Payer and ICD 10 Monopoly? Here's Your Get Out of Jail Free Card

Presented By: KMC University

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What We Will Cover

- Important Payer Updates
- New ICD-10 Diagnosis Codes
- Medicare Reminders
- Upcoming HIPAA Changes

2

What We Call "The Big Four"

3

What the Office Must Know

4

Payer Updates

YVETTE NOEL, CPCO
KMC University Specialist

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1 Sign Up For Payer Bulletins

PRO
REACTIVE

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United Healthcare

Eligibility and Referrals

Home › Resource Library › Network News

Network News

Your go-to source for administration, clinical and operational updates

See all news

Monthly overview
View recent updates on policy and protocol announcements, drug and pharmacy, prior authorization, code changes, provider reimbursement, medical policy alerts and more.
See the updates

News your way
Get news related to your role, specialty, health plan and state. When you subscribe to Network News, you can update your preferences to select what news you receive.
Sign up

1 Sign Up For Payer Bulletins

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1 Sign Up For Payer Bulletins

Your briefs will feature relevant updates on the news you need:

- Prior authorization
- Reimbursement policies
- Medical policies
- Protocols
- Administrative support
- Drug and pharmacy

August 01, 2024

August monthly overview

Prior authorization updates

Outpatient therapy and chiropractic prior authorization requirements
Medicare Advantage plans nationally will require prior authorization for outpatient therapy and chiropractic services.

August 15 publication

Policy and coverage changes

Outpatient therapy and chiropractic prior authorization requirements
Medicare Advantage plans nationally will require prior authorization for outpatient therapy and chiropractic services.

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August 01, 2024

Outpatient therapy and chiropractic prior authorization requirements

Last modified: Sept. 9, 2024
Update: Additional information provided regarding place of service codes and how to submit requests.

Effective Sept. 1, 2024, we'll require prior authorization for the following services delivered in multidisciplinary offices and outpatient hospital settings, excluding services in the home:

- Physical therapy (PT)
- Occupational therapy (OT)
- Speech therapy (ST)
- Medicare-covered chiropractic services (when billed with the AT-modifier)

Multidisciplinary practices may encompass settings where physical therapy, occupational therapy, speech therapy and chiropractic care are all provided within a single facility or office. Alternatively, they could refer to individual practices each specializing in a single discipline.

Prior authorization is required for the following place of service codes:

- 11 Office
- 19 Off-Campus Outpatient Hospital
- 22 On-Campus Outpatient Hospital
- 24 Ambulatory Surgical Center
- 49 Independent Clinic
- 62 Comprehensive Outpatient Rehabilitation Facility

This applies to UnitedHealthcare® Medicare Advantage nationally, excluding Dual Complete Special Needs Plans (SNP). Current prior authorization requirements in Arkansas, Georgia, South Carolina and New Jersey for outpatient therapies continues as previously deployed and will now include Medicare-covered chiropractic services.

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October 18, 2024

Medicare Advantage: Prior authorization resources for outpatient therapy and chiropractic services

On Sept. 1, 2024, we began requiring prior authorization for physical, occupational, speech therapy and chiropractic services for UnitedHealthcare® Medicare Advantage members. Optum Physical Health has been delegated to review the prior authorization request for medical necessity using CMS Chapter 15 criteria, applicable local coverage determinations (LCDs) and InterQual® criteria to render a determination. Medical necessity reviews are conducted by licensed medical professionals, including physical therapists, occupational therapists and speech-language pathologists.

Reviews are conducted after the member's initial consultation and evaluation and consider the specific circumstances of the individual member to approve a course of treatment supported by the clinical evidence.

Note: Treatment can begin the same day as the member's evaluation if you wish to do so, as authorizations, when issued, will cover dates retroactive to the date of the evaluation. You can submit an authorization up to 10 business days (14 calendar days) after the date of service, and authorizations, when issued, will be retroactive to the date of the evaluation.

Exclusions

The below plans and provider types are not required to submit for authorization:

- Out-of-network providers
- UnitedHealthcare® Dual Complete plans
- UnitedHealthcare Nursing Home and UnitedHealthcare Assisted Living plans
- Preferred Care Network and Preferred Care Partners of Florida
- UHCWest (specific plans in California and Arizona)
- Peoples Health Plan
- Rocky Mountain Medicare Advantage Plans
- Erickson Advantage

Note: OptumCare and WellMed contracted providers, please refer to the number on member ID card for prior authorization instructions.

Chiropractic care services

Routine (maintenance) chiropractic services will not require prior authorization. Only traditional Medicare-covered chiropractic services (which covers only manual manipulation of the spine to correct subluxation) require prior authorization.

Per CMS, traditional Medicare-covered chiropractic services are identified by an AT modifier. Please refer to cms.gov for additional information. The chiropractor will need to bill with the AT modifier for traditional Medicare services.

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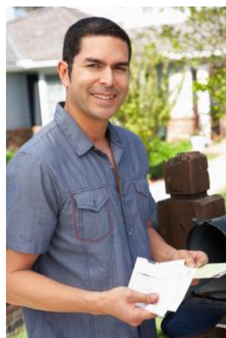

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myoptumhealthphysicalhealth.com

August 2, 2024

RE: **Changes to UnitedHealthcare® and AARP® MedicareAdvantage® Plans Clinical Submission Requirements for Chiropractic, Physical, Occupational and Speech Therapy Service**

Dear Provider:

Effective September 1, 2024, OptumHealth Care Solutions, LLC (Optum) Clinical Support Program, will require the online clinical submission of a Patient Summary Form (PSF), for certain UnitedHealthcare® and AARP® MedicareAdvantage® members. A PSF is not required for the initial evaluation. However, a PSF is required for subsequent treatment visits. **This includes treatment in progress after the effective date.** The Clinical Support Program is described in the Optum® Provider Operations Manual, which can be found at myoptumhealthphysicalhealth.com.

All Optum Physical Therapy, Occupational Therapy, Speech Therapy, and Chiropractic providers, including Tier 1A, Tier 1, and Tier 2, Updated Plan Summaries can be found at myoptumhealthphysicalhealth.com.

Your online clinical submission can be completed at myoptumhealthphysicalhealth.com. A tutorial and instructions on completing the online submission can also be found at this site. Please contact Optum Provider Services at 1-800-873-4575 if you need your provider ID or password for the Optum website or if you have any questions.

