Fundamentals
of
Chiropractic Billing

A complete guide to everything you need to know to submit your Chiropractic claims and get reimbursed properly for your services

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Introduction

More often than ever before, doctors calling us for assistance are asking about converting to 100% cash. My advice is always the same: Why? 73% of patients surveyed expect to be able to use insurance in the practice if they have it. Often, the decision to jump the insurance ship has more to do with training of the team and the hassles of billing than what's best for patients. Insurance participation and involvement are very personal decisions for doctors. Insurance billing for chiropractic services can be a little tricky. Each insurance company has different rules concerning the number of visits, order of diagnosis codes used, requirements of authorization or referral, payment and more.

There are many things that a chiropractor will need to know in order to be paid well for his or her services. When the billing process is not totally understood, much income is lost. I don't say "can be" lost. I say "is" lost. Claims will be denied for missing or incorrect information. Or you will just never get an answer after you send a claim.

In our experience a certain percentage of the claims that we file are reported "not on file" when we check on them. How does this happen? Now we know that we submitted them. The computer verifies that. If we submitted them electronically, we will get a report back that verifies that transmission.

We know that we mailed them if they were sent on paper. I oversee the mail myself I have a great system in place. That claim that I was told was not on file was probably in an envelope with several other claims which have been paid by then. How did that one get "not on file"?

At any rate if you don't keep track of your payments you will not collect everything you billed out. So whether you choose to do your billing yourself or get someone else to do it for you, you need to understand how it works so you can be sure everything that is necessary to insure payment is being done.

Another common reason claims are not paid is because they are handwritten. If a person has to sit and write out several insurance claims by hand, the neatness of the handwriting can suffer. If the person completing the form does not have very good handwriting in the first place, it may be difficult to identify important information on the claim.

Insurance companies do not like receiving handwritten claims. They highly discourage the use of handwritten claims and will deny any claim that they consider illegible. Some insurance companies will just return handwritten claims stating they are not acceptable, even if the handwriting is clear.

Many insurance companies use OCR scanners to scan any paper claims that come in. These claims are then automatically entered into their claim processing system as if they were received electronically. Electronic claims save insurance carriers much money so they strongly encourage, and in some cases require that claims are filed electronically.

If they are not filed electronically, then the insurance carriers require that the claims are filed on CMS 1500 forms and that the typed information is in the proper fields and not over the lines. That is because when the claims are scanned, if the data is on the red line, or not lined up properly the claim doesn't scan. If the claim doesn't scan it is returned to the provider stating it is 'off-line' and that the data must be inside the fields on the CMS form.

We bill insurance claims for many chiropractic providers and most of them come to us knowing they aren't receiving enough money for the work they are doing. They either don't know where to leek to find the leaks or they don't want to bother with the problems associated with the insurance billing process.

Many times a long time assistant is leaving and the chiropractor needs to find someone else to handle the billing. In looking over the records to turn things over to us, he will find that many claims were never paid. It is amazing how many chiropractors do not receive the income they could just because they do not have a good system in place for submitting claims and tracking payments not to mention keeping up with referrals and authorizations.

However you decide to do your billing, we will show you how to make sure it is done so you are paid for all the services you perform. You can file the claims yourself, you can hire a person to help you, or you can hire a service that specializes in insurance billing but the important thing is to check the process they use to make sure you get paid for everything.

What Is Chiropractic Insurance Billing?

Chiropractic insurance billing is the process of getting paid for services rendered by a medical professional primarily through the submission of insurance claims to the proper insurance carrier. This can involve sending primary, secondary, and possibly even tertiary insurance claims and patient statements.

It is accomplished by sending an insurance claim to the insurance company requesting payment. Chiropractic billing is a process, however, and that is just the first step in the process to get full payment.

There are many variables in the field of chiropractic billing. Claims are capable of being submitted either electronically or on paper. Electronically submitted claims are much quicker as in the case with electronically submitted tax returns. Payment is issued much sooner. And chances of the claim being lost are reduced.

Some of the smaller insurance companies are not yet capable of receiving electronic claims so they must be filed on paper on an approved claim form with all the required information.

Filing claims electronically can involve the use of a practice management system or medical billing software. There are many costs to consider in both the submitting the claims and the keeping track of the payments. Setting up a system to bill the claims electronically can be costly.

