Chiropractic Medicare
Quick Reference Tool

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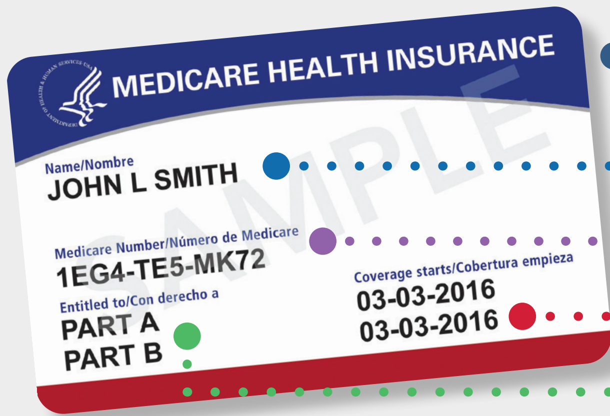
Chiropractic Medicare Quick Reference Tool

Medicare, as a federal program, includes very specific guidelines required to properly manage Medicare cases in your office. To effectively document medical necessity to correctly bill and collect for these services, there are critical keys to each step in the Medicare process. This quick reference tool (QRT) serves as your handy guide to each piece of the Medicare puzzle. **NOTE: This QRT is not meant to replace ongoing, comprehensive Medicare training, but rather to be a practical tool for everyday use by both doctors and team members.**



The Traditional Medicare Card

- Beneficiary Name
- Medicare ID Number
- Medicare Coverage Start Date
- Type of Medicare Coverage

Note: A new Medicare Beneficiary Identification (MBI) may be assigned due to attempted fraud from bad actors. Always confirm the MBI.

THE FOUR PARTS OF MEDICARE

PART A
HOSPITAL INSURANCE

PART B
MEDICAL INSURANCE

Chiropractic Benefits are included in Traditional Medicare Part B

PART C
MEDICARE ADVANTAGE PLANS
(HMOs/PPOs)
Includes Part A, Part B, and sometimes Part D coverage

PART D
MEDICARE PRESCRIPTION DRUG COVERAGE

CHIROPRACTIC MEDICARE BENEFITS AND LIMITATIONS

Recognize the Fundamentals of Medicare Coverage for Chiropractic Services

Covered and Payable	*Active Treatment (AT) Spinal Chiropractic Manipulative TX (CMT) CPT Codes 98940, 98941, 98942*
Covered but Not Payable *ABN form must be provided to the patient prior to rendering Covered but Not Payable services.	*Spinal CMT codes are deemed Covered but Not Payable when performed for:* • *Chiropractic maintenance treatment* • *More than one spinal manipulation per day*
Statutorily Excluded from Medicare Chiropractic Benefit *ABN is not required for these services. Office Financial Policy is recommended to communicate these limitations of Medicare coverage.	*All services/supplies ordered or provided by a chiropractor, other than those defined above, are excluded from the Medicare benefit, and therefore the patient is responsible for payment. This includes but is not limited to:* • *Extra-spinal CMT 98943* • *X-rays* • *Products/supplies* • *Therapies* • *Exams* • *Alternative treatment protocols*

MIPS REPORTING

(Merit-based Incentive Payment System)

- ***MIPS is a combination of former Medicare PQRS and Meaningful Use reporting programs***
- ***Participation requirement is based on certain thresholds***
- ***Payment penalties or bonuses may be assessed based on compliance/non-compliance***
- ***Requires reporting of certain HCPCS "G" codes for treatment quality measures***

KMC University's
Medicare Decision Making Matrix

Use this flowchart to help determine whether a Medicare patient's visit is active or maintenance care. Follow the prompts to support your decision making for an appropriate outcome.

Is this a Medicare patient?

