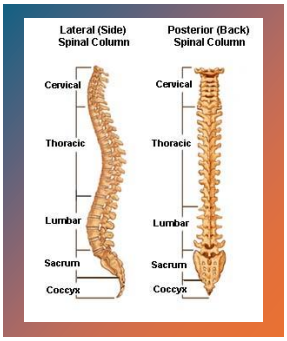
1

2

3



CMT Codes-Spine and Extremities

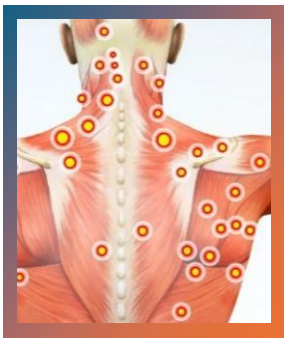
- 98940 – 1-2 Regions
- 98941 – 3-4 Regions
- 98942 – 5 Regions
- 98943 - Extremities
- 98940-98943 – the basic building blocks and best descriptions of the DC's work
- Most comprehensive physician code to describe chiropractic services

4

Extremity Adjusting – 98943

- Regions
  - Head
  - Upper extremities (shoulder to fingers)
  - Lower extremities (hip to toes)
  - Anterior ribs
  - Abdomen
- May be billed once per visit
- Can be billed along with spinal CMT code

5



CMT with Muscle Work

- May be mutually exclusive procedures
- 97140 billable only in separate body region
- 97124 may be billable along with CMT depending on edits

6

	Total	Total by Category	Ratios by Category
Chiropractic Manipulation			
98940	20		0.49%
98941	4092	4112	99.51%
98942	0		0.00%
98943	0	0	0.00%
S8990	0	0	

7

	Total	Total by Category	Ratios by Category
Chiropractic Manipulation			
98940	20		0.49%
98941	4092	4112	99.51%
98942	0		0.00%
98943	0	0	0.00%
S8990	0	0	

8

	Total	Total by Category	Ratios by Category
Chiropractic Manipulation			
98940	20		0.49%
98941	4092	4112	99.51%
98942	0		0.00%
98943	0	0	0.00%
S8990	0	0	

9

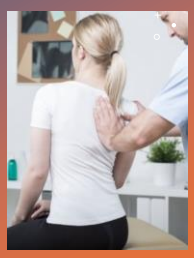
Modalities and Procedures													
97010													0
97012	250	232	286	298	245	240	222	252	252	195	177	217	2866
97110	370	378	364	387	304	312	263	284	316	289	234	277	3778
97140	360	410	395	347	296	300	245	215	259	246	197	165	3435
97150													0
97530													0
97535													0

Remember we had 99% of code 98941!

10

11

CMT with Evaluation and Management



CPT Asst. November 2018 page 11
Medicine: Chiropractic Manipulative Treatment

Question: *A chiropractic manipulative treatment (CMT) is performed with a review of prior radiologic imaging on the same date an evaluation and management (E/M) visit is also performed. How should this be reported?*

Answer: CMT procedures include the review of prior radiologic imaging, test interpretation, and test results and pre-manipulation patient assessment, and are considered inclusive components of the CMT codes (98940-98943). Additional E/M services are performed and reported separately with modifier 25, if and only if the patient's condition requires a significant separately identifiable E/M service above and beyond the usual preservice work associated with the CMT procedure.

Payer Policy vs. AMA

- Both CMT and E/M may not be paid on the same day
- Check payer policy/contractual obligation
- In the absence of policy, appeal, appeal, appeal!

12

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

13

Coding and Documentation Must Match

14

AMA CPT Codes for Chiropractic Manipulative Treatment (CMT)

- 98940 – CMT; spinal, one to two regions. Documentation must include a validated diagnosis for one or two spinal regions and support that manipulative treatment occurred in one to two regions of the spine.
- 98941 – CMT; spinal, three to four regions. Documentation must support that manipulative treatment occurred in three or four regions of the spine and one of the following: validated diagnoses for three or four spinal regions or validated diagnoses for two spinal regions, plus one or two adjacent spinal regions with documented soft tissue and segmental findings.
- 98942 – CMT; spinal, five regions. Documentation must support that manipulative treatment occurred in five regions of the spine (region as defined by CPT) and one of the following: validated diagnoses for five spinal regions or validated diagnoses for three spinal regions, plus two adjacent spinal regions with documented soft tissue and segmental findings validated diagnoses for four spinal regions, plus one adjacent spinal region with documented soft tissue and segmental findings.
- 98943 – Chiro, manipulation, extraspinal, one or more regions.

