Appendix

Answer Key & FAQs (Frequently Asked Questions)

Minnie Medders

Exercise 1

Diagnosis Codes

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

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

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

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

(M62.830) Muscle spasm of back

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

Exercise 2

Procedure Codes

99204-25-GY

98940-AT

97035-GY-GP

Exercise 3

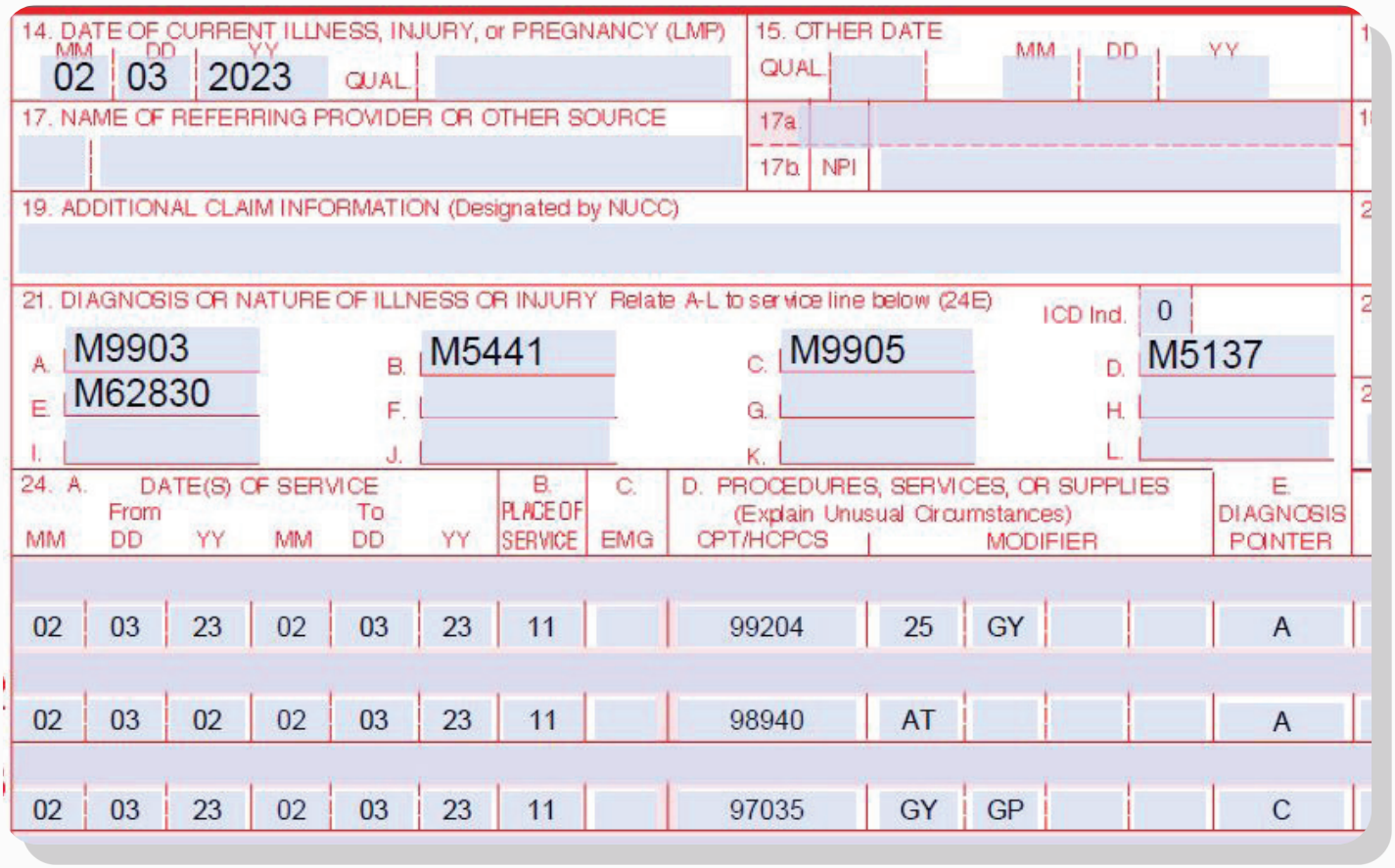
Diagnoses in Order

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

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

Exercise 4

Link Diagnosis to Procedure

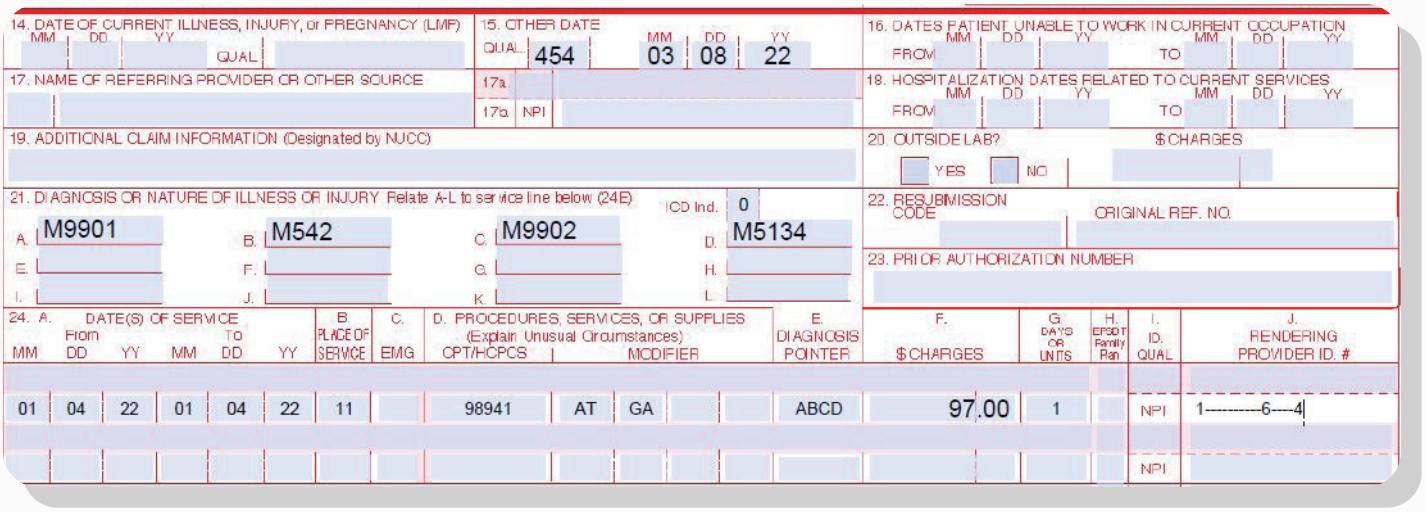


14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 02 03 2023 QUAL:
15. OTHER DATE QUAL: MM DD YY:
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a:
17b. NPI:
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line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

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

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

Exercise 5



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

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

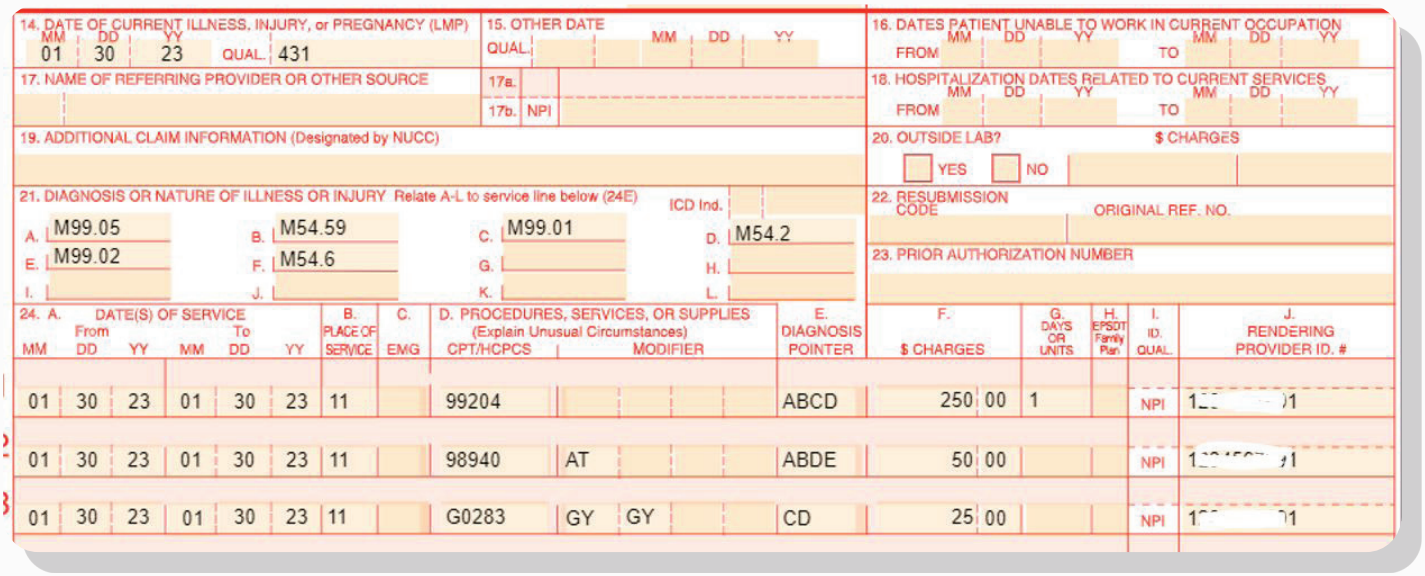
22. RESUBMISSION CODE: ORIGINAL REF. NO.:
23. PRIOR AUTHORIZATION NUMBER:

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

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

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

Exercise 6



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

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

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

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

Coding Quiz

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

Collections Stage

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. **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**

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**

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

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

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 procedure code 97140 is missing the required modifier (59 or X(E,P,U,S) which would designate it as a separate or distinct procedure from CMT. Per CPT the CMT code is considered 'mutually exclusive' of 97140 unless billed with a modifier since both are described as manual therapy 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.

Exercise 5

Let us put your line item posting skills to work. You are now looking at Minnie's EOB from Medicare. 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 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)

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?

99204, 97035

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?

$ 12.54

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

$ 307.46

Medicare FAQs

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

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

Option 1 - you must bill

Option 2 - you would not bill Medicare

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

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

Am I required to bill Medicare for statutorily excluded services?

No, not unless the patient requests you to do so. However, if you are in network with the patients' secondary or supplemental plan, then you must determine if those services are covered or non-covered. If the services are covered, you will be required to bill them to Medicare, so that Medicare will cross them over to the patients' secondary or supplemental payer. NOTE: If you are not required to bill the services, the patient is responsible for your full fee on all statutorily excluded services unless you are part of a medical discount plan such as ChiroHealth USA, or if you are offering a Time-of-Service discount (between 5% and 15%) and the patient is paying in full that day.

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

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

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

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