Some patients have more than one insurance policy. When this is the case, the primary insurance is billed first then the balance is billed to the secondary insurance carrier. Secondary claims if not sent electronically must be filed with a copy of the remittance, or the explanation of benefits statement, from the primary insurance company.

If there is a third, or tertiary insurance it is billed last with the explanation of benefits statements from the first two insurances. There are many things to consider and understand in getting proper payment for your services.

Definitions of Health Insurance Terms

ASO (Administrative Services Only) – An arrangement in which an employer hires a third party to deliver administrative services to the employer such as claims processing and billing; the employer bears the risk for claims.
♦ This is common in self-insured health care plans.

Coinsurance - A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid.
♦ Once any deductible amount and coinsurance are paid, the insurer is responsible for the rest of the reimbursement for covered benefits up to allowed charges: the individual could also be responsible for any charges in excess of what the insurer determines to be “usual, customary and reasonable”.
♦ Coinsurance rates may differ if services are received from an approved provider (i.e., a provider with whom the insurer has a contract or an agreement specifying payment levels and other contract requirements) or if received by providers not on the approved list.
♦ In addition to overall coinsurance rates, rates may also differ for different types of services.

Copayment - A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received. The insurer is responsible for the rest of the reimbursement.
♦ There may be separate copayments for different services.
♦ Some plans require that a deductible first be met for some specific services before a copayment applies.

Deductible - A fixed dollar amount during the benefit period - usually a year - that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have both per individual and family deductibles.
♦ Some plans may have separate deductibles for specific services. For example, a plan may have a hospitalization deductible per admission.
♦ Deductibles may differ if services are received from an approved provider or if received from providers not on the approved list.

Flexible spending accounts or arrangements (FSA) - Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee’s share of insurance premiums or medical expenses not covered by the employer’s health plan. The employer may also make contributions to a FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. Flexible spending accounts can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs.

Flexible benefits plan (Cafeteria plan) (IRS 125 Plan) – A benefit program under Section 125 of the Internal Revenue Code that offers employees a choice between permissible taxable benefits, including cash, and nontaxable benefits such as life and health insurance, vacations, retirement plans and child care. Although a common core of benefits may be required, the employee can determine how his or her remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes employee contributions may be made for additional coverage.

Fully insured plan - A plan where the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs.

Gatekeeper - Under some health insurance arrangements, a gatekeeper is responsible for the administration of the patient's treatment; the gatekeeper coordinates and authorizes all medical services, laboratory studies, specialty referrals and hospitalizations.

Group purchasing arrangement – Any of a wide array of arrangements in which two or more small employers purchase health insurance collectively, often through a common intermediary who acts on their collective behalf. Such arrangements may go by many different names, including cooperatives, alliances, or business groups on health. They differ from one another along a number of dimensions, including governance, functions and status under federal and State laws. Some are set up or chartered by States while others are entirely private enterprises. Some centralize more of the purchasing functions than others, including functions such as risk pooling, price negotiation, choice of health plans offered to employees, and various administrative tasks. Depending on their functions, they may be subject to different State and/or federal rules. For example, they may be regulated as Multiple Employer Welfare Arrangements (MEWAs).

♦ **Association Health Plans** – This term is sometimes used loosely to refer to any health plan sponsored by an association. It also has a precise definition under the Health Insurance Portability and Accountability Act of 1996 that exempts from certain requirements insurers that sell insurance to small employers only through association health plans that meet the definition.

Health Care Plans and Systems

♦ **Indemnity plan** - A type of medical plan that reimburses the patient and/or provider as expenses are incurred.

♦ **Conventional indemnity plan -** An indemnity that allows the participant the choice of any provider without effect on reimbursement. These plans reimburse the patient and/or provider as expenses are incurred.

♦ **Preferred provider organization (PPO) plan** - An indemnity plan where coverage is provided to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network, but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or nondiscounted
charges from the providers.

⬧ **Exclusive provider organization (EPO) plan** - A more restrictive type of preferred provider organization plan under which employees must use providers from the specified network of physicians and hospitals to receive coverage; there is no coverage for care received from a non-network provider except in an emergency situation.

