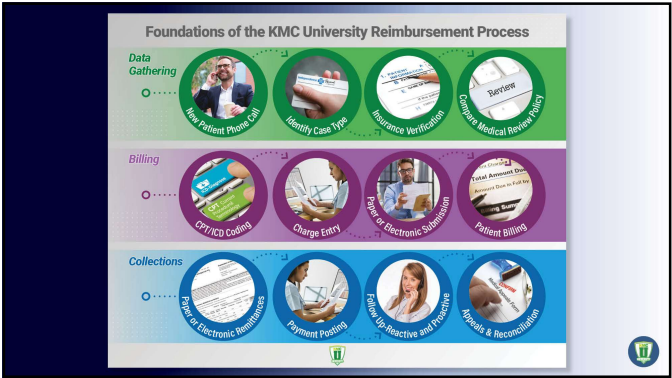
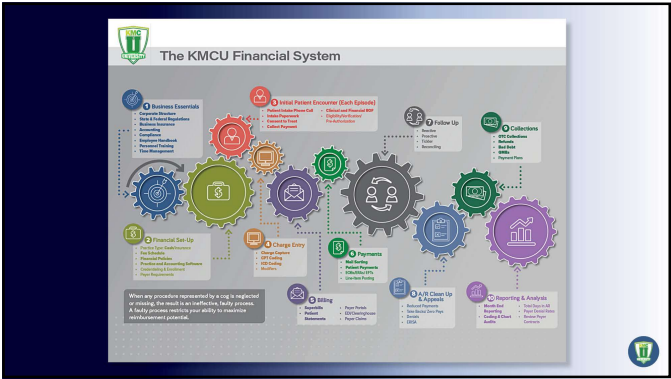




1



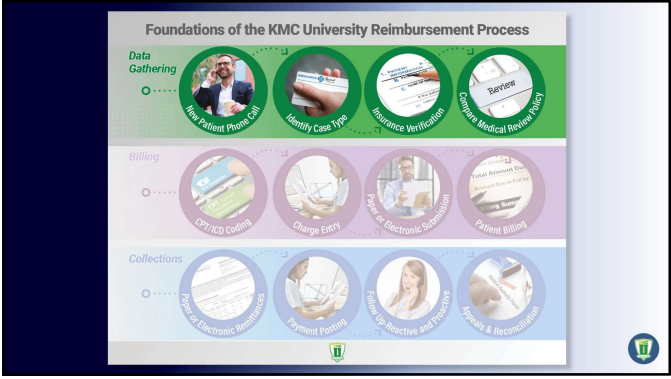
2



3



4



5



6

What We Call
"The Big Four"

WANT

MUST HAVE

NEED

7

What the Office Must Know

Is the patient eligible for services today?

Have I verified the specific benefits for the services I intend to render?

Did I compare the services I intend to render to the payer's medical review policy to check for services that may be deemed experimental, unproven, or investigational? And am I clear about the payer's definition of medical necessity?

Did I review the coding and documentation requirements in the payer's medical review policy to ensure we know the rules of engagement and can produce a valid, reimbursable claim?

8

1. Is the Patient Eligible for Services Today?

- Online portals are useful here
- Compliance Risk = using effective date on the card
- Compliance Risk = not checking eligibility at all

Save time and money with our market leading solutions

Streamlining your eligibility and benefits, claims management, and authorizations

Collaborating for patient care requires constant connectivity and up-to-date information. Simplifying how you exchange that information with your payers is more important than ever. Availity makes it easy to work with payers, from the first check of a patient's eligibility through final resolution of your reimbursement.

Availity is the destination where providers connect with their payers to get the answers they need to focus

Availity

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

9

Eligibility:
A Compliant Outcome

A good process produces good results.

Nick Saban

- The correct payer is billed
- Verification of the patient identity is completed
- Basic information needed to further the next steps is gathered

10

2. Have I verified the specific benefits for the services I intend to render?

TRUST BUT VERIFY

11

Benefit Verification:
A Compliant Outcome

A good process produces good results.