NO → ***This matrix specifically addresses Medicare. However, the noted concepts can apply to decision making for all types of patients.***

YES → *Is this visit part of an active episode of care?*

NO → **CONSIDER:** *Is the patient on PRN care or scheduled maintenance care?*

NO → **WAIT!** *The patient is always either in an active episode of care, on PRN, or maintenance care.* **START OVER!**

NO → *After a brief check, will today's visit be considered maintenance?*

YES → *Does the patient want the maintenance visit and does he/she understand the need to pay out-of-pocket?*

YES → *Is the patient a Qualified Medicare Beneficiary (QMB)?*

YES → **OUTCOME:** *Ensure QMB version of ABN is on file, with* ***Option 1 chosen****, and treat the patient, OR get new ABN signed today for maintenance care.*

NO → **OUTCOME:** *Ensure an ABN is on file, with* ***Option 1 or 2 chosen****, treat the patient, OR get new ABN signed today for maintenance care.*

NOTE: A signed ABN is good so long as there has been no change in Medicare coverage guidelines for the service or until another episode of active treatment begins.

NO → **OUTCOME:** *Have ABN signed with Option 3 chosen. Include witness signature. Do not provide CMT.*

YES → **FIND OUT:** *Is this a new condition, exacerbation or new injury necessitating beginning active treatment?*

NO → NO

YES → *To clarify the situation, determine whether the condition should be treated as an incident, burst, or full episode.*

YES → **ASK:** *Is it time to perform an extended evaluation of this condition and assess the need for further care?*

YES → **OUTCOME:** *Conduct re-evaluation to assess the need for further care.*

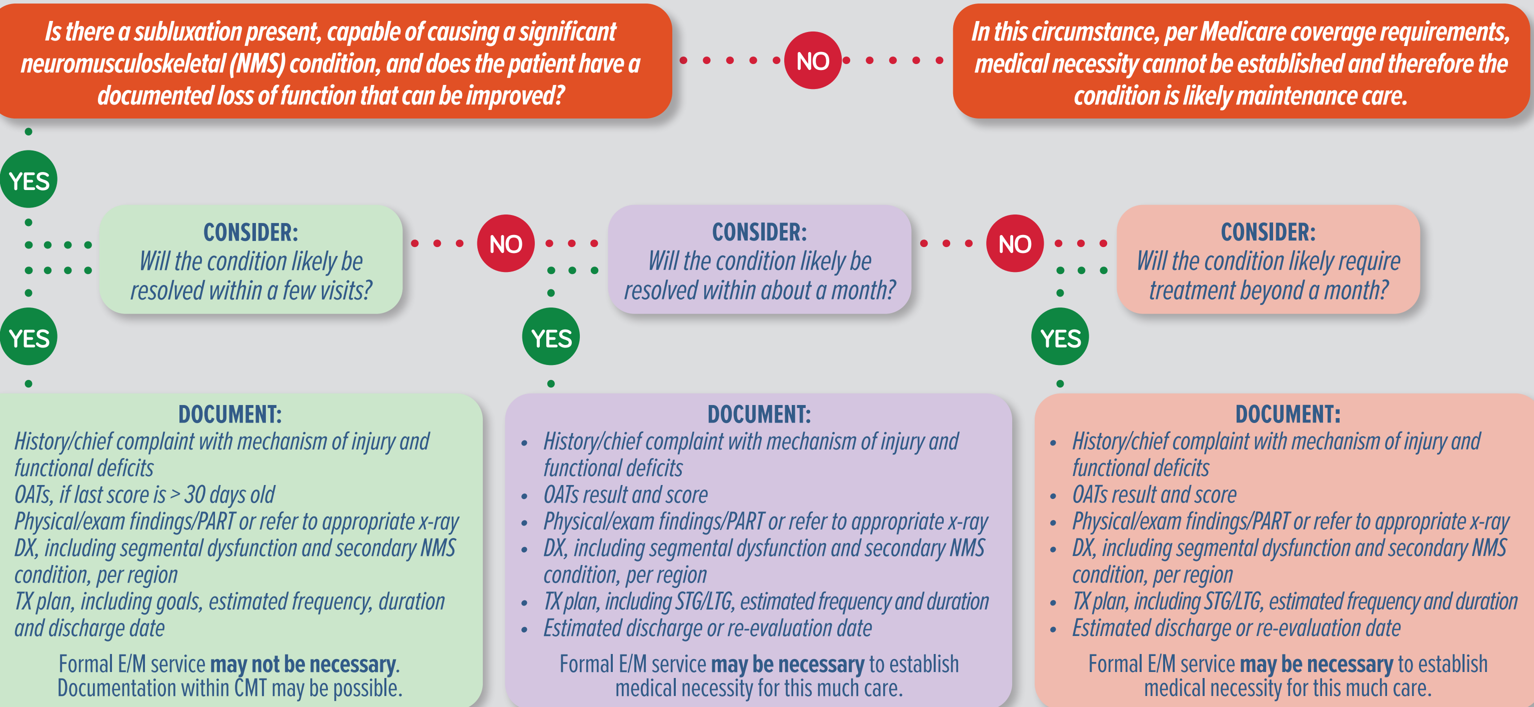
NO → **ASK:** *Can you still expect improvement of patient's function?*

