'Date of Current Issue' is set to 'September 01, 2017'. Below this, there are three buttons: 'CHRONIC', 'CLAR', and 'COPY', with 'COPY' also circled in red. The right-hand panel, titled 'PCSR Administrative User', contains a 'Subjective' section with a list of symptoms: 'Complaint 2D: Reports an acute complaint persisting after sitting or standing too long', 'Frequency/Quality: Occasional in 50%', 'Exacerbation of Symptoms: Corrected with Change in Complaint/VRG: Complaint is frequently noted (50%) being noted in previous examinations', 'Modifying Factors: Relieved by physical therapy', 'Previous Examinations: done and system', 'Previous Care: Received nothing as of 10/1/17', 'Recent Diagnostic Tests: No ADL functional deficits: Explains pain and weakness when she does this for exercise. No additional concerns relayed by patient.', and an 'Objective' section with a 'Post-Physical Examination' sub-section.

87115) Ther Exam 1 unit

ICD-9-CM 9.4-9.700

New Patient
On 1/8/2008

History 1.2 Prevalent
87115) Ther Exam 1 unit

Car Codes (1-10 of 10)

1.2 Prevalent CMT
3.4 Prevalent CMT
7 Prevalent CMT
Extremity CMT
Ther Exam 1 unit

Diagnosis Posting

Assign diagnosis for charge

☒ Use appointed diagnoses

Select diagnoses for this charge

ICD-9-CM Radiography - External leg
(M54.9) Low back pain

ICD 944
C L H L
G L H L
K L H L
L L H L
M L H L
N L H L
O L H L
P L H L
Q L H L
R L H L
S L H L
T L H L
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XI

```

graph TD
    A[Customize] --> B[Map]
    B --> C[Update]
    C --> D[Train]
  
```

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



Audit Skills



Exercise 5 – What is Wrong With This Claim?

[illegible]

27

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



163

Exercise 6 – What is Wrong With This Claim?

164

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



165

Answer

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

166

Coding Direction by Local MACs

- Some include ICD-10 Group Codes
- All have a revision history

167

Patient #1 Minnie Medders

We encourage clinics to scrub their claims prior to submission. Once you have confirmed that your data is mapping correctly from your practice management software to the claim form, you should drop some claims to paper to see if all the data is being captured correctly. Some billing issues are due to not properly mapping the data, while others are due to lack of knowledge about coding and modifier usage. Keep an eye out for these common mistakes.

1. Appending both the AT modifier and GA on the same procedure
2. Box 14 having a date that exceeds 90 days or more
3. Forgetting to append the GY modifier on excluded services
4. Forgetting to append the GP modifier on therapies and modalities
5. Failing to confirm OMB status prior to assigning patient responsibility and/or failing to add secondary Medicaid payer information when applicable

168