VA Description- Follows Optum

- Federal Plans mirror one another
- Most group health plans follow suit

15

The $64,000 Question

- Is the subluxation you found creating a secondary, neuromusculoskeletal condition?
- Or is it a subluxation that simply needs to be corrected?
- Is there a lack of function?

16

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

17

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

Spinal:

Cervical	The atlanto-occipital joint (C0/C1), and C1 through C7
Thoracic	T1 through 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

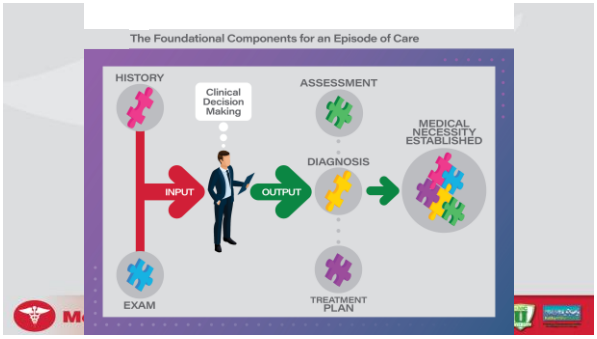
Extraspinal:

Head	Includes the TMJ, but excludes the atlanto-occipital joint
Upper Extremities	Shoulder, arm, elbow, wrist, and hand
Lower Extremities	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

The Codes: There are three spinal 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
98943	CMT, **Extraspinal**, 1 or more extraspinal regions as noted above

18



19

Medicare Documentation Guidelines in the Absence of Others

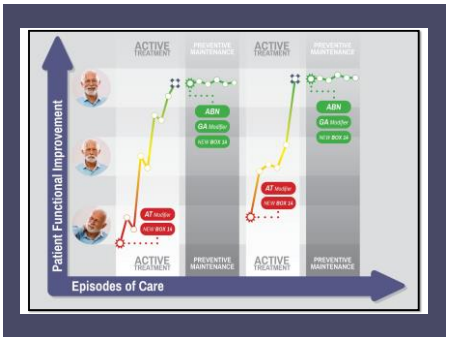
Initial Visit

- 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

20



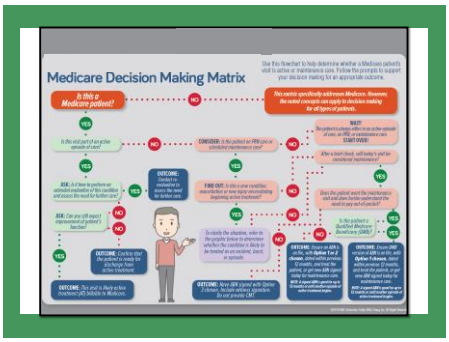
21

Understand and Implement Medical Necessity Definitions

The definition of Medical Necessity, per Medicare, is: The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function.

Medicare

22

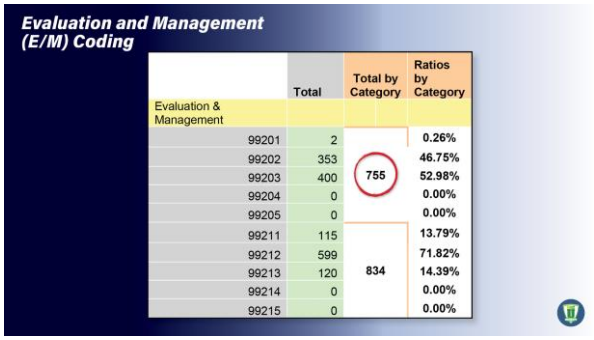


23

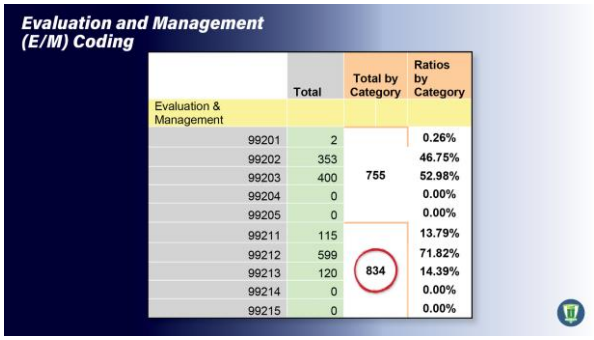
Evaluation and Management (E/M) Coding

Evaluation & Management	Total	Total by Category	Ratios by Category
99201	2		0.26%
99202	353		46.75%
99203	400	755	52.98%
99204	0		0.00%
99205	0		0.00%
99211	115		13.79%
99212	599		71.82%
99213	120	834	14.39%
99214	0		0.00%
99215	0		0.00%