NO → **OUTCOME:** *Confirm that the patient is ready for discharge from active treatment.*

YES → **OUTCOME:** *This visit is likely active treatment (AT) billable to Medicare.*

Is the condition likely to be treated as an INCIDENT, BURST, or FULL EPISODE?

KMC University's classification of treatment lengths for active treatment are described as incidents, bursts, and episodes. Follow these cues to verify that your documentation is sufficient to warrant the level of recommended care.



Do I Need a Signed ADVANCE BENEFICIARY NOTICE (ABN)?

An ABN is mandatory when a covered service under Medicare (Chiropractic Manipulative Treatment [CMT] for chiropractors) may not be covered today. This is usually because the visit will not meet medical necessity guidelines and the adjustment may be considered maintenance. Medicare patients must agree to pay for maintenance care if they want it. **Medicare does not require an ABN* form or advance notice for statutorily excluded services.**

NOTE: For Qualified Medicare Beneficiaries (QMB) use the appropriate version of the ABN* form.

Is the service a spinal CMT?

- **YES** → **DETERMINE:** *Is patient currently in an active episode of care?*
  - **YES** → **OUTCOME:** *This visit is likely active treatment (AT) billable to Medicare. ABN is not necessary for active treatment.*
  - **NO** → *After a brief check by the doctor, will today's visit be considered maintenance?*
    - **NO** → **OUTCOME:** *This visit is likely active treatment (AT) billable to Medicare. ABN is not necessary for active treatment.*
    - **YES** → *Does the patient want the maintenance visit and does he/she understand the need to pay out-of-pocket?*
      - **NO** → **OUTCOME:** *Have ABN signed with Option 3 chosen. Include witness signature. Do not provide CMT.*
      - **YES** → *Is the patient a Qualified Medicare Beneficiary (QMB)?*
        - **YES** → **OUTCOME:** *Ensure QMB version of ABN is on file, with* ***Option 1 chosen****, and treat the patient, OR get new ABN signed today for maintenance care.*
        - **NO** → **OUTCOME:** *Ensure an ABN is on file, with* ***Option 1 or 2 chosen****, treat the patient, OR get new ABN signed today for maintenance care.*
- **NO** → *Do you wish to provide a voluntary advance notice?*
  - **NO** → **OUTCOME:** *That's ok! It's not required.*
  - **YES** → **OUTCOME:** *Have the patient sign your voluntary advance notice document. Provide a copy and keep one on file*

It's best practice to inform the patients that they are financially responsible for excluded services. Any signed notice/agreement is sufficient. We suggest you refrain from using Medicare's official ABN form.

NOTE: A signed ABN is good so long as there has been no change in Medicare coverage guidelines for the service or until another episode of active treatment begins.

** Medicare Advantage plans do not accept the Medicare ABN. Locate the payer's Advance Notice of Non-Coverage form.*

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

The KMC University's Guide to MEDICARE MODIFIERS

Modifiers Used Only With 98940, 98941, 98942

Code	*Description/Instruction*	*Effect on Medicare Payment*
AT	Active/Corrective Treatment rendered; meets Medicare's medical necessity guidelines	Claim considered for payment.
GA	Mandatory ABN on file indicating maintenance or exceeded screen	Option 1 selected-must bill Medicare. Option 2 selected-do not bill Medicare. *QMB must select Option 1.
GZ	Failed to obtain signed ABN for maintenance care	Claim will be denied. Patient not financially responsible.

