

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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But What If You Get Caught?

8

With"

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



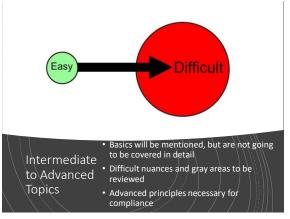
"We All Have to Decide for **Ourselves How** Much Sin Risk We Can Live



Know the Rules that Govern Healthcare

RULES 1. YOU CAN.... 2. YOU CANIT... 3. YOU CANIT... 4. YOU CANIT

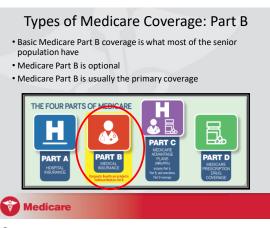


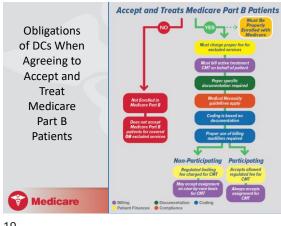


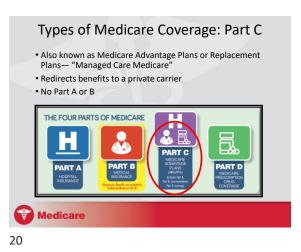


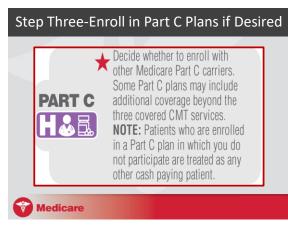










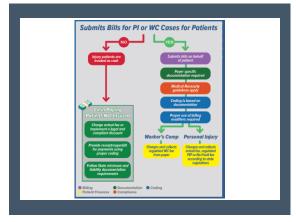


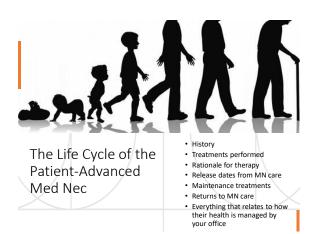
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Accepts and Treats Medicare Part C Patients

Submits Health Insurance Bills for Patients







27



Medicare

Absence of Others

Documentation

Guidelines in the

- 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



 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?

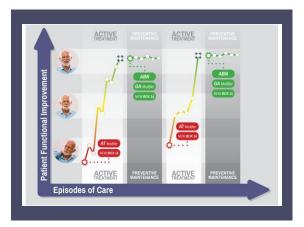
What Medicare Payers Want to See

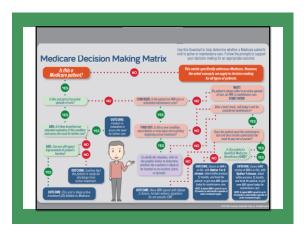
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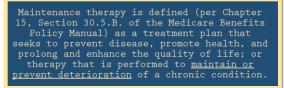


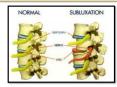


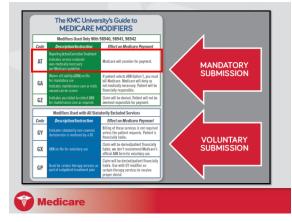




The Opposite of Active Treatment

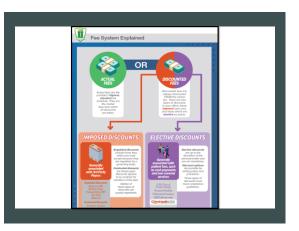








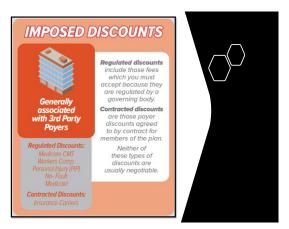
	This H	our's Plan	
Q			(J)
WE'LL REVIEW THE TOP ISSUES SEEN ON AUDIT AND FOUND WHEN DOCUMENTATION AUDITS OCCUR	HAVE A CLEAR UNDERSTANDING OF ALL ASPECTS OF YOUR FEE SYSTEM	RECOGNIZE HOW TO SET ACTUAL FEES CONSIDERING YOUR PRACTICE COSTS	INCLUDE ALL ASPECTS OF A FEE SYSTEM TO ACCOMMODATE ALL ASPECTS OF YOUR PATIENT BASE
	CREATE PO PROCEDURE TO LIN	KEEP YOU IN	
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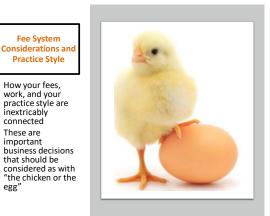
Fee System

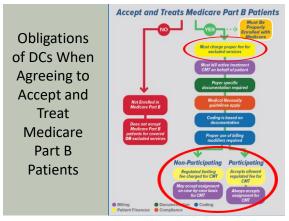
How your fees, work, and your

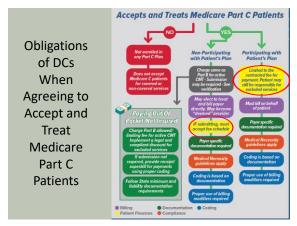
inextricably connected

 These are important

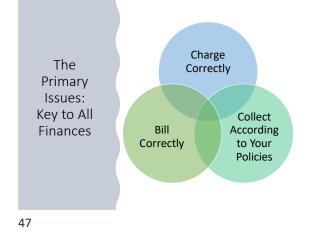
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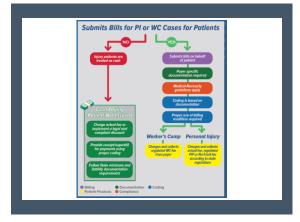




















May violate provider agreements

51



False Claims Act Violations

- Establishes liability when any person or entity improperly receives payment from or avoids payment to the Feds
- Prohibits "knowingly presenting or causing to be presented, a false claim for payment or approval"
- "Hello" waived deductible or copayment!



52

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Improper Time of Service Discounts

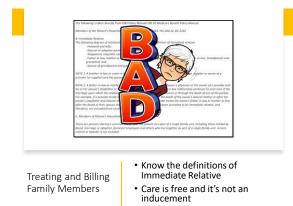
Discount should be based on **bookkeeping savings**

- May or may not be defined
- Often indefensible or unreasonable
- May not be permissible for federally insured patients

Avoid Anti-Kickback Violations person that offers or transfers to a Medicare Medicaid beneficiary **any remuneration** at the person knows or **should know** <u>is</u> **cely to influence the beneficiary's selection a particular provider**, practitioner, or pplier of Medicare or Medicaid payable **ms** or services may be liable for civil money naities (CMPs) of **up to 510,000** <u>for each</u>

The statute defines "remuneration" to include, without limitation, waivers of copayments and deductible amounts (or parts thereof) and transfer of items or services free of charge or for other than fair market value.

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57



59



Tuesday, March 6, 2018

Oelwein Chiropractor and Clinic Agree to Pay Nearly \$80,000 to Resolve False Claims Act Allegations Involving Free Electrical Stimulation

Bradley Brown, D.C., from Oelvein, Jowa, and his clinic, Brown Chiropractic, P.C., have agreed to pay 579,012 to resolve allegations Brown violated the False Claims Act by improperly billing Medicare and Medical for chiropractic adjustments after providing free electrical stimulation to beneficiaries to influence those beneficiaries to receive chiropractic adjustments from from. The covernment alleged that this conduct of the Anti-Kickback Statute and, in turn, the False Claims Act. The Jums at issue vere submitted between Jahmey, scans, and Steptember 70, 2016.