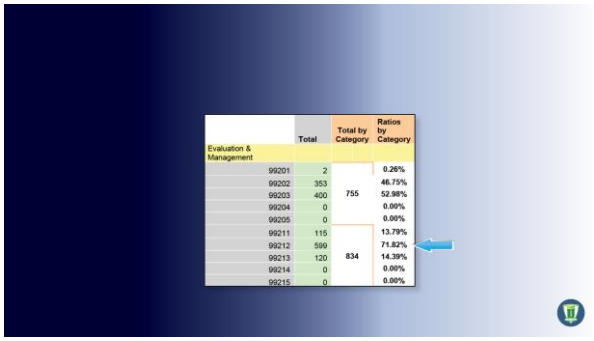
24



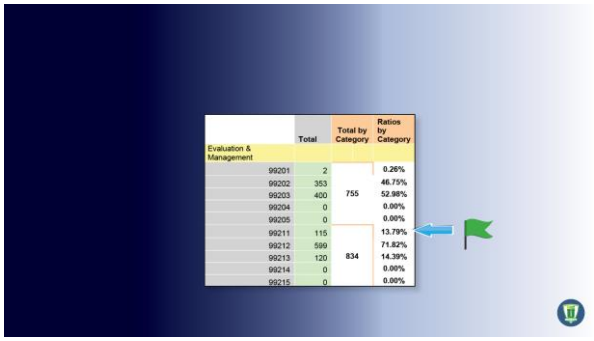
25



26



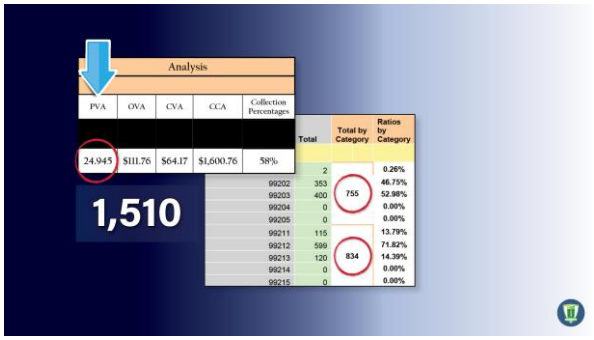
27



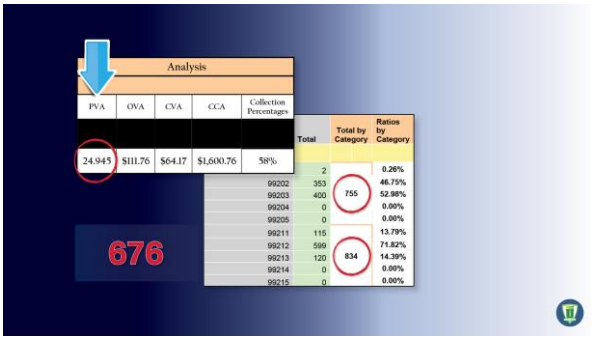
28

29

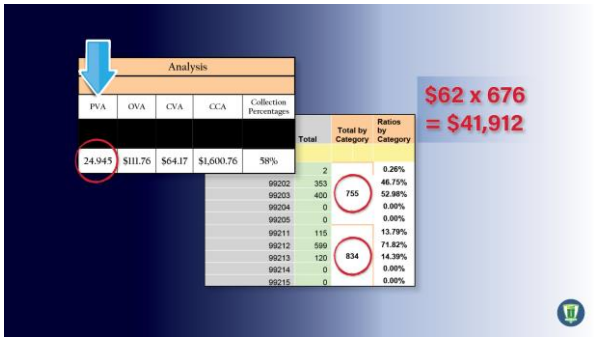
30



31



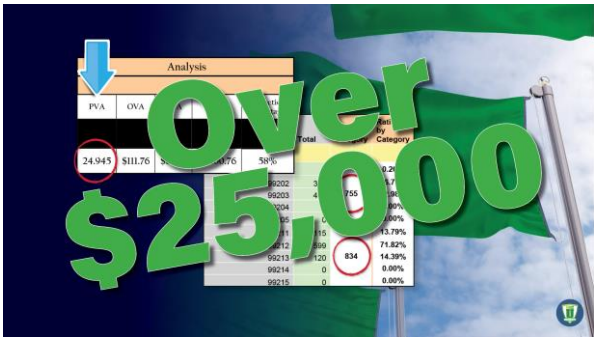
32



33

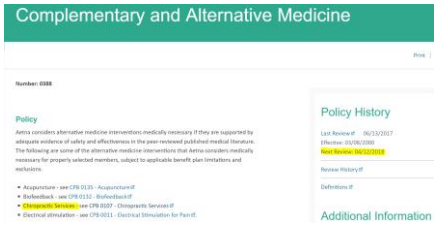
34

35

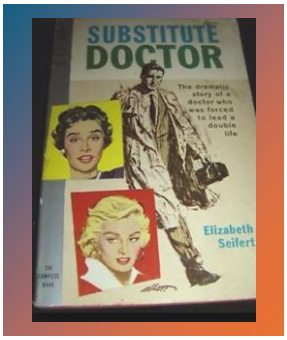


36

Experimental, Investigational, and Unproven CMT Techniques



37



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

38

Reciprocal Billing Arrangements (formerly known as Locum Tenens)

- Doctor goes on vacation
- Has an arrangement with another doctor to "cover"
- The other doc will go on vacation later and they trade
- Regular doctor charges for service on usual billing-Q5

39

Primary DX Must Be Subluxation/Segmental Dysfunction

Group 1 Codes:

ICD-10 Codes	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

40

Self-Auditing Is Part of Compliance

- Medicare expects self-auditing
- Required element of your compliance program
- Coding audit to review ratio of CMT codes and others
- ICD-10 audit to review coding "patterns"
- Identify red flags and weaknesses in coding

41

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

42

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

43

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

44

S9090 Decompression

- S9090 - *Vertebral Axial Decompression, per session*

- Differs from traction:
  - Angle(s)