Modifiers Used with Statutorily Excluded Services

Code	*Description/Instruction*	*Effect on Medicare Payment*
GY	Non-Covered service rendered	Unless patient request, billing not required. Patient financially responsible.*
GP	Physical Therapy service rendered; outpatient treatment plan on file	Claim denied. Use with GY Modifier. Patient is financially responsible.*
GX	ABN on file for voluntary use	Claim denied. Patient financially responsible.* Medicare ABN form not recommended by KMCU for *voluntary* use.

*Unless patient is a QMB with full Medicaid coverage that covers Medicare non-covered services when rendered by DC.

KMC University's Guide on DISCOUNTS TO MEDICARE PATIENTS

A network-based discount offered through KMC University's choice, ChiroHealthUSA, allows Medicare patients to access affordable care. Discount Medical Plan Organization (DMPO) utilization fills the gap in Medicare coverage limitations such as exhausted benefits, non-payable services (maintenance care), or for those services that Medicare never covers like exams, x-rays, and therapies. This is NOT an insurance plan, but rather a discount membership program for patients where DCs can set their own discounted fees. Visit www.chirohealthusa.com to learn more!

Chiropractic and Medicare

Medicare can be a worrisome, frustrating payer class to deal with in a chiropractic practice. Here at KMC University, we think Medicare can be the easiest class of patients to deal with based on the clear regulations and instruction provided. This step-by-step roadmap is intended to provide doctors and team members with a high-level overview of each stage in the journey of a Medicare patient, both clinically and financially, through your office. Use this quick reference tool to ensure you don't miss any important steps. Soon, you'll be brimming with confidence when you have the opportunity to welcome a Medicare patient into your office.

Step 1
Get Started with Medicare

Things to do:

★ Apply for a National Provider Identification number (NPI)

PART B

★ All DCs must enroll in Medicare in order to treat a Medicare patient. **There is NO Opt-Out for chiropractors.**

★ Providers must enroll their corporate business entity in Medicare and attach individual provider numbers by reassigning benefits.

★ Find out who your Medicare Administrative Contractor (MAC) is for your geographic jurisdiction. Visit their website, sign up for the chiropractic list-serve for updates, and locate the chiropractic local coverage determination (LCD). Sign up to use the online portal.

PART C

★ Decide whether to enroll with Medicare Part C plans. Some Part C plans include additional benefits which may cover more than CMT. **NOTE:** If you are out of network, do not treat Medicare Part C patients as cash patients. Plan type impacts billing requirements. PFFS plans require a provider to accept terms or refer the patient out. Other plan types bill the limiting fee.

★ Revalidate your enrollment every five years via PECOS, the online Medicare enrollment hub.

Associate Doctors, be aware! Physicians who reassign their right to bill and receive Medicare payments to their employer, by executing the CMS-855R application, will still be held liable for false claims submitted by entities to which they have reassigned those benefits. Always know what is being billed under your provider number and name.

Remember: KMC University offers enrollment and credentialing services!

INITIAL VISIT

The initial visit requirements reflect the necessary documentation for any initial visit...not just the first time the patient is ever seen in the office. For any new episode of care, for any new condition, or new injury, the initial visit requirements remain the same.

Step 2
Initial Visit - Administrative

Always...

★ Obtain and copy Medicare and Supplemental cards and check picture ID

★ Confirm whether Traditional Medicare Part B or Medicare Advantage Part C

Verify benefits (*we recommend using KMC University's Medicare Verification Forms*)

- Part B: Use MAC online portal
- Part C: Contact carrier for specific benefits/limitations

★ Confirm Secondary or Supplemental Coverage

- Does it cover *only* the remaining 20% of Medicare allowable?
- Does it cover excluded services?
- Does it cover the Medicare annual deductible?

STOP *Medicare patients are not required to obtain supplemental/secondary insurance.* In the event there is no additional coverage, Medicare patients are financially responsible for coinsurance, copayments, and deductibles.