Sincerely,

Network Management
Optum

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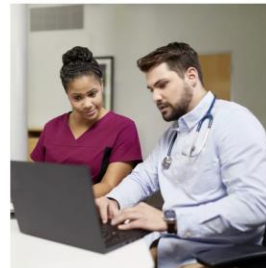

Humana Physician News

Our quarterly email features the latest news, resources and administrative information to support you in the care of your Humana-covered patients.

Read the latest issue of Humana Physician News (Q3 – 2024)

Read our 2024 – Q2 newsletter

Read our 2024 – Q1 newsletter

Read our 2023 – Q4 newsletter

Subscribe to Humana Physician News →

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September 01, 2024

New GA modifier requirement for UnitedHealthcare commercial plans

Beginning Feb. 1, 2025, we're adding the following GA modifier requirement for UnitedHealthcare commercial plans claims to our Charging members for non-covered services protocol. This requirement should help improve health care transparency by helping to ensure patients were made aware of their potential cost-sharing liability.

The new requirement

In addition to the consent requirements in the Protocol, if you know or have reason to suspect that a commercial member's benefits do not cover the service (as described further in the Protocol), a GA modifier must be submitted on the claim if you want to bill our member for the non-covered service. You will use the GA modifier to document when the enhanced content requirements of the consent were met. The aim of requiring use of the GA modifier is to improve health care transparency by helping ensure members were made aware of their potential liability in advance of any procedure or bill they may receive for services. If you didn't meet all of the consent requirements in the Protocol, it is not appropriate to submit the GA modifier on the claim and you cannot bill our member.

What you need to do

If you obtain written consent from a commercial member for a service you know or suspect is not covered by their benefits, and the consent met all the requirements in the Protocol, you must include the GA modifier on your claim for the non-covered service. Including the GA modifier on your claim for the non-covered service helps ensure it is adjudicated as member liability where appropriate.

Note, the new requirement will also be included in our 2025 Administrative Guide for Commercial Plans.

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See the information below for including modifiers on your claims:

- GA modifier: If you followed this protocol and requested a pre-service organization determination, and an IDN was issued before the noncovered service was rendered, you must include the GA modifier on your claim for the non-covered service. Including the GA modifier on your claim helps ensure your claim for the non-covered service is appropriately adjudicated as member liability.
- GZ modifier: If you know or have reason to believe that a service or item you are providing or referring will be denied as not reasonable and necessary and you did not provide an advance notice of non-coverage to member, you must include the GZ modifier on your claim. Including the GZ modifier on your claim helps ensure your claim for the non-covered service is appropriately adjudicated as provider liability.
- GY modifier: If you know the service or item you are providing or referring is statutorily excluded from Medicare coverage and the service is explicitly excluded in the members EOC, you must include GY modifier on claim. Including the GY modifier on your claim helps ensure your claim for non-covered service is appropriately adjudicated as member liability.

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Charging members for non-covered services

You may collect payment from our commercial members for services not covered under their benefit plan if you first get the member's written consent. The member must sign and date the consent before the service is done. Keep a copy in the member's medical record. If you know or have reason to suspect the member's benefits do not cover the service, the consent must include:

- An estimate of the charges for that service
- A statement of reason for your belief the service may not be covered

Generic, blanket or blank written consent forms are not allowed.

- **Generic written notices** — routine written notices to members only state that a denial of payment is possible or that you do not know if payment will be denied. Generic written notices are not acceptable evidence of written notice and will not protect you from liability. The written notice must specify the item and/or service and a genuine reason that denial is expected. Written notice standards are not satisfied by a generic document that is little more than a signed statement by the member to the effect that, should payment be denied, the member agrees to pay for the item and/or service.
- **Blanket written notices** — giving written notices for all claims or items or services (i.e., blanket written notices) is not an acceptable practice. Notice must be given to a member about the likelihood of payment for that individual's claim.
- **Signed blank written notices** — you are prohibited from obtaining member signatures on blank written notices and then completing the details later. For a written notice to be effective, it must be completed before giving it to the member.

You should know or have reason to suspect that a service or item may not be covered if we have:

- Provided notice through an article on UHCprovider.com, including clinical protocols and/or medical policies
- Determined that the planned service or item is not covered and have communicated that determination

Do not bill the member for non-covered services in cases where you do not follow this protocol.

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October 18, 2024

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Chiropractic therapy

Prior authorization requirements

Prior authorization for chiropractic services is required for all fully insured Humana commercial members in the following markets:

- Kentucky: Commonwealth of Kentucky outside the 410xx ZIP code and Indiana counties of Clark, Floyd, Harrison, Jefferson, Scott and Washington (ZIP codes 471xx and 472xx) and northern counties in ZIP code 410xx
- Illinois: Entire state of Illinois and Indiana (ZIP codes 463xx and 464xx)
- Ohio: Entire state of Ohio and the Indiana counties in ZIP codes 470xx, 473xx, and northern Kentucky counties in ZIP code 410xx
- Arizona: Entire state of Arizona
- Georgia: Entire state of Georgia
- South Florida: Broward, Miami-Dade and Palm Beach counties

Prior authorization requests for chiropractic therapy, including manipulative therapy, are reviewed by WholeHealth Networks (WHN), a utilization management company. WHN will review for medical necessity of the service and will request any needed medical records.

Please note: Prior authorization is not required for services provided by nonparticipating healthcare providers for patients with preferred provider organization (PPO) coverage.

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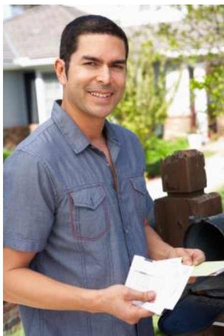

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Sincerely,

Network Management
Optum

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Optum | WebAssist Physical Health

Attention Humana Providers!

Requires Login

Public Facing

Clinical Forms

Please select form(s) to print from the following options:

- Patient Summary Form PSF-750
- Disabilities of the Arm, Shoulder and Hand (DASH)
- Lower Extremity Functional Scale (LEFS)
- Back Index
- Neck Index
- Texas Pediatric Supplement Form

You can view a brief tutorial or download instructions for these forms.