  - Computer assistance
  - Muscle guarding consideration
  - Intent

45

97014 Electrical Stimulation (EMS)

- Application of Electric stimulation to a specific area for nerve or muscle disorders
- Billed only once per visit
- Some payers allow 2-4 visits
- Sometimes you must use G0283 instead of 97014 for unattended EMS

Presently United Health Care & Medicare are the only carriers that require G0283

46

Constant Attendance Modalities

97032-97039 require direct one-on-one patient contact by provider

Expected 6-12 visits

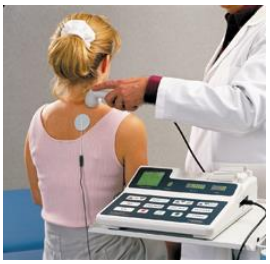
These are timed based codes for billing

Documentation should include total time spent

47

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!



48

97035 Ultrasound

- Ultrasound, each 15 mins. One or more areas
- Great for adhesive scars, spasm, soft tissue
- Passive phase of care
- Include location, time, settings in documentation

49

Laser Therapy

- Low-level laser therapy is a non-invasive light-source treatment that has no heat, sound or vibration
- By reducing the duration of inflammation and enhancing specific repair and healing processes, laser therapy has been proven to provide pain relief, reduce damage due to the injury and loss of function

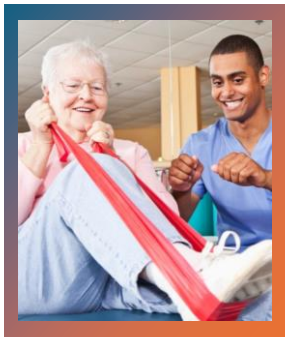
Coding is either 97039 or S8948

Both are billed in 15 min. increments

tions for laser therapy to ote healing

- Inflammation
- Pain
- Edema
- Muscle strains
- Ligament sprains
- Nerve injuries/irritations