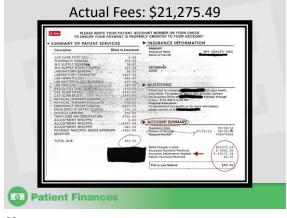
The Anti-Kickback Statute's purpose, in part, is to protect patients and federal healthcare programs from fraud and abuse by limiting the influence of money or improper incentives on healthcare decisions. It is intended to ensure, among other things, that improper financial incentives do not compromise providers' medical judgments and that inappropriate considerations do not cloud beneficiaries' decisions when determining which providers to utilize and which services to obtain.

"Our office takes seriously our responsibility to safeguard taxpayer dollars and to ensure a level playing field for healthcare providers," said Peter E. Deegan, Jr., United States Attorney for the Northern District of Iowa. "We appreciate Dr. Brown's cooperation in the investigation and hope this settlement ends a message to all providers that they must comply with all applicable rules and regulations or face consecuences."

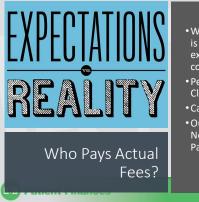
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FOR IMMEDIATE RELEASE



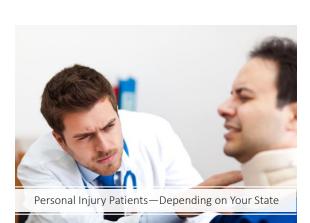


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- What you bill is what you expect to collect
- Personal Injury Claims
- Cash Patients •Out-of-Network
- Patients

63



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62

Evaluate Actual Fees Annually and Base Them on Your Costs



ls It

- not be what you collect PIP Fee Schedule
- No-Fault Fee
- Schedule Contracted Rates
- Inappropriate reductions
- Silent PPOs
- Attorney requests for adjustments





Cash Patients May Pay Actual Fee

• Using a DMP like ChiroHealthUSA takes cash paying patients out of the actual fee range

the Feds



Out of Network Patients-OOPS-No Surprises!! If you represent full fee to

- the insurer, the patient must pay full fee What you bill is what you
- expect to collect, outside of any agreements/contracts Charge correctly, bill
- correctly, collect according to your office policy



67

69



for the business is Cost to Deliver a Visit (CDV)

- Compared with "Collected per Visit" allows for knowledge of profitability
- As a practice grows, CDV usually comes down



Know Your Cost to

Deliver Services for

Maximum Profitability

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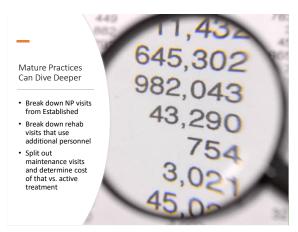
Necessary

minimum · Easy to do

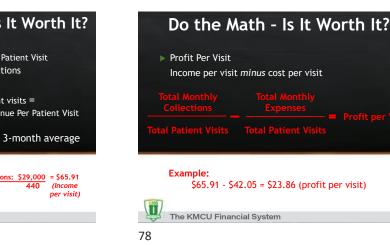






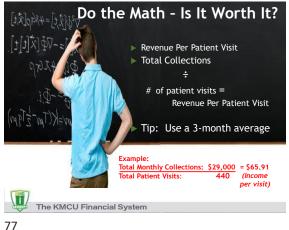


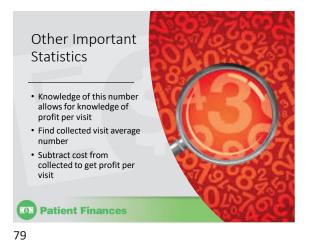
Do the Math - Is It Worth It? Cost Per Patient Visit Total Monthly Expenses (fixed and variable) + Total Patient Visits during the month = Your Cost Per Patient Visit TIP: Use a 3-month average as these are variable Example: \$42.05 Total Monthly Expenses: \$18,500 \$42.05 Cost p Total Patient Visits: 440 . visit) The KMCU Financial System 76



73

Simple Math to Calcula	ate CDV
How to calculate yo those to beliver a Vis	it (CDV)
Step 1 Enter the Total Practice Overhead during the last 12 months in the space on the right	
Step 2 Enter the Total Office Visits (OV's) during the last 12 months.	
Step 3 In order to get your CDV, divide the number on Step 1 by the number on Step 2.	Your CDV is:
How to calculate your Cost to Deliver a Vis	sit (CDV)
Step 1 Enter the Total Practice Overhead during the traditional state in the space on the right	\$120,000.00
Step 2 Enter the Total Office Visits (OV's) during the last 12 months.	3150
Step 3 In order to get your CDV, divide the number on Step 1 by the number on Step 2.	Your CDV is: \$38.09
Patient Finances	
75	



















Medicare Part B Fee Schedule

- Found on your contractor's website
- May change annually
- Applies ONLY to the three spinal CMT codes in Active Treatment
- Doesn't apply to Medicare Part C aka Medicare Advantage

86

Medicaid Fee Schedule

- Medicaid fees are regulated federally but applied state to state
- Found on the State Medicaid website
- Chiropractic may or may not be covered
- Medicaid must process Dually Eligible QMB patients





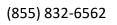


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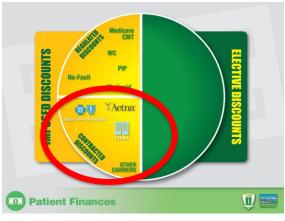
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Understand the Patient Type, then the Fees

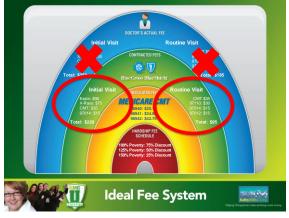
- Visit the KMC University Library courses on "What Is.." each payer type along with how to verify
 Practice Finances
- Apply the appropriate fee schedule in your system when seeing these types of patients



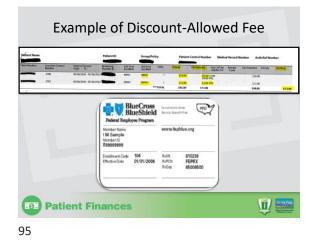


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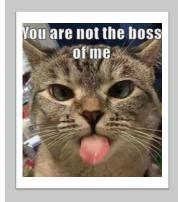


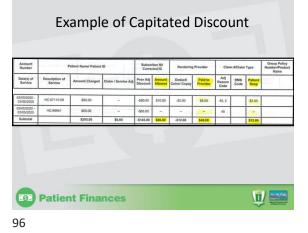
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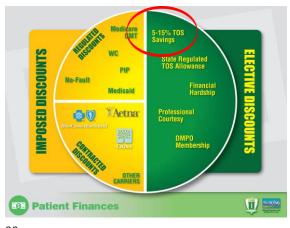
- A famous person once said, "Your fee is your fee is your fee!"
- Whether you join discount networks is a personal and business decision
- There is much to understand and consider when making these important business decision





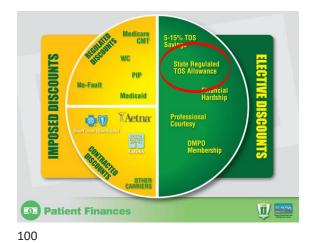






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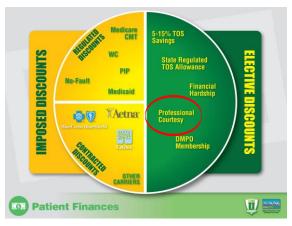
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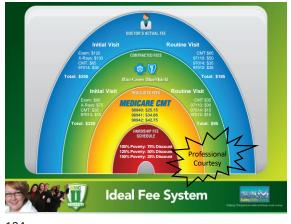
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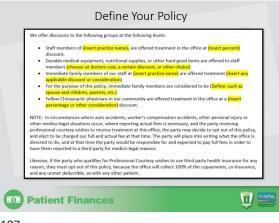