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Optum® by OptumHealth Care Solutions, LLC
2024 Utilization Management Program

OptumHealth Care Solutions, LLC
Provider Operations Manual

Optum

Welcome to WebAssist Optum Provider Portal

Discover How to Submit a PSF-750 Online

Published June 2024

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Profiling and Data Sharing (excludes Medicaid)

Optum uses data collected from claims and the clinical submissions to create reporting that summarize the processes of care and clinical outcomes of each provider. This reporting is useful to Optum for:

- Recognition of superior provider outcomes and/or efficiencies
- Communication to the Plan of network outcomes.
- Promotion of Physical Medicine inclusion in benefit structure.
- Selection of providers that may benefit from additional educational opportunities.
- Identification of providers with 'unsupported clinical variance', who haven't effectively adopted "best practice" approaches to delivering care.

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OVERVIEW

1.1 Overview of Clinical Support Program

The Optum "**Clinical Support Program**" has been designed to assist in the delivery of effective and efficient services emphasizing evidence-informed care. The goal of Clinical Support is to assist providers in delivering, and patients in obtaining optimal outcomes from care, while minimizing inefficiencies and unsupported clinical variance from evidence-informed care. The Clinical Support Program is built upon four core principles:

- **Practice According To Current Best Evidence**: Defining "best practices" in physical medicine and continually setting the information standard.
- **Accountability**: Encouraging providers to be accountable for their services and assisting patients to be knowledgeable health care consumers.
- **Education and Communication**: Engaging providers and patients, where delegated, in a learning culture, supplying them with evidence-informed health and well-being information.
- **Affordable Care**: Keeping costs manageable by streamlining processes and using communication, information and education to lead providers and their patients to a "best practice" health care experience.

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Optum Network Tiering

Tier 1 Provider	Providers that meet a minimal patient volume and have clinical decision-making consistently aligned with current evidence and community standards. Tier 1 providers participate in a minimal UR process. Following two consecutive years as a Tier 1 provider, while meeting a minimal patient volume, the provider moves to a no UR process (Tier 1 Advantage). Tier 1 Advantage providers, with minor plan exceptions, are no longer required to submit PSFs. See Medicare Addenda, Network Tiering below
Tier 2 Provider	Providers that are new to the network, have not met a minimum patient volume or have clinical decision-making not aligned with current evidence and community standards in one or more areas. Tier 2 providers participate in a comprehensive UR process. See Medicare Addenda, Network Tiering below

- Updated Annually or anytime at their sole discretion.
- During review, provider performance within the network determines if they qualify for a change

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1.2.1 Clinical Submission and Associated Forms

Optum providers are contractually required to comply with the Optum programs and procedures, including the Utilization Management processes. Optum conducts two forms of Utilization Management:

- *Utilization Review* – for contracted clients where submission of the Patient Summary Form is required i.e., where Optum renders adverse determinations and where appeals rights are provided.
- *Notification* – for contracted clients where the submission of the Patient Summary Form is not required for payment i.e., feedback from Optum is purely informational, and no adverse determinations are made.

The *Utilization Review* process requires contracted health care providers to submit the Patient Summary Form* at the beginning of a treatment plan (generally within the first 10 days). Utilization review shall not be conducted more frequently than is reasonably required to assess whether the health care services under review meet plan benefit coverage criteria. The patient may not be billed for covered services not reimbursed due to the health care provider's failure to properly follow Optum's Utilization Review requirements.

Prior to submission of the Patient Summary Form and while the clinical submission is being processed, the health care provider is obligated to provide necessary services to the patient.

The *Notification* process recommends but does not require contracted health care providers to submit the Patient Summary Form at the beginning of a treatment plan. The information submitted is typically used to identify opportunities for focused clinical outreach and support.

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Patient Summary Form

Online Submission of the Patient Summary Form (PSF-750) is Required

You must submit forms within 3 days but no later than 10 days.

The following directions will assist in making the online submission process easy and convenient for you and your staff.

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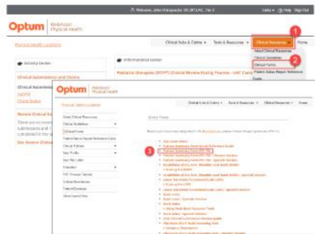
PSF-750 Form

Many offices print a hard copy of the PSF-750 first, have the provider and the patients fill out their sections, and then enter the information electronically on the Optum portal.

You can find the PSF-750 hard copy under the "Tools & Resources" menu click on Clinical Forms.

You will be presented with clinical forms. Click Patient Summary Form PSF-750.

Medicare requires some additional questions be answered that are not included in the paper PSF-750. See pages 15-16 for additional information.



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Patient Summary Form

- Patient
- Staff Prefill
- Doctor
- Patient

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Provider Completes This Section:

Date you want *THIS* submission to begin:

Patient Type

1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Cause of Current Episode

1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery

1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other

Diagnosis (ICD codes)
Please ensure all digits are entered accurately

1°
2°
3°
4°

Nature of Condition

1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level

98940 98942
98941 98943

Current Functional Measure Score

Neck Index DASH (other FOM)
Back Index LEFS

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Don't believe what you see?
Group number on patient card.

Get to know your UnitedHealthcare® Medicare Advantage member ID card

Your UnitedHealthcare® Group Medicare Advantage (PPO) plan member ID card includes information about you and your coverage. Carry it with you wherever you go and show it when you visit your provider or pharmacy so they know how to bill for their services. This is the only ID card that you will need to use for your UnitedHealthcare Medicare Advantage plan benefits.

Front of the card (sample)

- **Member ID and Group Number** Use these when registering on **www.UHCRetiree.com/GVI** or calling with questions. Also, **your providers (e.g., doctor, pharmacy)** will need this new information to verify your benefits and file claims.
- **Your Part D drug coverage** Your pharmacist will use this to file claims for Part D covered drugs. These Part D drugs are drugs you pick up at the local pharmacy or order via Optum Home delivery.

Back of the card (sample)

- **Your dedicated UnitedHealthcare Medicare Advantage Customer Service phone number** You will be asked to provide your member ID when you call the toll-free member phone number.
- **Provider website and phone number** If your provider has any questions about the plan, they can visit the website or call the number listed here.
- **Pharmacist phone number** If your pharmacist has any questions about your Part D drug coverage, they can call the number listed here.