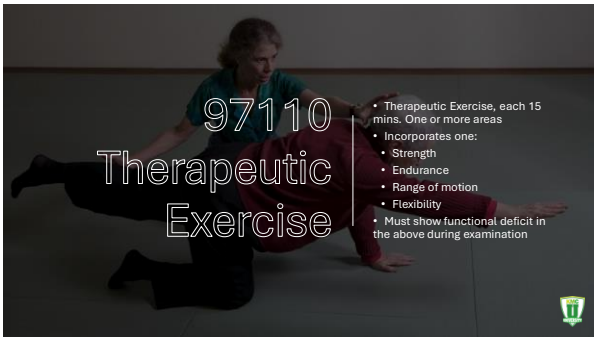
50



Therapeutic Procedures (97110-97546)

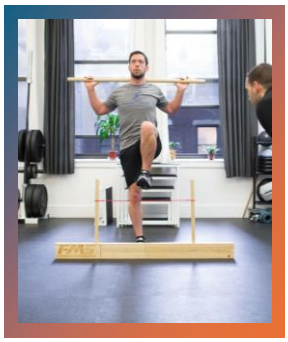
- Therapeutic Procedures are time-based codes for billing purposes
- The patient is ACTIVE in the encounter
- Requires direct one-on-one patient contact
- Documentation should include both the total time spent and the time spent doing each activity/exercise.
- Codes are billed per 15 min increments

51



- 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

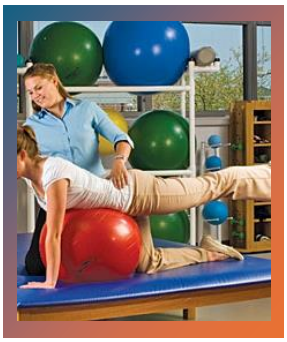
52



97112 Neuromuscular Re-education (NMRE)

- Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception
- Proprioceptive Neuromuscular Facilitation (PNF), Feldenkreis, Bobath, BAP'S Boards, and desensitization techniques
- Most likely indicated for neurological conditions

53

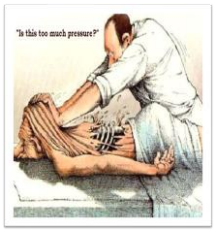


97530 Therapeutic Activities

- Dynamic activities to improve functional performance, direct (one-on-one) with the patient (15 minutes)
- Incorporates two or more:
  - Strength
  - Endurance
  - Range of motion
  - Flexibility
- Must show functional deficit in the above during examination

54

97124 Massage



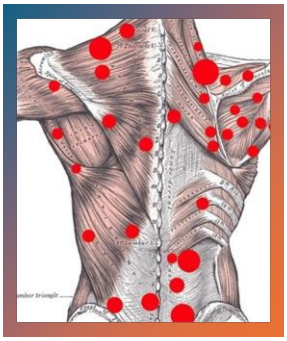
- Passive procedure used for restorative effect
- Used for effleurage, petrissage, and/or tapotement, stroking, compression, and/or percussion
- Considered separate and distinct from CMT

55

97140 Manual Therapy

- Includes soft tissue and joint mobilization, manual traction, trigger point therapies, passive range of motion, and myofascial release.
- With CMT - must be in a separate body region
- May require a -59 or X? modifier

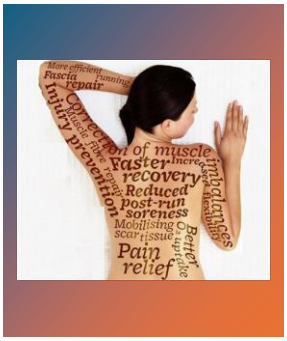
56



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

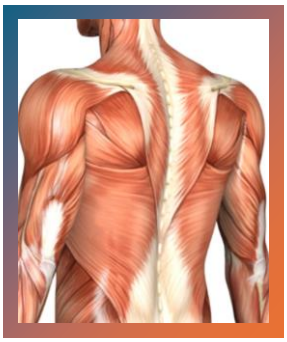
57



When to Use 97124

- Used to improve muscle function, stiffness, edema, muscle spasms or reduced joint motion
- When treatment is friction based, relaxation type massage that is less specific than 97140