Step 3
Initial Visit - Clinical

Remember:

★ Collect appropriate clinical intake information and reasons for care

★ Establish medical necessity by meeting REQUIRED COMPONENTS, including presence and documentation of the subluxation that causes a significant neuromusculoskeletal condition

Establish a Treatment Plan by implementing OATs to further establish and support medical necessity and address function (ADLs)

★ Estimate and document discharge date

Consider:

HISTORY OF PRESENT ILLNESS (HPI) REQUIREMENT	WHAT YOU SHOULD ASK
Documentation of ALL symptoms	Why is the patient seeking care?
Mechanism of onset/injury	How did the condition/injury happen? Avoid "insidious onset"
Quality, duration, frequency, etc.	Do descriptive adjectives describe severity?
Aggravating/relieving factors	What causes condition to improve/worsen?
Prior interventions/previous treatment	Previous treatment? What worked or didn't?
Family/Social History	Does anything in the family/social history relate?
Past health history	What aspects of the patient's history influences the current condition?

Step 4
Initial Visit - Documentation

Proceed to:

★ Document complaint and HPL as noted in Step 3

★ Evaluate musculoskeletal/nervous system through physical exam

P	Pain or tenderness	Pain elicited during the course of the examination. Describe in terms of location, quality, and intensity
A	Asymmetry or misalignment	May be described at the regional or segmental level
R	Range of Motion abnormality	Abnormal ROM - either hypermobility or hypomobility - may be described at the segmental or regional level
T	Tissue tone changes	Describe changes in the tone of soft tissue, such as muscles, tendons, fascia, skin, and ligaments

★ Document PRIMARY and SECONDARY DX per region

- Most MACs deem only M99.00-M99.05 as primary diagnosis options
- Secondary DX may be appropriate supporting DX
- Always document the secondary neuromusculoskeletal diagnosis in the medical record

★ Document the details of treatment plan, including:

- Recommended level of care (duration and frequency of visits)
- Specific, achievable, functional treatment goals for each complaint
- Objective measures to evaluate treatment effectiveness

★ Don't forget to record the date of initial treatment for the current condition

- This date is shown on Item 14 on the CMS-1500 claim form

STOP *Medicare's documentation requirements can be found in your MAC's Chiropractic Local Coverage Article (LCA).*

ROUTINE VISIT

Routine visits are subsequent visits in which the provider is executing a treatment plan established in the initial visit. They are typically documented in SOAP format.

Step 5
Routine Visit - Clinical

Please keep in mind:

As treatment progresses, at each routine visit the provider must evaluate patient progress toward Maximum Therapeutic Benefit (MTB). Consider the following:

- The original complaint(s) and original treatment goals
- Changes in the pain assessment
- Progress (or lack thereof) toward stated goals
- Changes in Activities of Daily Living (ADLs)
- Patient compliance with provider recommendations
- Diligence with home/self-care instructions
- Whether the patient is ready for discharge to maintenance or PRN care

Visit the ***MEDICARE DECISION MAKING MATRIX*** located in the support tables section of this QRT to better understand active vs. maintenance care.

STOP ***Medicare Medical Necessity:*** Patient symptoms/complaint must bear a direct relationship to the level of subluxation!

Step 6
Routine Visit - Documentation

Things to do:

★ Medicare documentation requirements for subsequent visits should reveal changes since last visit

- History: Review complaints, progress toward goals
- Physical exam: Exam of each area of spine involved in diagnosis
- Document today's treatment, changes in treatment plan, and exact segments adjusted, including compensatory adjustments

★ Additional details to include:

- Whether the patient has been compliant with treatment plan and home instructions
- Appropriate G-codes if reporting quality measures (MIPS) for active treatment (AT)
- Discharge language, if applicable. List goals met and comment on reasons other goals not met

STOP If the patient presents with a new complaint and/or begins a new treatment program, ***the initial treatment date for the current condition should be updated.*** *Go back to Initial Visit section

Step 7
Medicare Advanced Beneficiary Notice of Non-Coverage (ABN)

Things to do:

★ ABNs are *mandatory* when a covered service (CMT) may not be covered/paid. Such as:

- Maintenance Care (GA) 98940, 98941, 98942
- More than one CMT received on a single date-of-service
- Treatment has exceeded allowed screen for visits in jurisdiction and/or for condition

★ Patient may request a copy

★ ABNs may remain active for longer than 1 year for extended periods of maintenance care.