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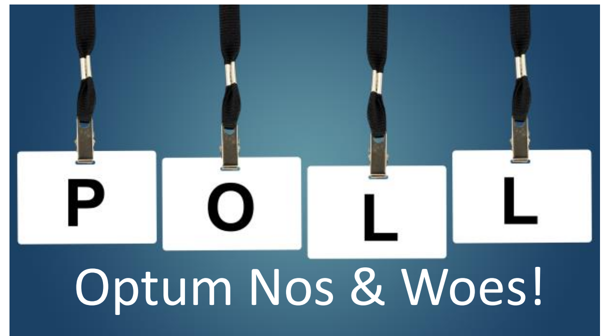

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Obtain Your One Healthcare ID and Password

Once you've logged in and created a One Healthcare ID and password, you will click on the One Healthcare ID login tab, use this ID and password to log into WebAssist in the future.

If you have any difficulty, you can also call our customer service center and they can assist you. Call: 800-873-4575 or 888-676-7768

Optum WebAssist Physical Health

Welcome to One Healthcare ID

Sign In

Optum

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Member Eligibility and Benefits

Providers are required to verify member eligibility and benefits online.

Under Clinical Subs & Claims menu, click 'Member Eligibility'.

Enter the member's name, ID and date of birth, then click 'Find Member.'

Optum WebAssist Physical Health

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Determine if Clinical Submission is Required

To determine if your UnitedHealthcare Medicare Advantage member* requires clinical submission, click on the Tools & Resources menu, then click 'M&R Quick Group Check.'

UHC Medicare Quick Group

*Excludes UnitedHealthcare Medicare Solutions West

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Determine if Clinical Submission is Required

The M&R Quick Group Check requires entering individual member's group number. Once you enter, click 'Submit.'

Member's Group Number:

Submit Reset

Clinical submission is required for Group 55400 members. Click here to continue the online submission.

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Submit a PSF Electronically – Patient Information

For established patients, pick their name off the patient list, which is in alphabetical order by last name. Their demographics will then populate in the form on the right.

For a new patient fill out the patient demographics section in the blank form.

If you have an established patient who has changed their name, address, or health insurance plan, complete a **new submission**, and include the new information as you would for a any other new patient.

Once the PSF is processed the patient's name with the new information will display on your patient list.

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Submit a PSF Electronically – Patient Information – Plan Name

In the 'Plan' section, make sure to select the appropriate Plan name, corresponding to the member's card, from the dropdown.

For Example: For UnitedHealthcare Medicare Advantage plans[1], select UnitedHealthcare Medicare. For UnitedHealthcare Medicare Solutions West[2] Select "United Healthcare Medicare Solutions West".

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Submit a PSF Electronically – Provider Office Information

After selecting an existing patient, or entering your new patient information, you must select the office location where the patient is being treated.

Once you select the location, the remainder of the electronic PSF-750 will display.

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Submit a PSF Electronically – Clinical Information

Enter all required the clinical information within the electronic form.

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Submit a PSF Electronically – Medicare Plans Only

When submitting a PSF for a UHC Medicare Advantage Plan or UHC Medicare Solutions (WEST) members, you will be presented with some additional questions, which will not be present for other plans.

The requested duration in weeks should be the **total number of weeks** of this requested treatment plan.

The requested number of visits should be the total number of visits, not the frequency of visits requested per week. *(i.e. 2 times per week for 8 weeks, equals 16 visits.)*

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Submit a PSF Electronically – Medicare Plans Only

Medicare requires some additional questions be answered that are not included in the paper PSF-750.

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Submit a PSF Electronically – Functional Outcome Measure (FOM) Score

If you have calculated the patient's current FOM, you can enter the score in the space provided.

To calculate a FOM score, click on the form that your patient has completed.

An electronic version of the form will open for you. Once complete, click the Calculate and Accept buttons.

Your score will be placed within the electronic form.

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Submit a PSF Electronically – Submit

When the electronic form is complete, click the 'Submit' button.

If you have forgotten to fill out any required information the site will prompt you to complete that question.

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Submit a PSF Electronically – Confirmation Page

You will then receive a confirmation page that will include the information you submitted electronically on the PSF, along with you Confirmation Number.

You can write this number down as confirmation that we have received your submission or print the page.

If you scroll to the bottom of the Confirmation Page, you will see a 'Print Page' hyperlink.

Once you click this link, you can either download or print this page for your records.

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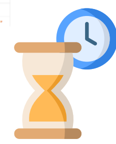
Submit a PSF Electronically – Checking Authorization Status

If there are no issues with the submission, it will take 24-48 business hours to process.

If there are any issues with your submission, Optum will contact you via phone or mail.

To check the status of your submission, go to the Optum WebAssist home page. Under the Activity Center, click the 'Check Status' hyperlink under Clinical Submissions.



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Submit a PSF Electronically – Checking Authorization Status

Upon clicking the 'Check Status' hyperlink under Clinical Submissions, you will be presented with a list of all your recent submissions.

If you chose to narrow your search results by selecting an Office Location, Decision Date, or Patient & Date of Birth information, you will then need to click the 'Search' button to view the results.

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Submit a PSF Electronically – Checking Authorization Status

To view additional details, you can click the hyperlink within the 'Status' section of the search results.

If a submission is in process, you will receive a short summary page. You can either download or print this page for your records.

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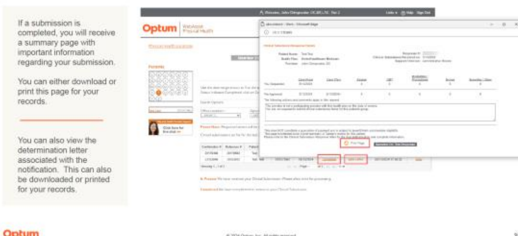
Submit a PSF Electronically – Checking Authorization Status

If a submission is completed, you will receive a summary page with important information regarding your submission.

You can either download or print this page for your records.

You can also view the determination letter associated with the notification. This can also be downloaded or printed for your records.



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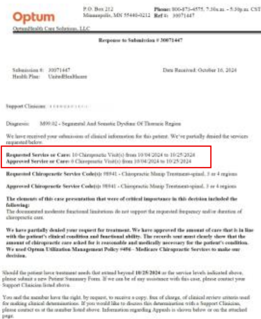

Optum
OptumHealth Care Solutions, LLC
P.O. Box 212
Minneapolis, MN 55440-0212
Phone: 800-873-4575, 7:30a.m. - 5:30p.m. CST
Ref #: 30071447

Response to Submission # 30071447

Submission #: 30071447 Date Received: October 16, 2024
Health Plan: UnitedHealthcare

Support Clinician:

Diagnosis: M99.02 - Segmental And Somatic Dysfunc Of Thoracic Region

We have received your submission of clinical information for this patient. We've partially denied the services requested below.