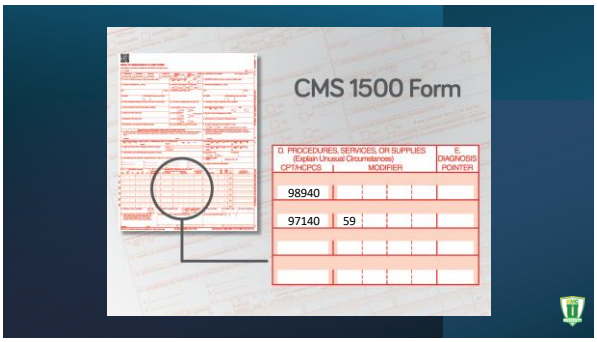
58



Muscle Therapies

- The National Correct Coding Initiative is a CMS program that prevents improper payment for procedures that should not be submitted together
- Use the -59 modifier to indicate that - *YES*, these services were both performed today *AND* – they should *BOTH* be paid today

59

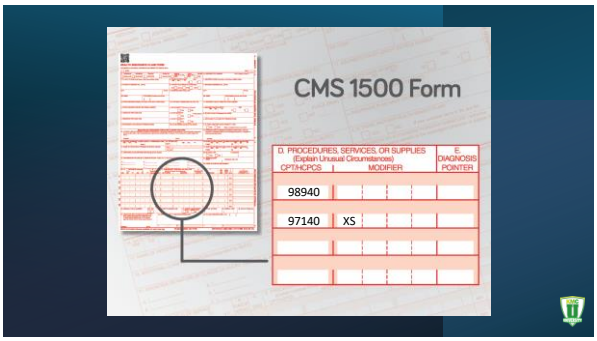


60

- X{EPSU} Modifiers

- -XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
- -XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
- -XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner
- -XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

61



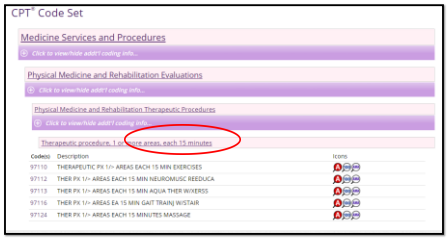
62

Timed Coding Rules

The Intersection of 15 Minutes and 8 Minutes

63

AMA/CPT Says "Each 15 Minutes"



64

Medicare's "8-Minute Rule" Meets "15 Minute Rule"

- For time-based codes, you must provide direct treatment for at least eight minutes in order to receive reimbursement from Medicare
- CMS and CPT have clarified that any timed based service, provided on its own, is not billable if performed for less than 8 minutes

65

Timed Treatment Codes

- For a single timed code being billed in a visit:
  - Less than 8 min = 0
  - 8 up to 23 min = 1
  - 23 up to 38 min = 2
  - 38 up to 53 min = 3
  - 53 up to 68 min – 4
  - And so on
- For multiple timed codes provided in the same session, add up the total minutes of skilled, one-on-one, time-based therapy and divide that total by 15
- If eight or more minutes are left over, you can bill for one more unit
- If seven or fewer minutes remain, you cannot bill an additional unit

66

6 Minutes of Therapeutic Exercise

- Document the chart to include the exercise performed and note it was 6 minutes of time spent
- Patient was unable to go beyond 6 minutes due to pain

67

21 Minutes of Therapeutic Exercise

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

68

28 Minutes of Therapeutic Exercise

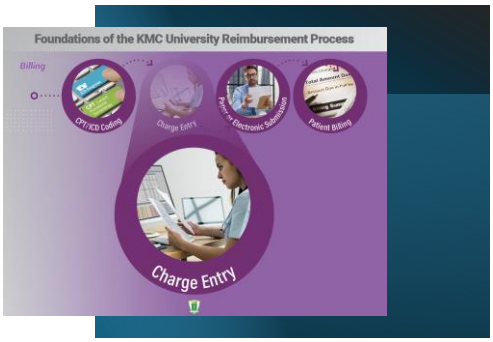
- Lumbar Isometric Exercises = 13 minutes
- Lumbar stretching= 9 minutes
- Lumbar strengthening exercises = 6 minutes
- Total time = 28 minutes = 2 billable units
- Note the chart with all services performed and time spent on each along with total time

69

10 Minutes of TherEx; 5 Minutes of Ultrasound and 5 Minutes of Manual Therapy

- 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

70



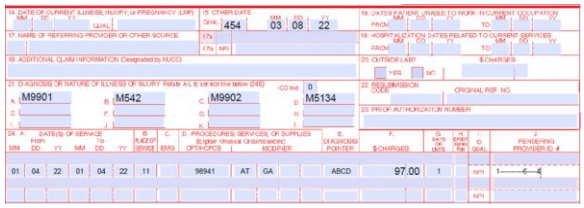
71

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

72

What is Wrong With This Claim?