- If patient presents with new Active Treatment incident/complaint, current ABN must be end-dated. New ABN to be issued when treatment meets one or more criteria as noted above

NOTE: Patient may not be financially liable if ABN is not issued properly. Medicare Advantage (MA) plans do not accept Medicare's ABN. Locate the MA's Patient Waiver or Advance Notice of Non-Coverage form.

Visit the ***MEDICARE ABN DECISION MAKING MATRIX*** located in the support tables section of this QRT to better understand when to use an ABN form.

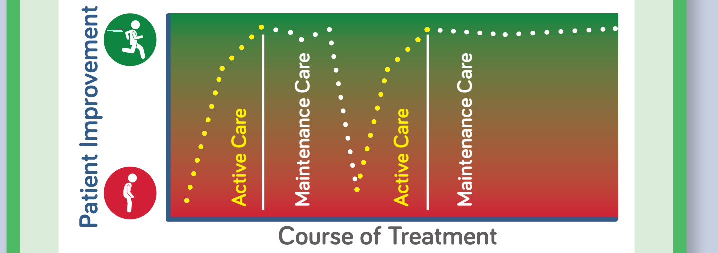
DO: Use the most current version of Medicare's official ABN form for mandatory ABN usage.

DON'T: Have an ABN form signed on every visit. Doing so without reason could nullify all ABNs on file.

Step 8
Routine Visit - Maintenance

Is it Active Care or Maintenance Care?

Patients will move into and out of maintenance care throughout their experiences in your practice. Refer to the Medicare Decision Making Matrix located in the support tables section of this QRT to better understand active vs. maintenance care.



Keep in mind the following:

★ Maintenance care may be patient-guided "as needed" or provider-guided per a schedule

★ Maintenance documentation differs slightly:

- Won't support medical necessity guidelines
- OATs not required to support medical necessity
- G codes on claims are not required
- Comprehensive treatment plans not required

★ ABN determines if patient wants:

- Option 1: Maintenance billed to Medicare
- Option 2: Maintenance NOT billed to Medicare
- Option 3: To deny having the maintenance service

*KMC University recommends Patient Media's Medicare Brochure to educate patients about chiropractic and Medicare. Visit **Patientmedia.com/brochures/***

Step 9
Medicare Billing

STOP Incomplete claims will be deemed "unprocessable." These are often easily corrected by calling the local MAC and completing the ***Reopening*** process.

The more you know:

Manual manipulation of the spine (CMT 98940, 98941, 98942) for treatment of spinal subluxation is the only covered service for DCs. CMT must be medically necessary to be covered. Secondary/supporting DX are recommended on Medicare claims for billing.

DOs:

- Submit all Active Treatment (AT) claims on behalf of the patient (Whether Par or Non-Par)
- Follow patient-chosen ABN Option for all maintenance care CMT billing
- File claim within one year of date of service
- Include initial treatment date or date of exacerbation in ITEM 14 of CMS-1500 or electronic equivalent
- Code G0283 rather than 97014 for unattended muscle stimulation

DON'Ts:

- Do NOT include date of last x-ray in Item 19 of 1500 Claim Form; leave blank
- Do NOT enter a qualifier in Item 14 of 1500 Claim Form; leave blank
- Do NOT enter qualifier or date in Item 15 of Claim Form: leave blank

DOs:

- Use modifier GA ('ABN on file') to 98940(1)(2) when rendering a normally covered service that may be deemed maintenance
- Append both modifier GY and GP for outpatient physical therapy services, and GY only for all other statutorily excluded services

DON'Ts:

- Do NOT use AT-GA modifers together
- Do NOT submit claims for maintenance treatment with modifier AT
- Do NOT use the AT modifier strictly for the purpose of getting paid. Care must be medically necessary and compliant with Medicare guidelines
- Do NOT use modifier GY on CMT codes deemed maintenance care
- Do NOT bill patient or Medicare for 97010 Hot/Cold packs; they are always a bundled service

Visit the ***MEDICARE MODIFIERS*** and ***PAR VS. NON-PAR*** tables located in the support tables section of this QRT for more billing tips.