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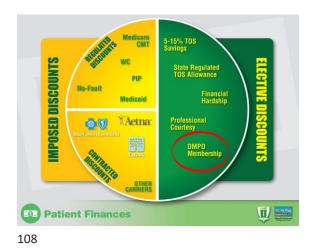


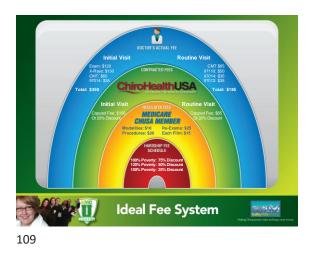


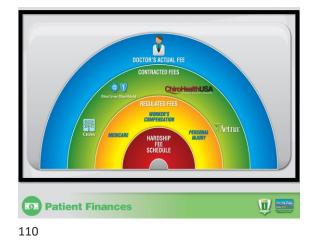


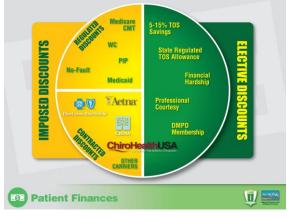












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 Non-Par

 Doesn't

 Mean Wild

 West!

 Approximate percentage of

 non-participating providers

 that are charging their

 Medicare patients the wrong

 fee for adjustments

113







- Medicare patients must be charged your ACTUAL fee for the services they pay for out-ofpocket
- If they qualify for a discount due to another program available in your office, they can be charged that fee



115









117



119



If not participating, decide whether to bill it (not suggested) and collect according to fee schedule

Medicare

Part C-In

Flux!

If you do not bill, keep to the Medicare Fee Schedule you follow for Part B





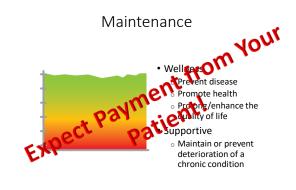


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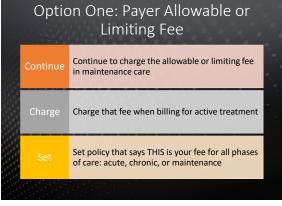


Choice

123



124



126

Three Choices for Fees in Maintenance Care

- Charge allowable fee or limiting fee
- Charge your actual fee
- Charge a discounted fee for maintenance if the patient qualifies and you offer this to ALL types of patients
- Codify this in your compliance policy

Option Two: Charge Actual Fee for Maintenance Care

50.7.3 - Effects of Lack of Notification, Medicare Review and Claim Adjudication (Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)
A. Beneficiary Liability
A beneficiary who has been given a properly written and delivered ABN and agrees to pay may be held liable. The charge may be the supplier provider's usual and customary fee for that item or service and is not limited to the Medicare fee schedule. If the beneficiary does not receive proper notice when required, s/he is relieved from liability.
Notifiers may not issue ABNs to shift financial liability to a beneficiary when full payment is made through bundled payments. In general, ABNs cannot be used where the beneficiary would otherwise not be financially liable for payment for the service because Medicare made full payment. See 50.13 for information on collection of funds.

Medicare Claims Processing Manual: Chapter 30; Section 50.7.3A

127



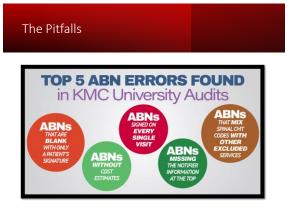
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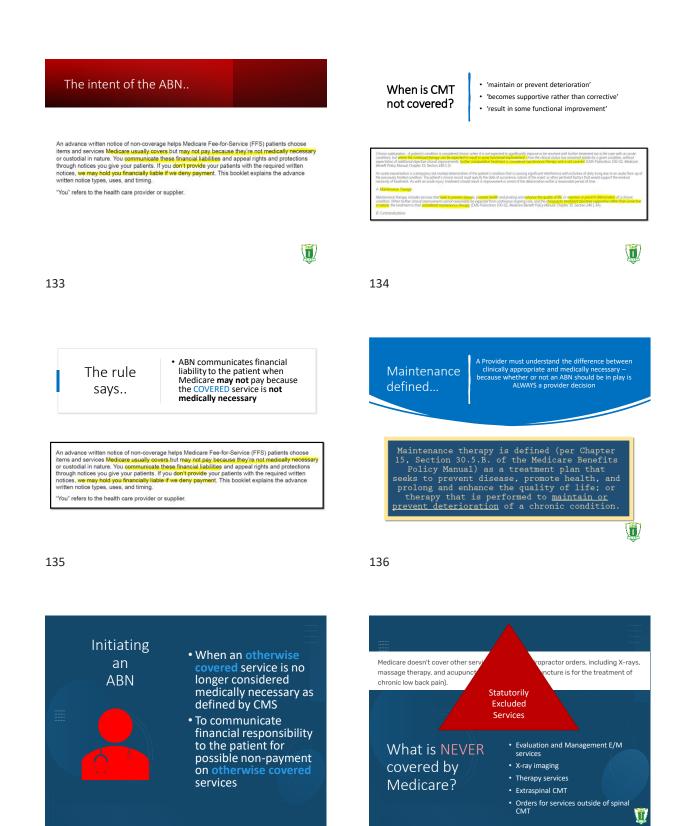


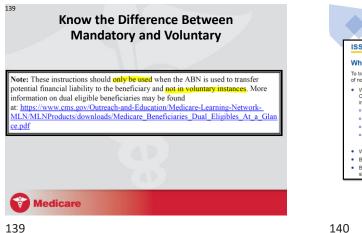
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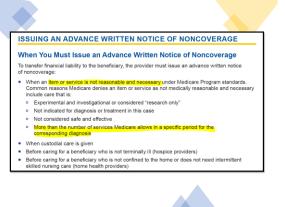


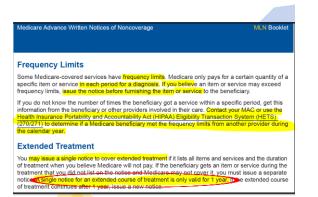
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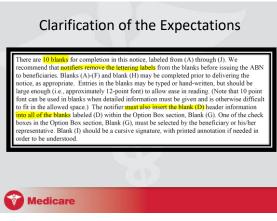
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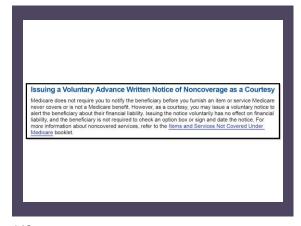