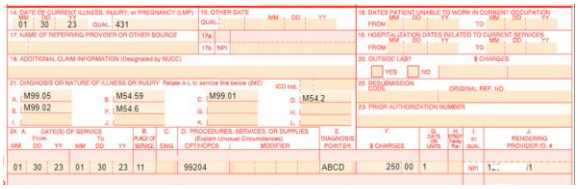
73

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

74

What is Wrong With This Claim?

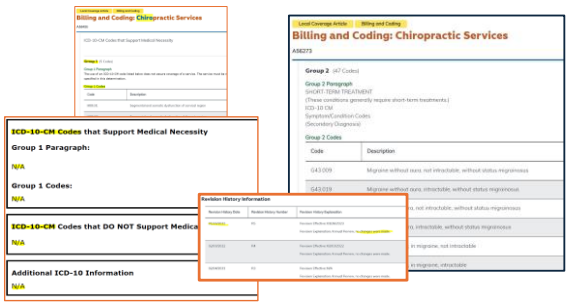


75

Answer

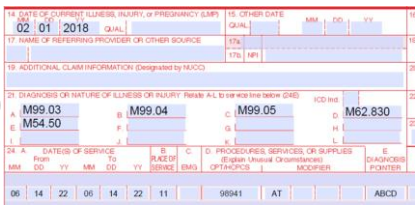
- Procedure code 99204 is missing required modifiers
- All services are pointing to more than one diagnosis code
- G0283 has duplicate modifiers appended
- Payer does not require a Qualifier in Box 14
- Units are missing on some procedure codes

76



77

What is wrong with this claim?



78

Answer

- Diagnosis coupling is wrong
- Diagnosis pointer is ABCD rather than just A
- Box 14 is dated 2018 (first time patient was seen in clinic rather than episode)
- Decimals are utilized in the diagnosis codes

79

Clean Claim

80

Let's Revisit the ABN Process

ISSUING AN ADVANCE WRITTEN NOTICE OF NONCOVERAGE

When You Must Issue an Advance Written Notice of Noncoverage

To transfer financial liability to the beneficiary, the provider must issue an advance written notice of noncoverage:

- When an item or service is not reasonable and necessary under Medicare Program standards. Common reasons Medicare denies an item or service as not medically reasonable and necessary include care that is:
  - Experimental and investigational or considered "research only"
  - Not indicated for diagnosis or treatment in this case
  - Not considered safe and effective
  - More than the number of services Medicare allows in a specific period for the corresponding diagnosis
- When custodial care is given
- Before caring for a beneficiary who is not terminally ill (hospice providers)
- Before caring for a beneficiary who is not confined to the home or does not need intermittent skilled nursing care (home health providers)

81

Medicare Advance Written Notices of Noncoverage — MLN Booklet

Frequency Limits

Some Medicare-covered services have frequency limits. Medicare only pays for a certain quantity of a specific item or service in each period for a diagnosis. If you believe an item or service may exceed frequency limits, issue the notice before furnishing the item or service to the beneficiary.

If you do not know the number of times the beneficiary got a service within a specific period, get this information from the beneficiary or other providers involved in their care. Contact your MAC or use the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) (270/271) to determine if a Medicare beneficiary met the frequency limits from another provider during the calendar year.

Extended Treatment

You may issue a single notice to cover extended treatment if it lists all items and services and the duration of treatment when you believe Medicare will not pay. If the beneficiary gets an item or service during the treatment that you did not list on the notice and Medicare may not cover it, you must issue a separate notice. A single notice for an extended course of treatment is only valid for 1 year. If the extended course of treatment continues after 1 year, issue a new notice.

82

Issuing a Voluntary Advance Written Notice of Noncoverage as a Courtesy

Medicare does not require you to notify the beneficiary before you furnish an item or service Medicare never covers or is not a Medicare benefit. However, as a courtesy, you may issue a voluntary notice to alert the beneficiary about their financial liability. Issuing the notice voluntarily has no effect on financial liability, and the beneficiary is not required to check an option box or sign and date the notice. For more information about noncovered services, refer to the Items and Services Not Covered Under Medicare booklet.