⬧ **Health maintenance organization (HMO) -** A health care system that assumes both the financial risks associated with providing comprehensive medical services (insurance and service risk) and the responsibility for health care delivery in a particular geographic area to HMO members, usually in return for a fixed, prepaid fee. Financial risk may be shared with the providers participating in the HMO.

⬧ **Group Model HMO** - An HMO that contracts with a single multi-specialty medical group to provide care to the HMO's membership. The group practice may work exclusively with the HMO, or it may provide services to non-HMO patients as well. The HMO pays the medical group a negotiated, per capita rate, which the group distributes among its physicians, usually on a salaried basis.

⬧ **Staff Model HMO** - A type of closed-panel HMO (where patients can receive services only through a limited number of providers) in which physicians are employees of the HMO. The physicians see patients in the HMO's own facilities.

⬧ **Network Model HMO** - An HMO model that contracts with multiple physician groups to provide services to HMO members; may involve large single and multispecialty groups. The physician groups may provide services to both HMO and non-HMO plan participants.

⬧ **Individual Practice Association (IPA) HMO**- A type of health care provider organization composed of a group of independent practicing physicians who maintain their own offices and band together for the purpose of contracting their services to HMOs. An IPA may contract with and provide services to both HMO and non-HMO plan participants.

⬧ **Point-of-service (POS) plan** - A POS plan is an "HMO/PPO" hybrid; sometimes referred to as an "open-ended" HMO when offered by an HMO. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans (e.g., provider reimbursement based on a fee schedule or usual, customary and reasonable charges).

⬧ **Physician-hospital organization (PHO)** - Alliances between physicians and hospitals to help providers attain market share, improve bargaining power and reduce administrative costs. These entities sell their services to managed care organizations or directly to employers.

Managed care plans - Managed care plans generally provide comprehensive health services to their members, and offer financial incentives for patients to use the providers who belong to the plan. Examples of managed care plans include:

⬧ Health maintenance organizations (HMOs),
⬧ Preferred provider organizations (PPOs),
⬧ Exclusive provider organizations (EPOs), and
⬧ Point of service plans (POSs).

Managed care provisions - Features within health plans that provide insurers with a way to manage the cost, use and quality of health care services received by group members. Examples of managed care provisions include:

⬧ **Preadmission certification** - An authorization for hospital admission given by a health care provider to a group member prior to their hospitalization. Failure to obtain a preadmission certification in non-emergency situations reduces or eliminates the health care provider's obligation to pay for services rendered.
⬧ **Utilization review** - The process of reviewing the appropriateness and quality of care provided to patients. Utilization review may take place before, during, or after the services are rendered.
⬧ **Preadmission testing** - A requirement designed to encourage patients to obtain necessary diagnostic services on an outpatient basis prior to non-emergency hospital admission. The testing is designed to reduce the length of a hospital stay.
⬧ **Non-emergency weekend admission restriction** - A requirement that imposes limits on reimbursement to patients for non-emergency weekend hospital admissions.
⬧ **Second surgical opinion** - A cost-management strategy that encourages or requires patients to obtain the opinion of another doctor after a physician has recommended that a non-emergency or elective surgery be performed. Programs may be voluntary or mandatory in that reimbursement is reduced or denied if the participant does not obtain the second opinion. Plans usually require that such opinions be obtained from board-certified specialists with no personal or financial interest in the outcome.

Maximum plan dollar limit - The maximum amount payable by the insurer for covered expenses for the insured and each covered dependent while covered under the health plan.
⬧ Plans can have a yearly and/or a lifetime maximum dollar limit.
⬧ The most typical of maximums is a lifetime amount of $1 million per individual.

Maximum out-of-pocket expense - The maximum dollar amount a group member is required to pay out of pocket during a year. Until this maximum is met, the plan and group member shares in the cost of covered expenses. After the maximum is reached, the insurance carrier pays all covered expenses, often up to a lifetime maximum. (See previous definition.)

Medical savings accounts (MSA) – Savings accounts designated for out-of-pocket medical expenses. In an MSA, employers and individuals are allowed to contribute to a savings account on a pre-tax basis and carry over the unused funds at the end of the year. One major difference between a Flexible Spending Account (FSA) and a Medical Savings Account (MSA) is the ability under an MSA to carry over the unused funds for use in a future year, instead of losing unused funds at the end of the year. Most MSAs allow unused balances and earnings to accumulate. Unlike FSAs, most MSAs are combined with a high deductible or catastrophic health insurance plan.