Nick Saban

- Services are clarified as covered or not covered
- Patient financial obligations are made clear
- Benefit verification leads to Medicare Review Policy comparison

12

3. Locate and Review Payer's Medical Review Policy

Did I compare the services I intend to render to the payer's medical review policy to check for services that may be deemed experimental, unproven, or investigational? And am I clear about the payer's definition of medical necessity?

Cigna Chiropractic MRP

13

MRP Review: A Compliant Outcome

- Experimental, Unproven, and Investigational services are identified
- Clarification on whether patient can opt in
- Medical necessity rules are clarified
- Treatment planning can be customized

A good process produces good results.

Nick Saban

14

4. Understand and Implement Coding and Documentation Policy

Did I review the coding and documentation requirements in the payer's medical review policy to ensure we know the rules of engagement and can produce a valid, reimbursable claim?

Cigna Chiropractic MRP

15

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.



16

The Opposite of Active Treatment

Maintenance therapy is defined (per Chapter 15, Section 30.5.B. of the Medicare Benefits Policy Manual) as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition.



17

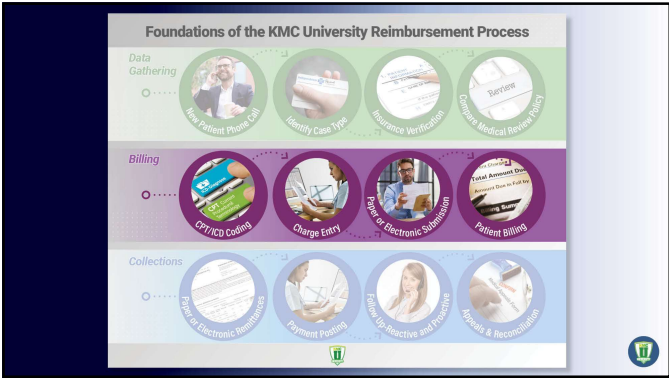
Coding and Documentation: A Compliant Outcome

- The rules of coding are clarified
- Modifier usage is defined
- Documentation requirements and diagnosis expectations are well-defined
- Treatment planning can be customized

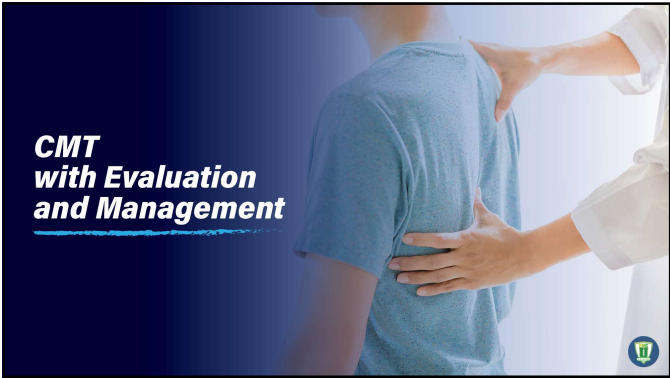
A good process produces good results.

Nick Saban

18



19



20

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!

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.

21

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

Lateral (Side) Spinal Column	Posterior (Back) Spinal Column
Cervical	Cervical
Thoracic	Thoracic
Lumbar	Lumbar
Sacrum	Sacrum
Coccyx	Coccyx

22

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

23

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

24



25



26

	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	

27

	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	

28

	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	

29

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

30

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



31

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



32

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



33

S9090 Decompression

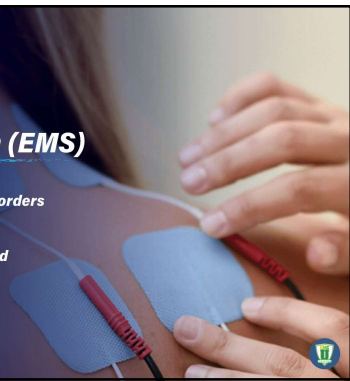
- S9090 - Vertebral Axial Decompression, per session
- Differs from traction:
 - Angle(s)
 - Computer assistance
 - Muscle guarding consideration
 - Intent