83

Notifier(Practice): Kathy's Chiropractic Heaven, 1234 Main Street Honolulu, HI 99998 999-888-7777

Patient Name: Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for Chiropractic maintenance care below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the maintenance care below.

Chiropractic Maintenance Care	Reason Medicare May Not Pay:	Estimated Cost
98940 98941 98942	Medicare does not pay for Chiropractic maintenance care	$24.71 $32.56 $41.87

Covered Services Codes — Reason is clear — Fee Choice Here

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the maintenance care listed above.

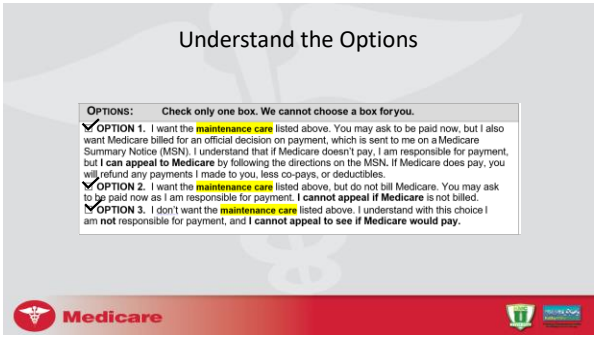
Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

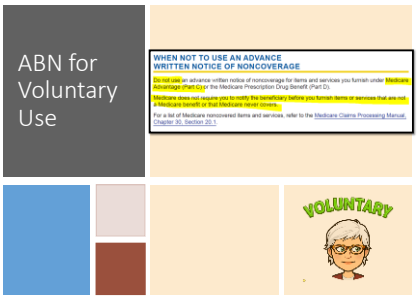
☐ OPTION 1. I want the maintenance care listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less coinsurance or deductibles.

☐ OPTION 2. I want the maintenance care listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

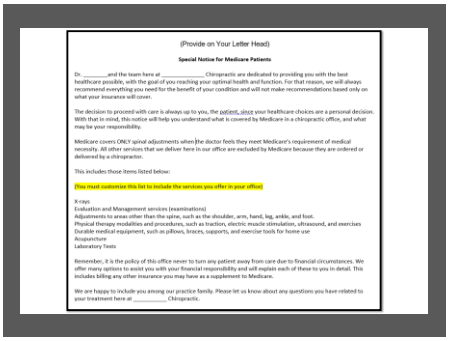
84



85



86



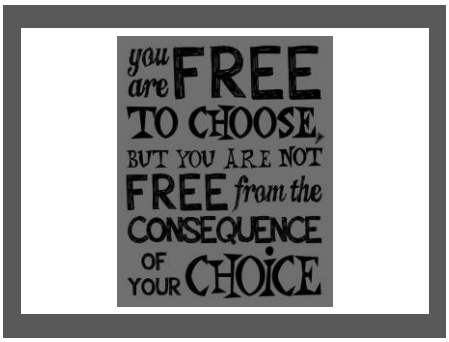
87

88

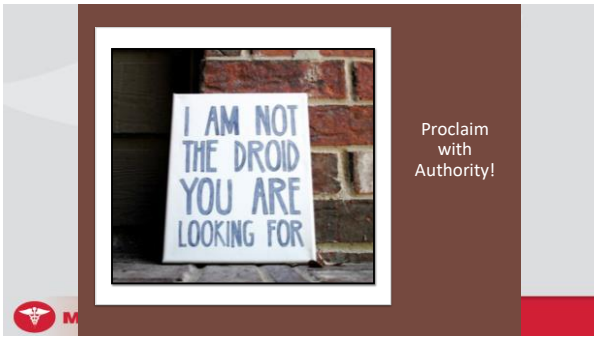
You Don't Have to KNOW All the Answers…

- Follow Official Coding Rules and Guidelines
- Have *current* coding resources available
- Rely on a certified coding specialist when you have questions, not your buddy!
- Ongoing training is essential and your obligation!

89



90


I AM NOT THE DROID YOU ARE LOOKING FOR
Proclaim with Authority!

91


Don't forget to sign up to our
MAILING LIST!
KMC U UNIVERSITY
KMCUniversity.com | (855) 832-6562

92