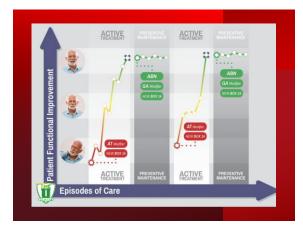




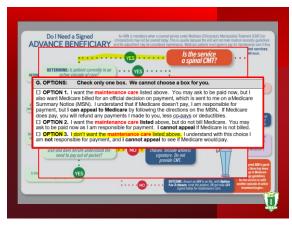


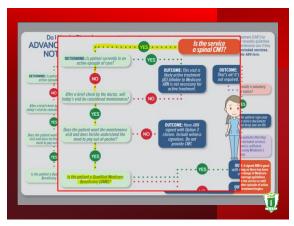


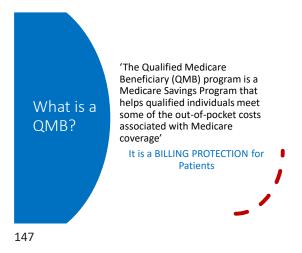


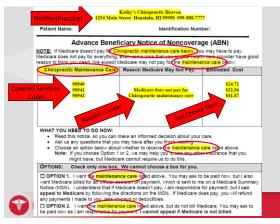


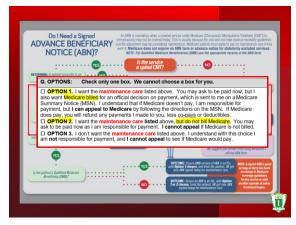


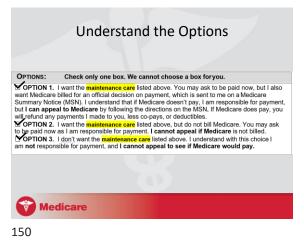


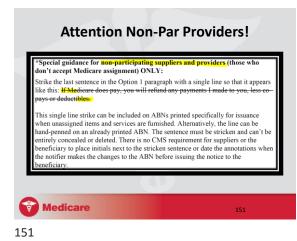




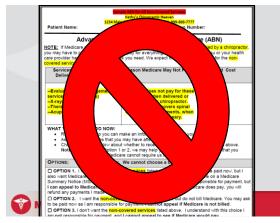


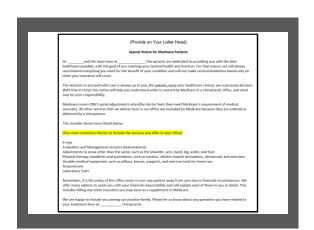






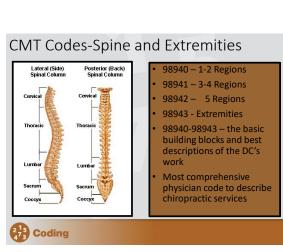








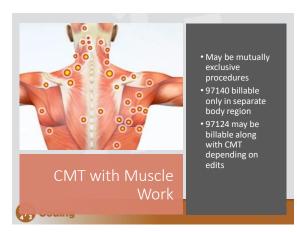




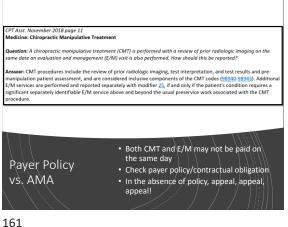




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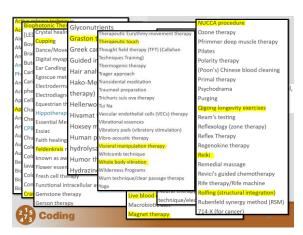
CMT with Evaluation and Management







	echnique (see CPB 0388 - Complementary and Alternative Medicine @)	
	tic Movement (ATM2)	investigational:
	uctural Correction (ABC) Chiropractic Technique	
D. Applied Spinal B	Q. Gonzalez Rehabilitation Technique	
E. Atlas Orthogona	R. Inertial traction (inertial extensilizer decompression table	
F. Bioenergetic Syr	S. IntraDiscNutrosis program	
G. Biogeometric In	T. Koren Specific Technique	
H. Blair Technique	U. Manipulation for infant colic	
I. Bowen Techniqu	V. Manipulation for internal (non-neuromusculoskeletal) disorders (Appli	ed Kinesiology)
J. Chiropractic Bio	W. Manipulation Under Anesthesia (see CPB 0204 - Manipulation Under G	General Anesthesia 🖄
K. Coccygeal Meni	X. Moire Contourographic Analysis	
L. ConnecTX (an in	Y. Network Technique	
M. Cox decompress	Z. Neural Organizational Technique	
N. Cranial Manipul	AA. Neuro Emotional Technique	
O. Directional Non	AB. Positional release therapy	
P. FAKTR (Function	AC. Sacro-Occipital Technique	
	AD. Spinal Adjusting Devices (ProAdjuster, PulStarFRAS, Activator)	
	AE. Therapeutic (Wobble) Chair	
	AF. Upledger Technique and Cranio-Sacral Therapy	
	AG. Webster Technique (for breech babies)	
	AH. Whitcomb Technique (see CPB 0388 - Complementary and Alternative	Medicine ≌).
Codi	ng	
160		
163		



So? I'm a Full Spine Adjuster! · Medical necessity definition dictates that you must prioritize each area of complaint • Every visit: S + O (P + ART) for every region treated • 2 DX codes for each region Treatment plan for each/short and long term goals

Record Keeping Requirements

A complaint involving at least one spinal region; AND
 An examination of the corresponding spinal region(s); AND

Claim must record a diagnosis code in the applicable region(s).

1. A complaint involving at least three spinal regions; AND

A diagnosis and manipulative treatment of a condition involving at *least one* spinal region.

Medical record must document:

Medical record must document:

165

CPT

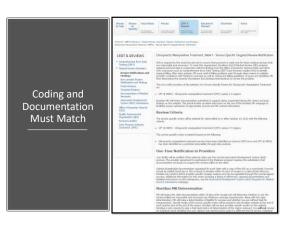
98940

98941

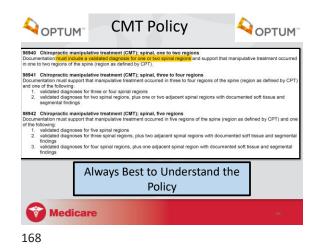
Description

Chiropractic manipulative treatment (CMT) involving one to two spinal regions

nt (CMT) involving three



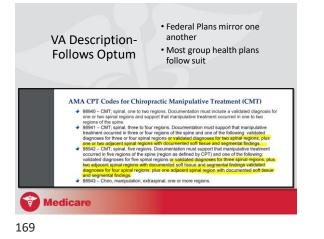
166

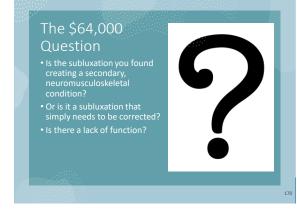


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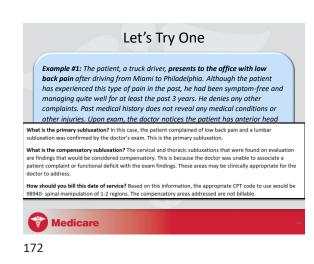




This Means Causally Related in All Areas to be Treated

- The complaint drives the examination, which drives the diagnosis and assessment, which drives the treatment plan
- No complaint, no covered adjustment
- Compensatory areas may be addressed for the patient and documented as such-correlate to examination findings

171





Moral of the Story:

Always Check Medical Review Policy Before You Jump in the Sandbox with a Third-Party Payer!

CMT and CPT Coding is Exactly the Same In and Out of Medicare

Cervical	The atl	anto-occipital joint (CO/C1), and C1 through C7		
Thoracic		ugh T12, including the posterior ribs (costotransverse and costovertebral joints		
Lumbar		L1 through L5		
Sacral	The sacrum, including the sacrococcygeal joint			
Pelvic	The sacroiliac joints and other pelvic articulations			
Head		Includes the TMJ, but excludes the atlanto-occipital joint		
Head		Includes the TMJ, but excludes the atlanto-occipital joint		
Upper Extre		Shoulder, arm, elbow, wrist, and hand		
Lower Extre	emities	Hip, leg, knee, ankle and foot		
Rib Cage		Anterior rib cage, including the costosternal joints, but excluding the costovertebral joints		
Abdomen		Includes the soft tissue of the abdomen		
<u>es</u> : There are 1	three spin	al CMT codes and one extraspinal CMT code. They are:		
	98940	CMT, 1 or 2 spinal regions as noted above		
	98941	CMT, 3 or 4 spinal regions as noted above		
	98942	CMT, 5 spinal regions as noted above		