Requested Service or Care: 10 Chiropractic Visit(s) from 10/04/2024 to 10/25/2024
Approved Service or Care: 0 Chiropractic Visit(s) from 10/04/2024 to 10/25/2024

Requested Chiropractic Service Code(s): 98941 - Chiropractic Manip Treatment-spinal, 3 or 4 regions

Approved Chiropractic Service Code(s): 98941 - Chiropractic Manip Treatment-spinal, 3 or 4 regions

The elements of this case presentation that were of critical importance in this decision included the following:
The documented moderate functional limitations do not support the requested frequency and/or duration of chiropractic care.

We have partially denied your request for treatment. We have approved the amount of care that is in line with the patient's clinical condition and functional ability. The records sent most clearly show that the amount of chiropractic care asked for is reasonable and medically necessary for the patient's condition. We used Optum Utilization Management Policy #486 - Medicare Chiropractic Services to make our decision.

Should the patient have treatment needs that extend beyond **10/25/2024** or the service levels indicated above, please submit a new Patient Summary Form. If we can be of any assistance with this case, please contact your Support Clinician listed above.

You and the member have the right, by request, to receive a copy, free of charge, of clinical review criteria used for making clinical determinations. If you would like to discuss this determination with a Support Clinician, please contact us at the number listed above. Information regarding Appeals is shown below or on the attached page.

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QUICK RESPONSE

Optum
OptumHealth Care Solutions, LLC
P.O. Box 212
Minneapolis, MN 55440-0212
Phone: 800-873-4575, 7:30a.m. - 5:30p.m. CST
Ref #: 30071095

Response to Submission #

Submission #: Date Received: October 16, 2024
Health Plan: UnitedHealthcare

Support Clinician:

Submitted Initial Date: 09/18/2024
Dates this response applies to: **09/18/2024 - 10/30/2024**
Number of visits: **8 Visit(s)**

Supported level of CMT: **98941 or 98940**

We have received your submission of clinical information for this patient regarding a request for services. The requested services have been approved as noted above.

Should the patient have treatment needs that extend beyond **10/30/2024** or the service levels indicated above, please submit a new Patient Summary Form. If we can be of any assistance with this case please contact your Support Clinician listed above.

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Payers Are Not Excused

CMS-0057-F 459

TABLE E1: PRIOR AUTHORIZATION DECISION TIMEFRAMES FOR IMPACTED PAYERS BEGINNING IN 2026 (EXCLUDING DRUGS)

Payer	Final Expedited Prior Authorization Decision Timeframes	Final Standard Prior Authorization Decision Timeframes
MA Organizations and Applicable Integrated Plans	As expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request.* 42 CFR 422.572(a) 42 CFR 422.631(d)(2)(iv)	As expeditiously as the enrollee's health condition requires but no later than 7 calendar days after receiving the request for the standard organization determination* and standard integrated organization decision. 42 CFR 422.568(b)(1) 42 CFR 422.631(d)(2)(i)(B)

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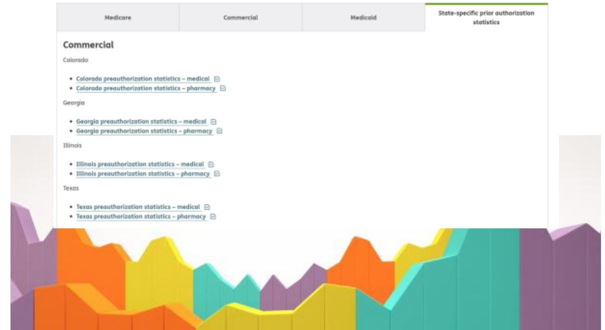
PROVIDER_SPECIALTY	REASON FOR REQUEST DENIAL	TYPE OF SERVICE	TOTAL ANNUAL REQUESTS	APPROVED REQUESTS	PARTIALLY APPROVED REQUESTS	DENIED REQUESTS	TAT NOTIFICATION TO RESPONSE	NUMBER APPEALED	OVERTURNED ON APPEAL	UPHELD ON APPEAL
CHIROPRACTOR		Procedure	43	43	0	0	0.526315789	0	0	0
CHIROPRACTOR-OCCUPATIONAL HEALTH		Diagnostic Test	3	3	0	0	0	0	0	0
CHIROPRACTOR-REHABILITATION		Diagnostic Test	3	3	0	0	0	0	0	0

- Georgia
  - Diagnostic Requests – 6
    - Diagnostic Approved – 6
  - Procedure Requests – 43
    - Procedure Approved - 43
- Illinois
  - Diagnostic Requests – 17
    - Diagnostic Approved -17
  - Procedure Requests – 20
    - Procedure Approved – 20
- Colorado
  - Diagnostic Request – 3
    - Diagnostic Approved – 3
  - Procedure Requests – 4
    - Procedure Approved – 4
- Texas
  - Diagnostic Request – 365
    - Diagnostic Approved – 364
    - Diagnostic Denied – 1 – Not Medically Necessary
  - Procedure Requests – 124
    - Procedure Approved – 124
  - Radiology Request – 1
    - Radiology Approved – 1

Humana

55



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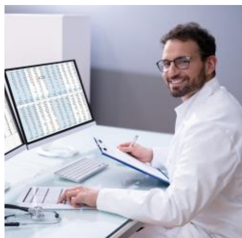
ICD-10 Coding in Practice



- Centers for Medicare and Medicaid Services (CMS) post the updates for the ICD-10 codes annually.
- The goal for this annual update is to provide greater specificity for diagnosis classifications for providers.
- These updates take effect on October 1st of each year.
- Use these codes for patient encounters occurring from October 1, 2024 – September 30, 2025
- Sign up for email updates.