Step 10
Medicare Collections

Things to do:

Follow the examples given in this table as a guide to estimate Medicare collections. All figures are only examples.

	MEDICARE REIMBURSES 80% OF THIS FEE*		DIFFERENCE BETWEEN LIMITING FEE AND NON-PAR ALLOWABLE IS NOT RECOVERED BY THE PATIENT
PROCEDURE CODE	PAR ALLOWABLE	NON-PAR ALLOWABLE	NON-PAR LIMITING FEE (LF)
98940	$28.93	$27.48	$31.60
98941	$41.55	$39.47	$45.39
98942	$54.18	$41.47	$49.19

Only Three Covered Services for DCs
Participating Provider Max Reimbursement
Non-Participating Provider Max Reimbursement

*Par providers may bill their actual fee to Medicare. The fee is automatically reduced by Medicare to the appropriate negative adjustment if the provider has not participated in EHR and/or MIPS reporting
**Non-par providers must only charge the appropriate limiting fee
*** Medicare Advantage Plans have their own billing and collection requirements

STOP ***Par and Non-Par providers may be assessed payment penalties*** if they did not participate in Medicare reporting programs (EHR/Meaningful Use and PQRS, currently known as MIPS).

Step 11
Billing and Collecting from Medicare Patients

The more you know:

★ Patients are responsible for the full charge for statutorily non-covered services, unless other insurance or a DMPO is available****

★ Patient financial responsibility for CMT depends on the provider's enrollment status (Par or Non-Par) and whether the service is active (AT) or maintenance (GA)

The provider collects:

SERVICE	PARTICIPATING (PAR)	NON-PARTICIPATING (NON-PAR)
Spinal CMT (AT)	Only 20% of Medicare allowed fee*. Patient may have secondary insurance that will pay this amount.	Up to 100% of the Limiting Fee for non-assigned claims. 20% of non-par allowable fee for selectively assigned claims*.
Spinal CMT (GA)**	1 of 3 choices: Medicare's **par allowable** fee; the provider's actual fee; a published maintenance fee through a DMPO***	1 of 3 choices: Medicare's **Limiting Fee**; the provider's actual fee; a published maintenance fee through a DMPO***

*After annual deductible is met
**With properly executed ABN
***Set on a legally discounted fee schedule, such as with ChiroHealthUSA
**** Check patient's QMB status prior to collecting.

For more information about ***DISCOUNT MEDICAL PLAN ORGANIZATIONS (DMPO)*** see the section on ***DISCOUNTS TO MEDICARE PATIENTS.***

MEDICARE PROHIBITS THE BILLING OF THE PROVIDER'S FAMILY MEMBERS. Medicare will not pay for these services that would ordinarily be furnished at no cost.

Step 12
Medicare Appeals Process

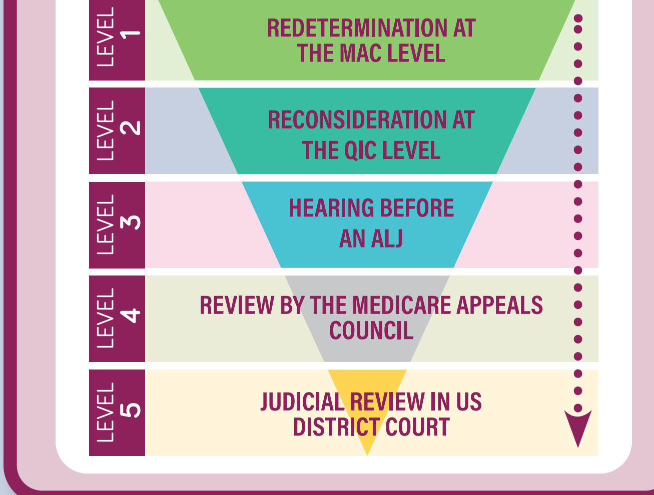
Things to do:

★ Appealing Medicare claims may be warranted when:

- Claim(s) improperly processed resulting in underpayment or denial
- Rejected claims
- Overpayment decision by Medicare, resulting in practice receiving request for refund of payment(s) previously made

★ Most common reason for appeal is Medical Necessity Denial. The denial code will usually start with CO.