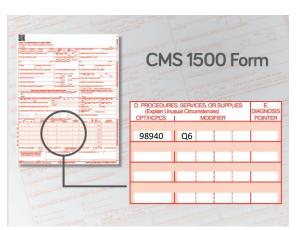
174

www.KMCUniversity.com

Fee for Time Compensation (formerly known as Locum Tenens)

- •Less than 60 days
- •The substitute doesn't own a practice
- Regular physician unavailable and not part of a group
- Contracted provider





176



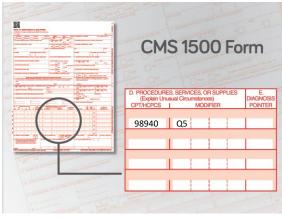
Coding



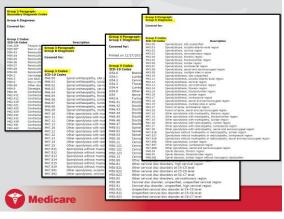
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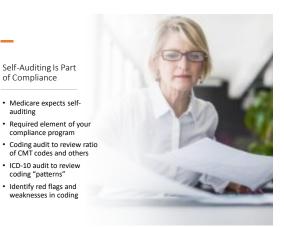


179



Group 1 Co	odes:
ICD-10 Co	des Description
M99.00	Segmental and somatic dysfunction of head region
M99.01	Segmental and somatic dysfunction of cervical region
M99.02	Segmental and somatic dysfunction of thoracic region
M99.03	Segmental and somatic dysfunction of lumbar region
M99.04	Segmental and somatic dysfunction of sacral region
M99.05	Segmental and somatic dysfunction of pelvic region





182



183

His office supurrvisor

Supervised Modalities

- 97010-97028 DO NOT require one-on-one contact by the provider
- Billed only once per encounter
- Are not time based for billing purposes
- Expected 2-12 visits
- However documentation should include the time spent on the modality

Coding

Coding

186

184



97012 Mechanical Traction

- Force used to create tension of soft tissue or to separate joints
- Untimed & billed only once a visit
- Intersegmental or Roller tables meet criteria, BUT check with 3rd party payer guidelines
- Flexion Distraction technique is a CMT & should be coded as an adjustment

97010 Hot/Cold Packs

- Application of hot packs, ex. hydrocollator packs or moist towels
- Application of Ice packs or cryotherapy
- Often a non-covered service
- Does NOT include applying BioFreeze or any other type of topical analgesic
- Never charge a Medicare patient

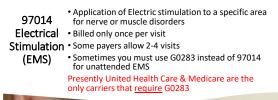
Coding

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(855) 832-6562

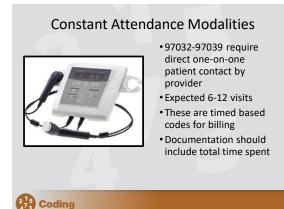








188



189



191

97032 Attended Electrical Stimulation

- Application of a modality to one or more areas; electrical stimulation [manual] each 15 minutes
- •Most often combo unit
- •You can't just move the pads and call it attended!



27. Coding

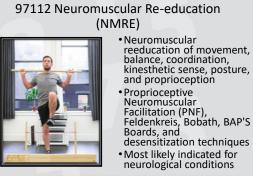


Therapeutic Procedures

- Therapeutic Procedures are time-based codes for billing purposes
- The patient is ACTIVE in the encounter
- on-one patient contact
- Documentation should include both the total time spent and the time spent doing each
- Codes are billed per 15 min increments



193



195

Coding



- Passive procedure used for restorative effect
- Used for effleurage, petrissage, and/or tapotement, stroking, compression, and/or percussion
- Considered separate and distinct from CMT

(97110-97546)



Requires direct one-

activity/exercise.

97530 Therapeutic Activities

Dynamic activities to improve functional performance, direct

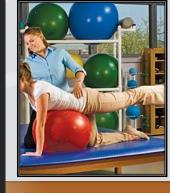
- (one-on-one) with the patient (15 minutes) Incorporates two or
- more:
- Strength Endurance
- Range of motion

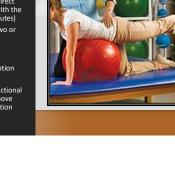
Coding

198

- Flexibility
- Must show functional deficit in the above during examination

196







197

97110 Therapeutic Exercise

- Therapeutic Exercise, each 15 mins. One or more areas
- Incorporates one: Strength
 - Endurance
 - Range of motion
 - Flexibility

 Must show functional deficit in the above during examination

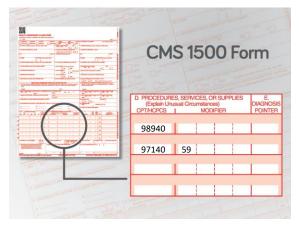
Coding



199



201



203

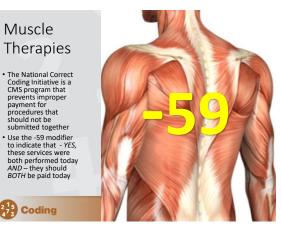
When To Use 97140

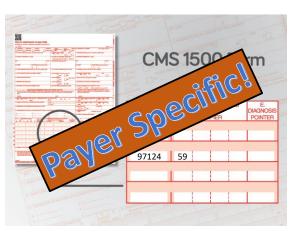


- To effect changes in soft tissues, articular structures, and neural or vascular systems
- To address a loss of joint motion, strength, or mobility
- Must be part of an active treatment plan directed at a specific outcome
- Daily routine visit documentation should include progress toward those stated goals

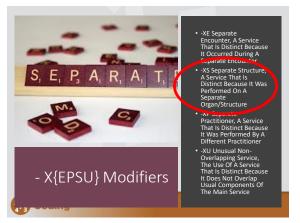
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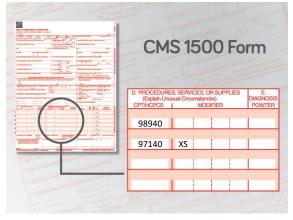
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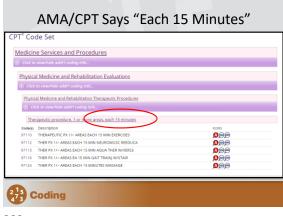






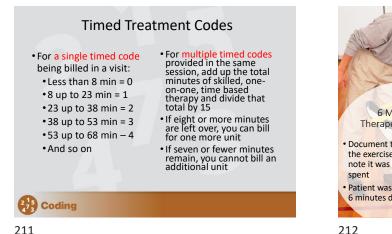














28 Minutes of 21 Minutes of Therapeutic Exercise Therapeutic Exercise Lumbar Isometric Exercises = 13 minutes Lumbar stretching= 9 minutes Lumbar strengthening exercises = 6 minutes Total time = 28 minutes = 2 billable units Note the chart with all services performed and time spent on each along with total time Coding Coding 214

26 Minutes of NMR & 25 Minutes of **Therapeutic Exercises**

- •26 minutes of various proprioceptive strengthening exercises
- •13 minutes of lumbar stabilization exercises
- •12 minutes of lumbar stretching exercises
- Total time = 51 minutes = 3 billable units
- Documentation includes all services and time spent

Coding

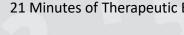


51 divided by 15 = 3 with 6 left over Did not make it to a fourth unit



- 10 + 5 + 5 = 20 total minutes = 1 billable unit
- US and MT are each less than TE
- · Bill where most time was spent
- Total time didn't reach 23 minutes

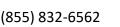




- Abdominal hollowing exercises = 12 minutes
- Cervical range of motion exercises = 9 minutes
- •5 minutes of rest in between exercises



213









The No Surprises Act Complexity

Independent Dispute Resolution (IDR) Process	
Requires Good Faith Estimates	
Advance Explanation of Benefits	
Patient Provider Dispute Resolution	
Transparency & Balance Billing Protections	

218

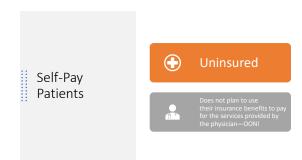
"Health care providers and health care facilities are required under PHS Act section 2799B-6 to furnish a notification of the good faith estimate of expected charges to an uninsured (or selfpay) individual who schedules an item or service..."