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Most Software Automatically Update ICD10 Codes

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ICD10 CM Tabular Addenda 2025

- Chapter 1, Certain infectious and parasitic diseases (A00-B99)
- Chapter 2, Neoplasms (C00-D49)
- Chapter 3, Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)
- Chapter 4, Endocrine, nutritional and metabolic diseases (E00-E8...
- Chapter 5, Mental, Behavioral and Neurodevelopmental disorders (F01-F99)
- Chapter 6, Diseases of the nervous system (G00-G99)
- Chapter 7, Diseases of the eye and adnexa (H00-H59)
- Chapter 9, Diseases of the circulatory system (I00-I99)
- Chapter 10, Diseases of the respiratory system (J00-J99)
- Chapter 11, Diseases of the digestive system (K00-K95)
- Chapter 12, Diseases of the skin and subcutaneous tissue (L00-L9...
- Chapter 13, Diseases of the musculoskeletal system and connective tissue (M00-M99)

Chapter 13 -
- Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)
- Primary chapter affecting Chiropractors

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No Change	**M51.36 Other intervertebral disc degeneration, lumbar region**
Add	**M51.360 Other intervertebral disc degeneration, lumbar region with discogenic back pain only**
Add	Other intervertebral disc degeneration, lumbar region with axial back pain only
Add	**M51.361 Other intervertebral disc degeneration, lumbar region with lower extremity pain only**
Add	Other intervertebral disc degeneration, lumbar region with leg pain only
Add	Other intervertebral disc degeneration, lumbar region with referred sclerotomal pain only
Add	**M51.362 Other intervertebral disc degeneration, lumbar region with discogenic back pain and lower extremity pain**
Add	Other intervertebral disc degeneration, lumbar region with discogenic back pain and leg pain
Add	Other intervertebral disc degeneration, lumbar region with axial back pain and referred sclerotomal pain
Add	**M51.369 Other intervertebral disc degeneration, lumbar region without mention of lumbar back pain or lower extremity pain**
Add	Other intervertebral disc degeneration, lumbar region without mention of lumbar back pain or leg pain
Add	Other intervertebral disc degeneration, lumbar region, NOS

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No Change	**M51.37 Other intervertebral disc degeneration, lumbosacral region**
Add	**M51.370 Other intervertebral disc degeneration, lumbosacral region with discogenic back pain only**
Add	Other intervertebral disc degeneration, lumbosacral region with axial back pain only
Add	**M51.371 Other intervertebral disc degeneration, lumbosacral region with lower extremity pain only**
Add	Other intervertebral disc degeneration, lumbosacral region with leg pain only
Add	Other intervertebral disc degeneration, lumbosacral region with referred sclerotomal pain only
Add	**M51.372 Other intervertebral disc degeneration, lumbosacral region with discogenic back pain and lower extremity pain**
Add	Other intervertebral disc degeneration, lumbosacral region with discogenic back pain and leg pain
Add	Other intervertebral disc degeneration, lumbosacral region with axial back pain and referred sclerotomal pain
Add	**M51.379 Other intervertebral disc degeneration, lumbosacral region without mention of lumbar back pain or lower extremity pain**
Add	Other intervertebral disc degeneration, lumbosacral region without mention of lumbar back pain or leg pain
Add	Other intervertebral disc degeneration, lumbosacral region, NOS

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No Change	**M65.9 Synovitis and tenosynovitis, unspecified**
Add	**M65.90 Unspecified synovitis and tenosynovitis, unspecified site**
Add	**M65.91 Unspecified synovitis and tenosynovitis, shoulder**
Add	**M65.911 Unspecified synovitis and tenosynovitis, right shoulder**
Add	**M65.912 Unspecified synovitis and tenosynovitis, left shoulder**
Add	**M65.919 Unspecified synovitis and tenosynovitis, unspecified shoulder**
Add	**M65.92 Unspecified synovitis and tenosynovitis, upper arm**
Add	**M65.921 Unspecified synovitis and tenosynovitis, right upper arm**
Add	**M65.922 Unspecified synovitis and tenosynovitis, left upper arm**
Add	**M65.929 Unspecified synovitis and tenosynovitis, unspecified upper arm**
Add	**M65.93 Unspecified synovitis and tenosynovitis, forearm**
Add	**M65.931 Unspecified synovitis and tenosynovitis, right forearm**
Add	**M65.932 Unspecified synovitis and tenosynovitis, left forearm**
Add	**M65.939 Unspecified synovitis and tenosynovitis, unspecified forearm**
Add	**M65.94 Unspecified synovitis and tenosynovitis, hand**

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No Change	**M54.3 Sciatica**
Add	**Excludes1**: intervertebral disc degeneration, lumbar region with lower extremity pain only (M51.361)
Add	intervertebral disc degeneration, lumbosacral region with lower extremity pain only (M51.371)
No Change	**M54.4 Lumbago with sciatica**
Add	**Excludes1**: intervertebral disc degeneration, lumbar region with discogenic back pain and lower extremity pain (M51.362)
Add	intervertebral disc degeneration, lumbosacral region with discogenic back pain and lower extremity pain (M51.372)
No Change	**M54.5 Low back pain**
Add	**Excludes1**: intervertebral disc degeneration, lumbar region with discogenic back pain only (M51.360)
Add	intervertebral disc degeneration, lumbosacral region with discogenic back pain only (M51.370)
No Change	**Disorders of muscles (M60-M63)**
No Change	**M62 Other disorders of muscle**
No Change	**M62.8 Other specified disorders of muscle**
Add	**M62.85 Dysfunction of the multifidus muscles, lumbar region**

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KMC University Members

DOWNLOAD NOW

ICD-Diagnose

Common Chiropractic ICD Codes List

Electronic Version

KMC UNIVERSITY

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Rachel Soucy
KMC University Helpdesk Specialist

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What Is An LCD?

- A decision made by a Medicare Administrative Contractor (MAC) on whether a particular service or item is reasonable and necessary, and therefore covered by Medicare within the specific jurisdiction that the MAC oversees.
- MACs develop an LCD when there is no national coverage determination (NCD) or when there is a need to further define an NCD for the specific jurisdiction.
- LCDs outline how the contractor will review claims to ensure that the services provided meet Medicare coverage requirements.

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What Is An Article?

- A type of document published by the Medicare Administrative Contractors (MACs) often contains coding or other guidelines and may or may not be in support of a Local Coverage Determination (LCD).
  - Articles which directly support an LCD are known as "**LCD Reference Articles**".
  - Articles identified as "**Not an LCD Reference Article**" are articles that do not directly support a Local Coverage Determination (LCD).