★ Appeals must be completed per Medicare's process on Medicare's forms.



Medicare's Frequently Used Acronyms and Terms

ACRONYMS

Acronym	Meaning
ABN	Advance Beneficiary Notice
ALJ	Administrative Law Judge
COB	Coordination of Benefits
DX	Diagnosis
EFT	Electronic Funds Transfer
EOMB	Explanation of Medicare Benefits
ERA	Electronic Remittance Advice
LTG	Long Term Goals
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MLN	Medicare Learning Network
MSP	Medicare is the Secondary Payer
MUE	Medical Unlikely Edits
OATS	Outcomes Assessment Tools
PECOS	Provider Enrollment, Chain, and Ownership System
PQRS	Physician Quality Reporting System
PTAN	Provider Transaction Access Number
STG	Short Term Goals
QIC	Qualified Independent Contractor
QMB	Qualified Medicare Beneficiary
TX	Treatment

TERMS

Term	Definition
ACTIVITIES OF DAILY LIVING	*Also known as ADL, Activities of Daily Living are those activities patients usually perform during a normal day, such as getting in and out of bed, dressing, bathing, eating, walking, sleeping, sitting, and using the bathroom.*
ADVANTAGE PLAN	*Also known as Medicare Part C – similar to an HMO, the patient has elected to purchase the Advantage Plan instead of traditional Medicare.*
ACTIVE TREATMENT	*Designated by use of the AT modifier, it's care that is considered to be medically necessary, for the purpose of restoring function.*
ACUTE TREATMENT	*A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression of, the patient's condition.*
CHRONIC TREATMENT	*When a patient's condition is not expected to significantly improve or be resolved with further treatment (e.g. an acute condition), but where continued therapy may result in some functional improvement. However, once the clinical status for the condition is stable, and no additional improvement is expected, the treatment will be considered maintenance and is not covered.*
COINSURANCE	*A percentage of total costs for which the patient is responsible. In managed care plans, this is often called a copayment. The physician can bill for coinsurance that was not collected at the time of service.*
CROSSWALK	*A feature where Medicare already has patient's secondary/supplemental insurance information on file and automatically transfers the claim adjudication information to that secondary carrier for you.*
DEDUCTIBLE	*A fixed amount of money that must be paid annually, by the patient, before insurance begins paying benefits. Some Medicare supplemental insurances may cover patient deductible amounts.*
DISCOUNT MEDICAL PLAN ORGANIZATION	*Also known as DMPO, a Discount Medical Plan Organization is a network designed to allow providers to offer legal, network-based discounts to cash and Medicare patients.*
EPISODE OF CARE	*Visits that comprise the entire course of treatment surrounding a patient complaint, from the first initial visit to the discharge visit.*
EXACERBATION	*Temporary but significant deterioration in the patient condition, also known as a flare-up.*
EXCLUSIONS	*Expenses that may not be covered under the insured's contract. The insured is required to pay for services not covered by the health plan.*
JURISDICTION	*Medicare Administrative Contractors (MACs) are responsible for a specific defined geographic area. Each MAC area is considered a jurisdiction.*
MAINTENANCE TREATMENT	*Care considered to be not medically reasonable or necessary and not payable under the Medicare program. Defined as care rendered 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.*
MEDICAL NECESSITY	*Medicare's definition for chiropractic care – 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 a reasonable expectation of recovery or improvement of function.*
MEDIGAP	*Another name for secondary or supplemental insurance with Medicare as primary; its intent is to fill the gap of coverage that is beyond Medicare's allowable fees.*
MODALITIES	*Physiotherapies such as traction, ultrasound, and electrical muscle stimulation are considered an excluded service under Part B Medicare when ordered or delivered by a chiropractor.*

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