34

G0283/97014 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



35

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



36

97032 Attended Electrical Stimulation

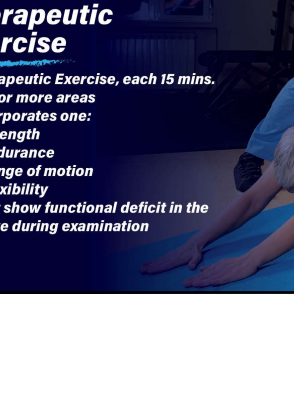
- Application of a modality to one or more areas; electrical stimulation [manual] each 15 minutes
- Most often combo unit
- You can't just move the pads and call it attended!



37

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



38

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

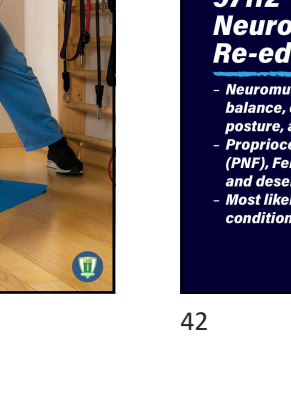
- Indications for laser therapy to promote healing
 - Inflammation
 - Pain
 - Edema
 - Muscle strains
 - Ligament sprains
 - Nerve injuries/irritations



39

Therapeutic Procedures (97110-97546)

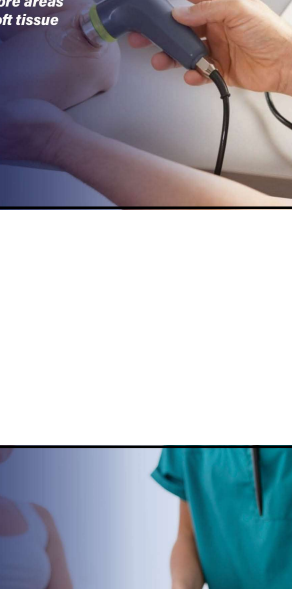
- Therapeutic Procedures are time-based codes for billing purposes
- The patient is ACTIVE in the encounter
- Requires direct one-on-one patient contact
- Documentation should include both the total time spent and the time spent doing each activity/exercise.
- Codes are billed per 15 min increments



40

97110 Therapeutic Exercise

- Therapeutic Exercise, each 15 mins. One or more areas
- Incorporates one:
 - Strength
 - Endurance
 - Range of motion
 - Flexibility
- Must show functional deficit in the above during examination



41

97112 Neuromuscular Re-education (NMRE)

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




42

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



43

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




44

97140

Manual Therapy

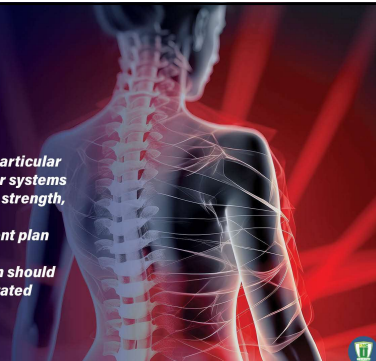
- Includes soft tissue and joint mobilization, manual traction, trigger point therapies, passive range of motion, and myofascial release.
- With CMT - must be in a separate body region
- May require a -59 or X? modifier



45

When To Use 97140

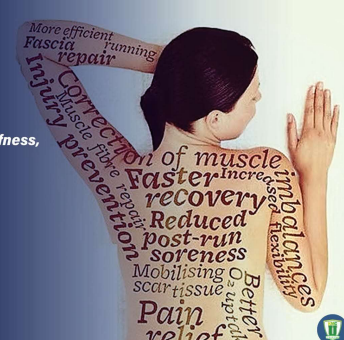
- To effect changes in soft tissues, articular structures, and neural or vascular systems
- To address a loss of joint motion, strength, or mobility
- Must be part of an active treatment plan directed at a specific outcome
- Daily routine visit documentation should include progress toward those stated