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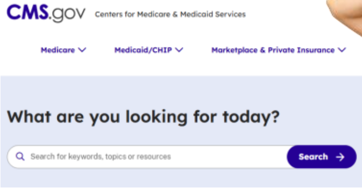
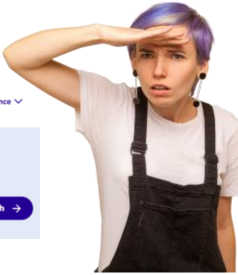
Where Can I Find Them?





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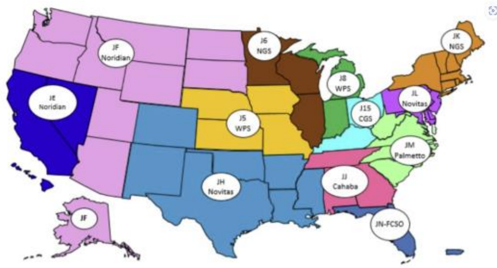

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Billing and Coding Article

WPS Billing and Coding: Chiropractic Services

Billing and Coding articles

- Provide guidance for the related Local Coverage Determination (LCD) and assist providers in submitting correct claims for payment.
- Billing and Coding articles typically include CPT/HCPCS procedure codes, ICD-10-CM diagnosis codes, as well as Bill Type, Revenue, and CPT/HCPCS Modifier codes.
- The code lists in the article help explain which services (procedures) the related LCD applies to, the diagnosis codes for which the service is covered, or for which the service is not considered reasonable and necessary and therefore not covered.

Article Information

General Information

Article ID
A56273

Article Title
Billing and Coding: Chiropractic Services

Article Type
Billing and Coding

Original Effective Date
03/19/2019

Revision Effective Date
10/01/2024

Revision Ending Date
N/A

Retirement Date
N/A

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Medicare WPS Local Coverage Article

(effective 10/1/24)

Group 1 (6 Codes)

Group 1 Paragraph

Note: diagnosis codes must be coded to the highest level of specificity.

The level of the subluxation must be specified on the claim and must be listed as the primary diagnosis. The neuromusculoskeletal condition necessitating the treatment must be listed as the secondary diagnosis. All diagnosis codes must be coded to the highest level of specificity, and the primary diagnosis must be supported by x-ray or documented by physical examination.

These are the only covered diagnosis codes that support medical necessity:

Primary: ICD-10-CM Codes (Names of Vertebrae)

The precise level of subluxation must be listed as the primary diagnosis.

Group 2 (48 Codes)

Group 2 Paragraph

SHORT-TERM TREATMENT

(These conditions generally require short-term treatments.)

ICD-10 CM

Symptom/Condition Codes

(Secondary Diagnosis)

Group 3 (193 Codes)

Group 3 Paragraph

Moderate-Term Treatment

ICD 10 CM

Symptom/Condition Codes

(Secondary Diagnosis)

Group 4 (70 Codes)

Group 4 Paragraph

Long-Term Treatment

ICD 10 CM

Symptom/Condition Codes (Secondary Diagnosis)

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Time to Dig!

Live Search

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Important Dates!

Rebecca Scott, CPC, CPCO, CPB

KMC University Specialist

Train My Biller Coach

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SAVE THE DATE

IMPORTANT

- **Physician Open Enrollment** Mid-Nov - December 31
- **Patient Open Enrollment** Oct 15 - December 7
- **Fee Schedule Updates** 2025 Rates Coming Soon

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- **Annual Medicare Physician Participation Open Enrollment**
  - Mid-November - December 2024
- Open Time to Change Participation Level with Medicare
  - Participating vs Non-Participating
  - Opt-Out Is Not An Option for Chiropractors

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KMC University's Guide to PARTICIPATING (PAR) VS. NON-PARTICIPATING (NON-PAR) MEDICARE PROVIDER

Participating Provider (Par)	*Non-Participating Provider (Non-Par)*
Collects the participating allowable fee schedule amount for CMT services	Collects no more than the Limiting Fee set by Medicare at the time-of-service
Must submit claims to Medicare	Must submit claims to Medicare
Always accepts assignment in Item 27 of 1500 Claim Form	Usually does not accept assignment in Item 27 of 1500 Claim Form but may elect to accept assignment on a case-by-case basis
Submits to secondary/Medigap carriers	No obligation to submit to secondary/Medigap carriers
Reduces out-of-pocket expense for patient	Increases out-of-pocket expense for patient

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Patient Open Enrollment

Enrollment period:	You can:	Coverage starts:
Open Enrollment Period October 15-December 7.	• Join, drop, or switch to another Medicare Advantage Plan (or add or drop drug coverage). • Switch from Original Medicare to a Medicare Advantage Plan **or** from a Medicare Advantage Plan to Original Medicare. • Join, drop, or switch to another Medicare drug plan if you're in Original Medicare.	January 1 of the next year. **NOTE TO SELF:** • Update Insurance Cards • Verify Patient Eligibility • Change Payer in Software

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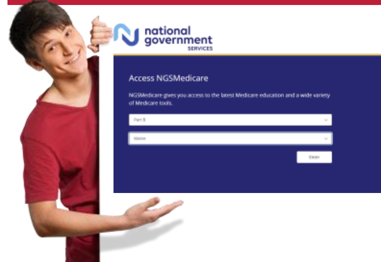
Medicare Fee Schedule



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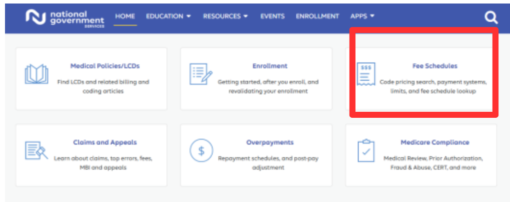
Medicare Fee Schedule



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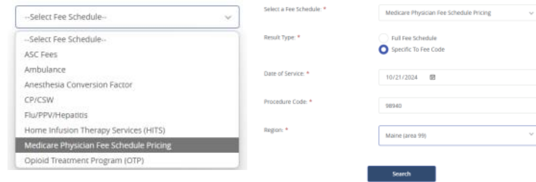
Medicare Fee Schedule



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Medicare Fee Schedule

Medicare Physician Fee Schedule Pricing Fee Schedule

Procedure Code	Effective Date	State/Territory	Locality	Short Description
98940	03/09/2024	14112	99	Chiropract manj 1-2 regions

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	26.17	24.86	28.59	21.00	19.95	22.94