Good Faith Estimate



220







	G	ood Faith Est	timate	John D	loe Chiropra		ness Cente Dr. John Do N 29-00000
Estimate	Name Addre	ent Information Judy Jones 55 1 Paradise Lane Rimplicity			Apl.	Bith 04-02-	1997
SE RVICE/IT EM		CONDITION	DIAGNOS IS CODE	NUMBER OF UNITS	COST PER UNIT	. 101.	AL
Exam (Evaluation)		low back, shoulder, neck, midback		1	145.00	145	.00
Imaging		diagnostic		1-2	105.00	210	.00
Electrical Stimulation	h	muscle spasm		1	36.00	36.	00
		Total E	xpected Charg	es \$ 521.00			
		Exam (Evaluation)	Ion back, shoulder, neek, restback		1	145.00	145.00
		Imaging	diagnostic		1-2	105.00	210.00
		Electrical Stimulation	muscle spasm		1	36.00	36.00
			Total	Expected Charges	\$ 521.00		

223

New Patient Visit	Customization	with a	Range

Estimate					
SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Exam (Evaluation)	Pain		1	145-230.00	230.00
Imaging	diagnostic		1-2	65-105	215.00
Electrical Stimulation	muscle spasm		1	36.00	36.00
	Total E	Expected Charges	\$ 481.00		

	F (
Second Step of the GFE Process	

Good Faith Esti	Findings imate			П	Dr. John E IN 20-0000
Patient Information					
Name Judy Jones			Data of	Eim 04-02-	-1997
Address: 1 Paradise Lane			Act.		
City Simplicity		Sale KY		7e 41000	
Phone 555-555-1111 The following is a list of items and services which		you will need once your initial		n has been com	pieled.
	the provident/linic anticipates	you will need once your initial		fas been com	pieried. 7978L
The following is a list of items and services which The recommended treatment is to begin on <u>46</u>	the provident link and is projected to concorrow	yes will need once your initial o campleted by	NOMBER 67 UNITS	C887	
The following is a list of items and services which The recommended treatment is to begin on <u>34</u> SERVICE ITEM	the provident link and is projected to concorrow	yes will need once your initial o campleted by	NOMBER 67 UNITS	65.00	797AL
The following is a list of items and services which the recommended treatment is to begin or <u>services</u> SERVICE: Spinal Manipulation 3 areas	the provident links anticipates 	yes will need once your initial completed by <u>m</u> / <u>m</u> / <u>m</u> / <u>m</u> masemose code M5600, M5602, S33500A M7541	NOMBER SFORTS 15	саят рак имт 65.00	797AL 975.0 540.0
The following is a list of terms and services which the recommended treatment is to begin or <u>services</u> services/mark Spinal Manipulation 3 areas Manual Therapy	the providentifies anticipates <u>/a</u> and is projected converting terms between these terms the Shoulder pain	Ves will need once your initial completed by m //m //m MSH00, MSH02, S33500A M7541 M9900, M9903	NOMECT OF OWES 15 12 UNION VISIO	65.00	787AL 975.0

225

226

TOTAL

210.00

Treatment Plan from the DC The following is a list of items and services which the pr the recommended treatment is to begin on item / too / Ader/clinic anticipates you will need once your initial exam or re-exam has been completed. SERVICE/ITEM DIAGNOSIS CODE NUMBER OF UNITS COST PER UNIT CONDITION 65.00 975.00 M9900,M9902,S335xxA 15 M7541 45.00 540.00 Shoulder pain 65.00 1300.00

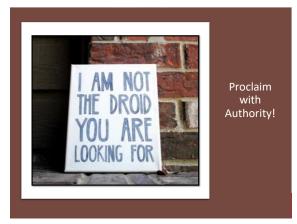
al Manipulation 3 areas Manual Therapy Exercise Therapy M9900,M9903 Re-Exam N/A 2 85.00 oine & sh

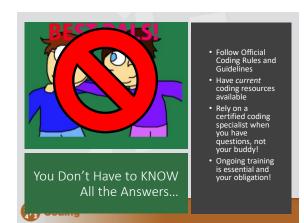
Maintenance Plan

	06 / 19 / 2022 and is projected to	e completed by			
SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Adjustment S8990	Maintenance		24		





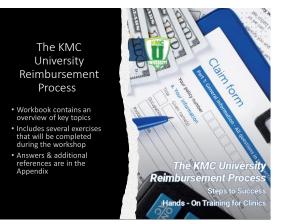






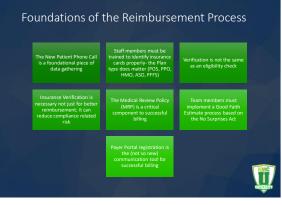


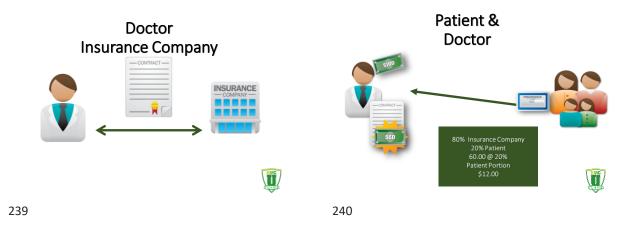
Part 2

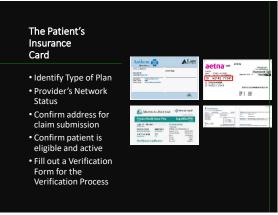












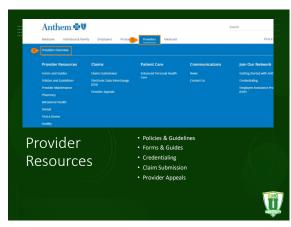


Payer Relationships



242



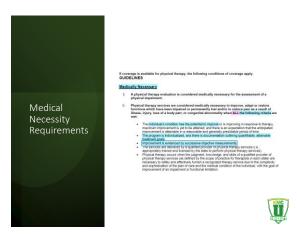






244







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 Providers and Terminology (CPT) instructions state that modifier (4 should not be used when a more descriptive modifier is available. Providers instructions (Use the more specific --X modifier when appropriate. CPT code 97140 (manual heneys technics) may not be used to the same date of service as an extraspinal CMT code when the manual heneys service is provided to any extrapmal body region or area. In this instance, CPT 97140 is considered to be a component of the extraspinal CMT code used to be same date of service as an extraspinal CMT code when the manual heneys service is provided to any extrapmal body region or area. In this instance, CPT 97140 is considered to be a component of the extraspinal CMT code used as the extra service as an extra ser

Payer Specific Modifier Guidance



248

Availity

247

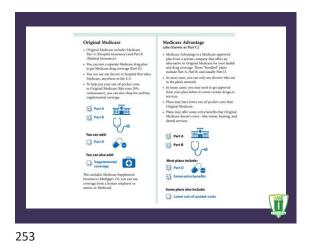
Availity is where healthcare connects Payer-provider collaboration starts here!

One stop log in to access a variety of payer portals Payer Collaboration Sites













Follow the Rules

TriWest Healthcare Alliance

Chiropractic and Acupuncture Services Quick Reference Guide - All Regions

- Included. If VAIs 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. Cherperators should follow the same applicing and authorization. Cherperators should follow the same applicing and authorization access as dher <u>Guide</u> for more information.