46

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



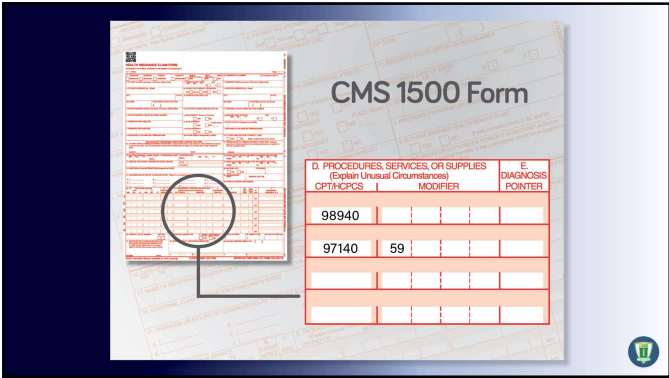
47

Muscle Therapies

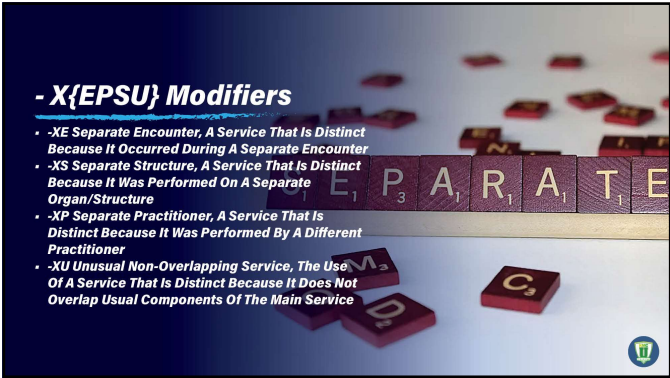
- The National Correct Coding Initiative is a CMS program that prevents improper payment for procedures that should not be submitted together
- Use the -59 modifier to indicate that - YES, these services were both performed today AND - they should BOTH be paid today



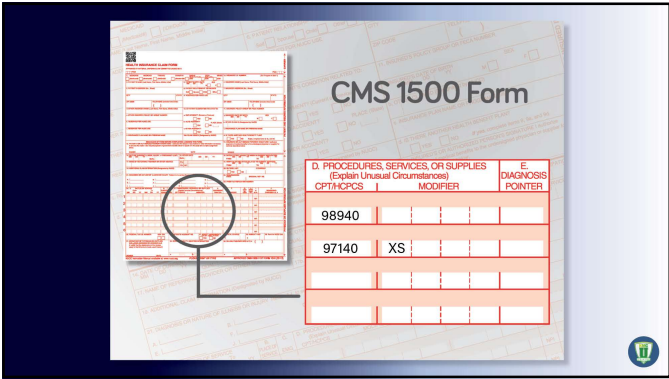
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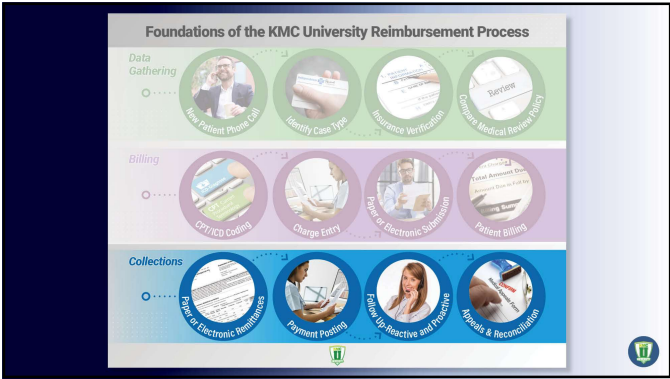
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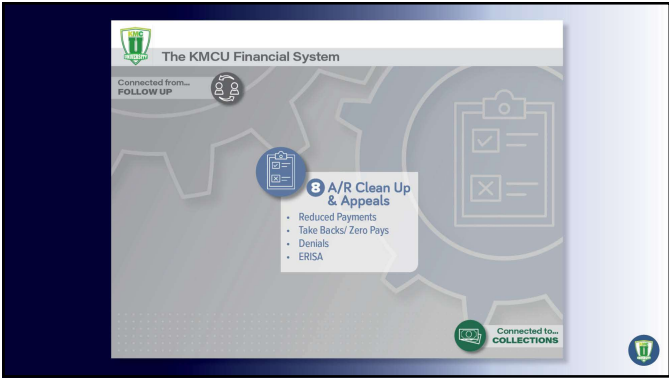
50



51



52



53



54

When Might an Appeal Be Necessary?

