Appendix
Answer Key & FAQs (Frequently Asked Questions)

Minnie Medders

Exercise 1

Diagnosis Codes

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

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

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

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

(M62.830) Muscle spasm of back

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

Exercise 2

Procedure Codes

99204-25-GY

98940-AT

97035-GY-GP

Exercise 3

Diagnoses in Order

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

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

Exercise 4

Link Diagnosis to Procedure

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

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

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

Exercise 5

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

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

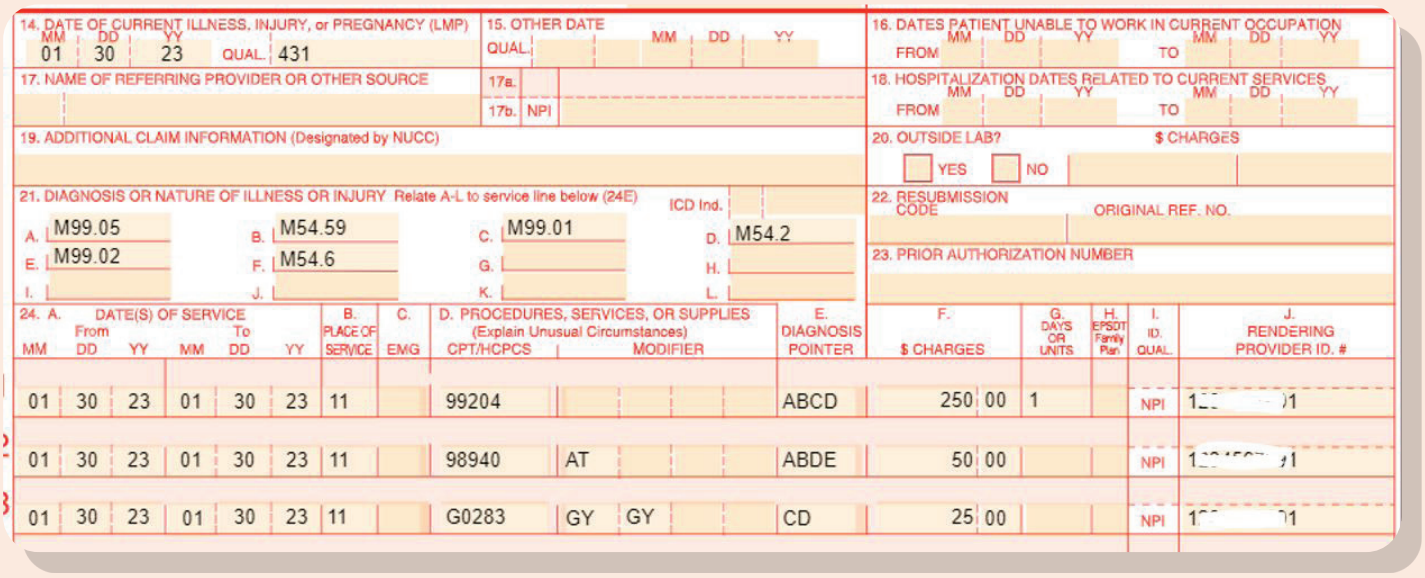
22. RESUBMISSION CODE: ORIGINAL REF. NO.:
23. PRIOR AUTHORIZATION NUMBER:

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

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

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

Exercise 6



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

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER			E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
01	30	23	01	30	23	11		99204				ABCD	250 00	1		NPI	12 01
01	30	23	01	30	23	11		98940	AT			ABDE	50 00			NPI	12 01
01	30	23	01	30	23	11		G0283	GY	GY		CD	25 00			NPI	12 01

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

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

Coding Quiz

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

Medicare FAQs

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

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

Option 1 - you must bill

Option 2 - you would not bill Medicare

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

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

Am I required to bill Medicare for statutorily excluded services?

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

to Medicare, so that Medicare will cross them over to the patients' secondary or supplemental payer. NOTE: If you are not required to bill the services, the patient is responsible for your full fee on all statutorily excluded services unless you are part of a medical discount plan such as ChiroHealth USA, or if you are offering a Time-of-Service discount (between 5% and 15%) and the patient is paying in full that day.

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

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

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

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