255



State Health Facts		😻 Almud State Health St
area ${\cal R}$ transmitting ${\cal R}$ matrixes (or ${\cal R}$	mainstands θ further leves λ mainstands	- Search Some Health Fless Date: Q
Medicaid Benefits	: Chiropractor Service	15
(
This indicator is part of the collections 18/30	e inveña	
Timeframe: 2018		
REFINE RESULTS	TABLE	Tools i A 20
THEFRAM	Linceton + Covered 1	Ceverage Capeyoneet Code i Regulared? i Limits on Services
https://www.kff.org >	medicaid > state-indicator > cl	hiro I
Medicaid Bene	fits: Chiropractor Se	arvices - KEE

Keep an Eye Out for Medicaid Cards

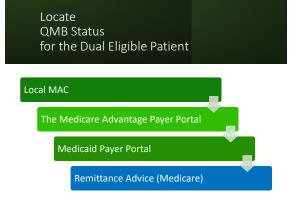
Look for words : Community Plan; Community Health; Home State Health; Department of Social Services



UnitedHealthcare Community	-∰yCa Connecting Me	areOhio
Health Plan (80840) 911-87726-04		
Member ID: 999999999		
Member: SUBSCRIBER M BROWN SR MMIS: 999999999999	Payer ID: 87	726
PCP Name: DR. PROVIDER BROWN	Medi	careR
PCP Phone: (999)999-9999	Rx Bin:	610097
	Rx Grp:	MMPOH
	Rx PCN:	8500



256



Library Member Resources

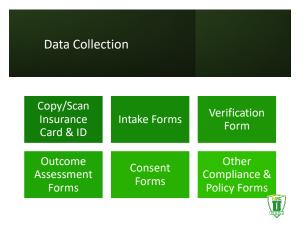
Laying the Poundation to Practice Finances The information in this source is a	How Insurance Works This course covers a variety of pa- types and discusses how each or	will understanding all there is also
beneficial to a clinic that has been established for yes that is just about t	THE PATIENT INTAKE	
Strodules-My.ac	New Patient Data Colle 7 Resources 1Quiz	iction ×
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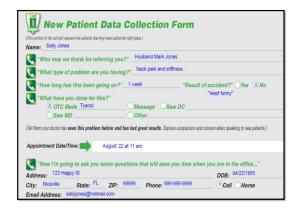
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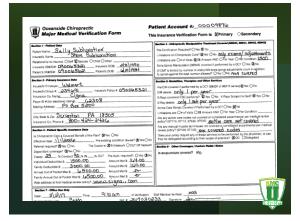




Electronic Health



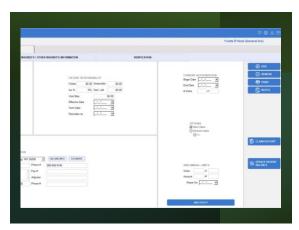
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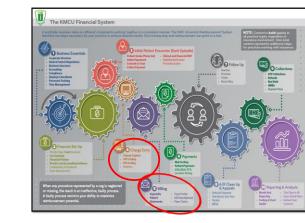
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Daniel Boutlon St

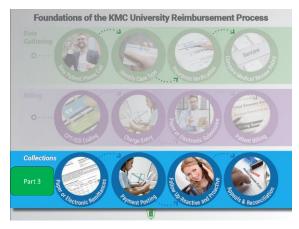
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Encounter Form- Routing Slip



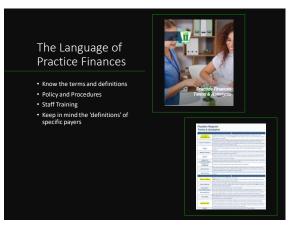












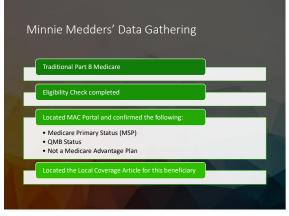


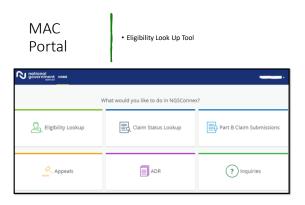


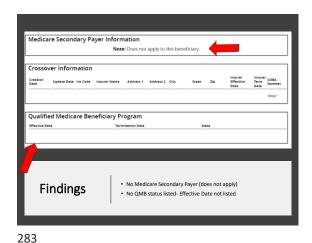




	Demo _§	graphics		
Overview Clinical Profile Appointments	Documents Billing In Mesunds 🗗		laims Worklist	Cases (1)
Demographics Basic Information		Alerts & Notes		
Medders, Minnie Fernale 01/01/1954 (69 years old)	Medical Record Number CT10002 Status Active	Type Message There are no Alerts or Notes I	for this patient.	
Additional Information Social Security Number 005-08-7654 Relationship Status	Employment Status Retired	Set as Payer	Plan Name	Insured ID
Widowed Preferred Provider	Preferred Location Kathy Mills Chang, Inc.	Primary Medcaire	Medicare	SKG8j88D747
Auchenbach, Colleen				
	Email minnie 1954@gmail.com	Active Guarantors (1) Name	Relation	Balance







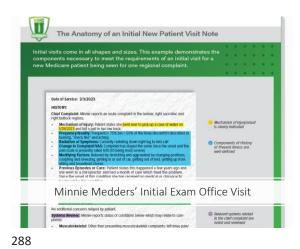
Finding the Coverage Determinations redical Policy Articles Vedical Policy Articles Medical Coverage Documents

•Medical Policy Articles

284



286

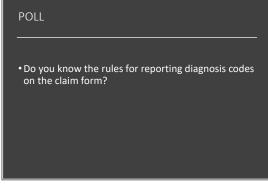


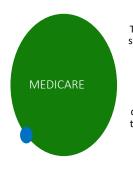


285









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.

291



293

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, Scollosis, etc.

Position 3: Functional: Examples include Restricted Range of Motion, Deconditioning Syndrome, and muscle wasting.

wasning.
• Position 4: Soft Tissue/Extraspinal/Other:
Fibromyaigia, myofascitis, and myaigia are excellent diagnoses to support manual therapy. Examples of extraspinal diagnoses includer. Foraen 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.

toms or co-morbialities. **Position** 6: External cause, Activity, and Location Codes: Examples are related to mechanisms of injury, like sijns, rijns, 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.





292



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

- 4.

Time to Complete



(M99, dysfur (M54, side (M99, dysfur (M51, degen (M62,

(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

296

295

.....

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.