- An entire claim is denied
- A partial claim (line item) is denied
- There is an underpayment on one or more items or services according to the policy guidelines or provider contract

APPEAL

55

Appeals Process

- Determine Reason for Denial
- Investigate the Issue—is the Provider at fault or is the Payer at fault?
- Review the process for appeals as outlined by the payer (e.g., Medicare has its own unique appeals process)
- Gather supporting information and file the appeal
- Do not delay the process—the clock is ticking
- Medicare appeals process has five stages... some differ

APPEAL

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Medicare Appeals Processes Have 5 Levels

LEVEL 1

Medicare Administrative Contractor (MAC) Redetermination

LEVEL 2

Qualified Independent Contractor (QIC) Reconsideration

LEVEL 3

Office of Medicare Hearings and Appeals (OMHA) Decision

LEVEL 4

Medicare Appeals Council (Council) Review

LEVEL 5

U.S. District Court Judicial Review

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Payer Appeals Draft Template Letters

Appeals Letter Templates

Content	
CMT with 0140 Appeal.....	2
E/M with CMT Appeal.....	4
ERISA Appeal Letter.....	6
ERISA Request for SPO.....	8
Maintenance Denial Appeal.....	9
Medical Necessity Comprehensive Appeal.....	13
Medical Necessity General Appeal.....	13
NCCI Edits Appeal Letter.....	14
Recoupment Appeal.....	15
Timely Filing - Department of Insurance Complaint.....	16
Genetics Letter for Appeal.....	17

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Part B-What's Missing Here?

CHECK/EFT #:

Are your Medicare files full of paper? Do Paperless - It saves time, money, & increases productivity. Go to [www.Medicare.com](#), search ESI Solutions.

Get NISConnect? NISConnect is a free, secure web-based portal that provides access to self-service functions. Learn more and sign-up at [www.NISConnect.com](#).

Interactive Voice Response: 1-877-844-6504

171 For Hearing Impaired: 1-800-762-7335

National Government Services Hotline: [www.Medicare.com](#)

PERF	PROV	SERV DATE	POS	MS	PRG	MODS	BILLED	ALLOWED	DEDUCT	COINS	SRP/RC-ANT	PROV PD
NAME	0796	09/08/11	1.0	07112	01	ACNT XXXXX7131	20.00	0.00	0.00	0.00	CO-18	20.00
PT RESP	0.00											
CLAIM TOTALS							20.00	0.00	0.00	0.00	CO-18	20.00
NAME	0796	09/08/11	1.0	07112	01	ACNT XXXXX7089	20.00	0.00	0.00	0.00	CO-18	20.00
PT RESP	0.00											
CLAIM TOTALS							20.00	0.00	0.00	0.00	CO-18	20.00
NAME	0796	09/08/11	1.0	07112	01	ACNT XXXXX7090	20.00	0.00	0.00	0.00	CO-18	20.00
PT RESP	0.00											
CLAIM TOTALS							20.00	0.00	0.00	0.00	CO-18	20.00
NAME	0796	09/08/11	1.0	07112	01	ACNT XXXXX7134	20.00	0.00	0.00	0.00	CO-18	20.00
PT RESP	0.00											
CLAIM TOTALS							20.00	0.00	0.00	0.00	CO-18	20.00

59

Part B-What's Missing Here?