OPPS Capped Payment Rates (OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	0.00	0.00	0.00	0.00	0.00	0.00

The full Fee Schedule for this code can be downloaded in the following formats below:

Excel File CSV File

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What's New with HIPAA? A Quick Overview

- Revised penalty structure
- Guidance on Tracking Technologies (website)
- New Guidance on Telehealth
- Privacy Rule Changes- On the Horizon
- Notice of Privacy Policy Changes
- New rules for Reproductive Rights
- Cybersecurity Risk & Breach Notification
- New Rules for substance use disorder

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Civil Penalties – *No Penalty* Update

- Falling into the 'did not know category' is hard to do with all the information and guidance available
- Per violation can be per safeguard violated and/or per patient $$$$
- Good news! No penalty if corrected within 30 days as long as NOT willful neglect

*Provided by Holland & Hart Legal Counsel

Category	Penalty
Did not know and should not have known of violation	• $141* to $71,162* per violation • Up to $2,067,813* per type per year • No penalty if correct w/in 30 days • OCR may waive or reduce penalty
Violation due to reasonable cause	• $1,379* to $71,162* per violation • Up to $2,067,813* per type per year • No penalty if correct w/in 30 days • OCR may waive or reduce penalty
Willful neglect, but correct w/in 30 days	• $14,232* to $71,162* per violation • Up to $2,067,813* per type per year • Penalty is mandatory
Willful neglect, but do not correct w/in 30 days	• $71,162 to $2,134,831* per violation • Up to $2,134,831* per type per year • Penalty is mandatory

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How to Avoid Willful Neglect Category

- Appoint Compliance Officer-Contact
- Have in place policies and procedures
- Have on file a thorough Risk Assessment report along with corrective actions (within the past 12 months)
- Tangible evidence of risk management (monitoring, reporting events and enforcement (sanctions))
- Documented HIPAA training
- Up to date Notice of Privacy Practices
- Self report breaches

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Online Tracking Technologies

Use of Online Tracking Technologies by HIPAA Covered Entities and Business Associates

*On June 20, 2024, the U.S. District Court for the Northern District of Texas issued an order declaring unlawful and vacating a portion of this guidance document. See Am. Hosp. Ass'n v. Becerra, — F. Supp. 3d —, No. 4:23-cv-1110, 2024 WL 3075865 (N.D. Tex. June 20, 2024). Specifically, the Court vacated the guidance to the extent it provides that HIPAA obligations are triggered in "circumstances where an online technology connects (1) an individual's IP address with (2) a visit to a[n] [unauthenticated public webpage] addressing specific health conditions or healthcare providers." Id. at *2. HHS is evaluating its next steps in light of that order.*

The Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) is issuing this Bulletin to highlight the obligations of Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entities[1] and business associates[2] ("regulated entities") under the HIPAA Privacy, Security, and Breach Notification Rules ("HIPAA Rules") when using online tracking technologies ("tracking technologies").[3] OCR administers and enforces the HIPAA Rules, including by investigating breach reports and complaints about regulated entities' noncompliance with the HIPAA Rules. A regulated entity's failure to comply with the HIPAA Rules may result in a civil money penalty.[4]

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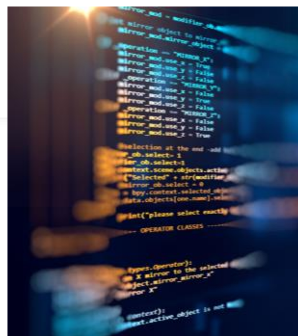
Tracking

*"a tracking technology is a script or code on a website or mobile app used to gather information about users or their actions as they **interact with a website** or mobile app. After information is collected through tracking technologies from websites or mobile apps, it is then **analyzed by owners of the website or mobile app**.."*

Mobile Apps

Business Associates (BA)

who manage your website



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To Dos

- Make sure you review the HHS guidance and query your website vendors https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/hipaa-online-tracking/index.html
- Know the 18 identifiers of PHI and track PHI on your website
- Data mining NOT permitted by Business Associate (BA)
- Don't assume this falls into TPO [treatment, payment, healthcare operations]
- Ask BA to de-identify information on behalf of the provider or choose a new vendor
- Learn about unauthenticated webpages vs. authenticated from a compliance specialist
- Obtain patient's HIPAA authorization if necessary [heads up- a statement on your website or in your NPP is NOT sufficient]

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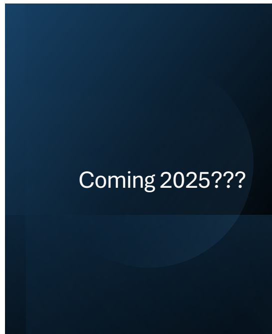

Update to the Privacy Rule

Pending since 1/21/2021 but hopefully final in early 2025

You will need to…

- Modify content in Notice of Privacy Practices
- Change process for obtaining patient acknowledgement
- Update your medical record's policy and patient's right of access

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Notice of Privacy Practices will need updating by **February 2026**

- HHS will publish a Model notice (but still needs to be customized to your clinic and services provided)
- Government wants to get all federal updates in place before enforcing NPP changes
- Changes will take into consideration Reproductive Rule, SUD Part 2, and the upcoming privacy law changes

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Home What We Do Our Expertise Why KMCU Free Stuff

KMC University HIPAA Assessment

Home • KMC University HIPAA Assessment

Take a Closer Look

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) has developed regulations to protect the privacy and security of health information. To help doctors with meeting the requirements, HHS published both the HIPAA Privacy Rule and the HIPAA Security Rule. Unfortunately, the extensive amount of reading material and the constant misinformation have left doctors overwhelmed and at risk for a HIPAA violation.

HIPAA

What requirements apply to providers?

Is there a small provider exemption?

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WHAT'S NEXT?

- Sign Up For Payer Bulletins
- Update Fee Schedules in January
- Create Proven Systems for Tracking Authorizations
- Update All Patient Cards Beginning of Year
- Make Sure You Are Using the Updated Diagnosis Codes
- Stay Up to Date With HIPAA Compliance Changes

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Is Your Documentation a "Chance" Card?
Find out with the help of our Certified Specialists!

KMC UNIVERSITY

PROACTIVE CHART REVIEW

GET **$50 OFF** WITH CODE **MONOPOLY**
AND GET YOURS FOR JUST **$199**
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96