297



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



Time to Complete



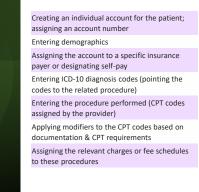
298

The

Charge

Entry

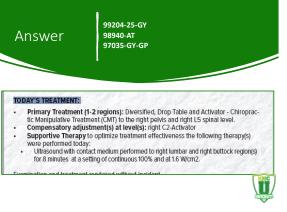
Process



Exercise 2 Procedure Code

	ntation for Minnie Medders and list below the procedure codes that best represe
	ure to include any required modifiers. The information you gathered in the intaki
	uld be referenced during this process. The verification process helps staff memi requirements, and expectations.
	requiremente, una experiatione.
,	oquitomente, una expectatione.
	No. Marillan
	Modifier Modifier

301



303



305

Time to Complete



302

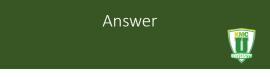


Exercise -3 The Diagnosis

21, DI	AGNOBIS CR I	NATURE	OFILLI	IESS Ö	RINJUR	(Pelat	e A-L to service line b	elow (24E) ICD Ind.		
AL		-	8	L		_	c	D.	1	
EL		-	F.			-	a 📖	н	_	
1.1.		_	J.			-	К.	L		
24. A	From DD YY	OF SERV	TO DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, (Explain Unus) OPT/HCPCS	SERVICES, OR SUPPL val Orcumstances) MODIFIER	IES	E. DIAGNOSIS POINTER

304

21. DIAGNOSIS OR NATUR	RE OF ILLNESS OR INJURY Re	late A-L to service line below (24E)	ICD Ind. 0
M9903	в IM5441	с. IM9905	M5137
M62830	F. L	a	н
L	J	к.	L



Exercise 4- Diagnosis Pointing

D. PROCEDURE (Explain Unu CPT/HCPCS		CES, OR SUPPLIES Imstances) MODIFIER	E. DIAGNOSIS POINTER
99204	25	GY	
98940	AT		
97035	GY	GP	1 1

307

	M99			B.	M54	441		с. <mark>М99</mark>	905	. D.	M5	137
E. I	M62	830		E.	L			a. 📖		н	<u> </u>	
L I				J.				к. L		L	L	
24. MM	Fro	DATE(S) n YY	OF SER	VICE To DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURE (Explain Uni OPT/HCPCS		CES, OR SUPPL mstances) MODIFIER	IES	E. DIAGNOSI POINTER
02	03	23	02	03	23	11		99204	25	GY		A
02	03	02	02	03	23	11		98940	AT			A

Answer

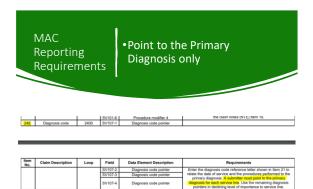
Productions of the KMC University Reimbursement Process

311

Time to Complete



308

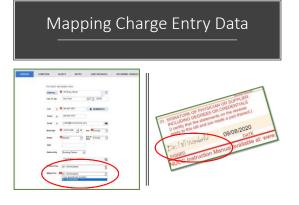


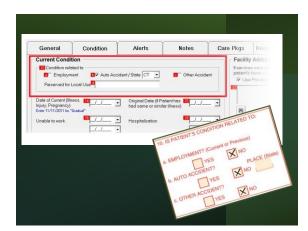
310

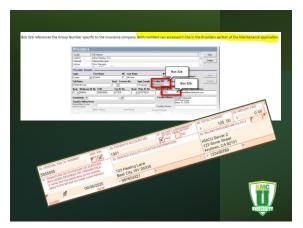


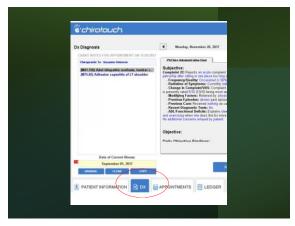


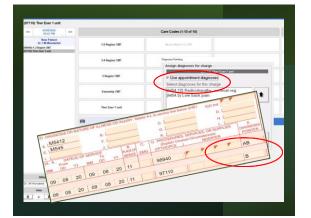
Here Patient Visit
 Here Patient Visit
 http://www.internet.com/out/internet.com











Invest In Your Charge Entry Process

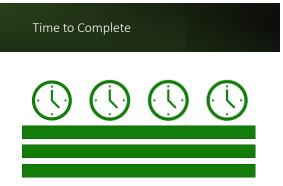
Customize	Each field should be clearly defined in your software
Мар	Track data from software field to claim field
+	
Update	Update data fields quarterly based on payer & coding changes
+	
Train	Charge Entry staff NEED to know the outcome of each entry point



Exercise 5 – What is Wrong With This Claim?

				(2JAL				13	4	54	0:	3 08		22	10 DATES				10	W 100 YY
12.8	IANE OF	1010	IRNO P	icvici	A CR	on-ea s	ouece		S NPI						TE HOSPIT	ME NO	2 DATES	FELAT	ED TO	MM DO YY
19.7		14 Q./	AN INFO	(140E)	ON CH	ingn a tect t									20 0/180		1 m		\$0	HURGER
	M990		UATUPE	OF RL	M5		r Petate	ALE ST	M990		(IV	CO Hd	0 M5	134	22 SECO	NOBION	1	OPEC	XNAL P	EF NO
-				P.	-			4			-	H.			23. PRIOR (NOHORS	DATION N	I, MEE		
54 1	Filon	(0) 374 YY	MM	10 10	W	B RAZO IENVE		OPTINO	the Unit		CES, OF	#\$3	53	E CLACINGERS POINTER	SCHAR	969	dia an	train Le	0	PENDERING PROVIDERID.#
01	04	22	01	04	22	11		9894	11	AT	GA			ABCD		97.00	1		Net	164
																			10	

320



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



321

Exercise 6 – What is Wrong With This Claim?

0		CUTVIE		GUAL.		er Pracon	EANCY	GUAL	IN CLATE	NN	DO	AA.	HON PHON	Seren a	o wo	TS		CUPATION
(7.1	AME OF	ACTUR	ING P	ROVIDE	nonc	CHERN SA	2.ACE	176. 175 NP					HE HOSPITALIZATIO	DATES	QUAT.	ED TO		Sincesy
18.4	como	AL CLAI	M Pero	PRAATS	3N (De	ogramed in	y NJ,CC	9					25. OUTBIDE LABY	110			HARDES	
	M99.0	5	ATURE .	OF BLD	M54		r new	c. (M99		HET ICO	n M5	42	22. DEBURMASSION				NP. NO.	
1	M99.0				M54			a (H.L.		23 PRIOR AUTHORS	EATION N	UMBICT			
MM.	True DD	YY	NM	Te DO	-	R. MACE OF SUBJECT	C.			Moore		DIAGNOSIS POINTER	F.	-	1000	1 0		
01	30	23	01	30	23	11		99204	1			ABCD	250 00	1		NPI	122	71
01	30	23	01	30	23	11		98940	AT			ABDE	50 00			NPS	1	1
	30	23	01	30	23	11		G0283	GY	GY		CD	25 00			-	1	1

322

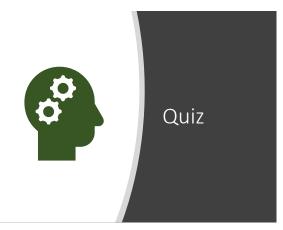
Time to Complete



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





326

325



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

328



330

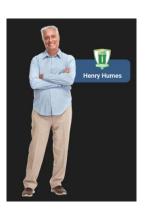


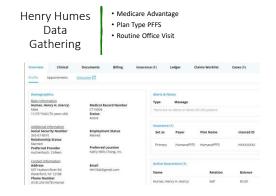




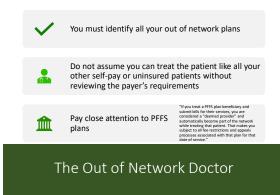












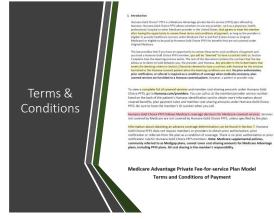
Checking the Local MAC

Effective Date	Termination Date	Administering Ins Co	Plan Name	Plan Website	Plan Phone Number	Contract Number		Plan Option Code Description
01301/2023	12/34/2823	Bunana Gold	PIIS	www.HUMANA.com/modicare	888-XX-XXXX	Horse	115	C - Submit claims to the MA plan. Exception: If an MA plan enrolled beneficiary elects
Effective Date	Termination Date	Administering Ins Co	Plan Name	Plan Website	Plan Phone Number	Contract Number		Plan Option Code Description the Medicare
								hospice benefit,
								submit claims to
								NGS.

337

Check the Medical Review Policy & Resources

338



339