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NAME	0796	09/08/11	1.0	07112	01	ACNT XXXXX7131	20.00	0.00	0.00	0.00	CO-18	20.00
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NAME	0796	09/08/11	1.0	07112	01	ACNT XXXXX7089	20.00	0.00	0.00	0.00	CO-18	20.00
PT RESP	0.00											
CLAIM TOTALS							20.00	0.00	0.00	0.00	CO-18	20.00
NAME	0796	09/08/11	1.0	07112	01	ACNT XXXXX7090	20.00	0.00	0.00	0.00	CO-18	20.00
PT RESP	0.00											
CLAIM TOTALS							20.00	0.00	0.00	0.00	CO-18	20.00
NAME	0796	09/08/11	1.0	07112	01	ACNT XXXXX7134	20.00	0.00	0.00	0.00	CO-18	20.00
PT RESP	0.00											
CLAIM TOTALS							20.00	0.00	0.00	0.00	CO-18	20.00

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[illegible]

Part C- Complete PPO Plan

Explanation of Benefits

CARRIER:

AARP MEDICARE COMPLETE PPO
8778623210

POSTED DATE:

05/06/2024

PROVIDER:

[REDACTED]

PROVIDER:

[REDACTED]

TIN #:

[REDACTED]

PATIENT:

[REDACTED]

INSURED:

[REDACTED]

PATIENT A/CCT

[REDACTED]

CLAIM #:

[REDACTED]

Serv Date	Code	Unit	Billed	Allowed	Disallowed	Pri Paid	Sec Paid	Pat Rslp	Pat Paid	Bal	Check#
04/05/24	98941 AT	1	91.00	29.00	55.00	13.00		15.00	15.00	08108620	
04/05/24	97012 G7099-59	1	29.00	29.00				29.00	29.00	08109620	
04/05/24	99212 G7099-25	1	116.00	116.00				116.00	116.00	08109620	
TOTAL			226.00	173.00	53.00	13.00		160.00	160.00		

This is Why We Verify!

Are we PAR or NON-PAR?

Part C—What Else Is Wrong?

Part C—What Else Is Wrong?

Part C—What Else Is Wrong?

Patient: [REDACTED] Remit Provider: [REDACTED] Claim #: [REDACTED]
 DRG: [REDACTED] Patient Control #: 138230100.00 Group/Policy: CO0004

Reprinted: Optum Physical Health Network agreement applies Clm Dn: 12/06/2024
 11/20/24 - 11/20/24 09.00 09.00 19.00 0.00 PR-1 CO-45 N381 0.00
 11/20/24 - 11/20/24 09.00 0.00 0.00 0.00 25.00 0.00 CO-97 N20 0.00
 Total for Claim 85.00 50.00 50.00 0.00 33.00 0.00

Adjustment Reason Codes

Code	Description	Code	Description
PR-1	Deductible Amount		
CO-45	Charge exceeds fee schedule/maximum allowable or contracted/registered fee arrangement	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges
CO-97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.

Remarks Codes

CO-97

N381

N20

Medicare Secondary Payer (MSP)

Insured Name: [REDACTED]		Mfr No: [REDACTED]		MSP: [REDACTED]		Claim/Ctrl No: [REDACTED]								
Patient Name: [REDACTED]		SvcProv No: [REDACTED]		PatCtrl No: [REDACTED]		Group/Inst Total Care								
Billing Provider: [REDACTED]		NPI: [REDACTED]												
Srv	Date	Svc/Mod	Rev/Mod	Days/CO	Charged/Allowed	Deduct	CoPay	CoInsur	Discount/Interest	Med Allow/Mod Paid	Third Party Payer	Denied	EXPL Codes	Payment/Withhold
0100	9/7/2024	98940	98940	1.00	\$0.00 \$24.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00 \$0.00	\$0.00	\$0.00	WA, JA, CA, PA	\$0.00
Sub-total					\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		\$0.00

Payment/Denial/Adjustment Explanation codes used on one or more of the claims above

CA 45	Charge exceeds fee schedule/maximum allowable or contractual/registered fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payment(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
CA 23	The impact of prior payment(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)

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you are **FREE**
TO CHOOSE,
BUT YOU ARE NOT
FREE from the
CONSEQUENCE
OF YOUR CHOICE

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Let's Discuss and Q/A



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