Minimum premium plan (MPP) – A plan where the employer and the insurer agree that the employer will be responsible for paying all claims up to an agreed-upon aggregate level, with the insurer responsible for the excess. The insurer usually is also responsible for processing claims and administrative services.

Multiple Employer Welfare Arrangement (MEWA) – MEWA is a technical term under federal law that encompasses essentially any arrangement not maintained pursuant to a collective bargaining agreement (other than a State-licensed insurance company or HMO) that provides health insurance benefits to the employees of two or more private employers.

Some MEWAs are sponsored by associations that are local, specific to a trade or industry, and exist for business purposes other than providing health insurance. Such MEWAs most often are regulated as employee health benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA), although States generally also retain the right to regulate them, much the way States regulate insurance companies. They can be funded through tax-exempt trusts known as Voluntary Employees Beneficiary Associations (VEBAs) and they can and often do use these trusts to self-insure rather than to purchase insurance policies.
Other MEWAs are sponsored by Chambers of Commerce or similar organizations of relatively unrelated employers. These MEWAs are not considered to be health plans under ERISA. Instead, each participating employer's plan is regulated separately under ERISA. States are free to regulate the MEWAs themselves. These MEWAs tend to serve as vehicles for participating employers to buy insurance policies from Statelicensed insurance companies or HMOs. They do not tend to self-insure.
Multi-employer health plan – Generally, an employee health benefit plan maintained pursuant to a collective bargaining agreement that includes employees of two or more employers. These plans are also known as Taft-Hartley plans or jointly-administered plans. They are subject to federal but not State law (although States may regulate any insurance policies that they buy). They often self-insure.
Premium - Agreed upon fees paid for coverage of medical benefits for a defined benefit period. Premiums can be paid by employers, unions, employees, or shared by both the insured individual and the plan sponsor.
Premium equivalent - For self-insured plans, the cost per covered employee, or the amount the firm would expect to reflect the cost of claims paid, administrative costs, and stop-loss premiums.
Primary care physician (PCP) - A physician who serves as a group member's primary contact within the health plan. In a managed care plan, the primary care physician provides basic medical services, coordinates and, if required by the plan, authorizes referrals to specialists and hospitals.
Reinsurance – The acceptance by one or more insurers, *called reinsurers or assuming companies*, of a portion of the risk underwritten by another insurer that has contracted with an employer for the entire coverage.
Self-insured plan – A plan offered by employers who directly assume the major cost of health insurance for their employees. Some self-insured plans bear the entire risk. Other self-insured employers insure against large claims by purchasing stop-loss coverage. Some self-insured employers contract with insurance carriers or third party administrators for claims processing and other administrative services; other self-insured plans are selfadministered.
Minimum Premium Plans (MPP) are included in the self-insured health
plan category. All types of plans (Conventional Indemnity, PPO, EPO, HMO, POS, and PHOs) can be financed on a self-insured basis. Employers may offer both self-insured and fully insured plans to their employees.
Stop-loss coverage – A form of reinsurance for self-insured employers that limits the amount the employers will have to pay for each person's health care (individual limit) or for the total expenses of the employer (group limit).
Third party administrator (TPA) – An individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer.

Types of health care provider arrangements

- **Exclusive providers** - Enrollees must go to providers associated with the plan for all non-emergency care in order for the costs to be covered.
- **Any providers** - Enrollees may go to providers of their choice with no cost incentives to use a particular subset of providers.
- **Mixture of providers** - Enrollees may go to any provider but there is a cost incentive to use a particular subset of providers.

Usual, customary, and reasonable (UCR) charges - Conventional indemnity plans operate based on usual, customary, and reasonable (UCR) charges. UCR charges mean that the charge is the provider's usual fee for a service that does not exceed the customary fee in that geographic area, and is reasonable based on the circumstances. Instead of UCR charges, PPO plans often operate based on a negotiated (fixed) schedule of fees that recognize charges for covered services up to a negotiated fixed dollar amount.

Participating With Insurance Carriers

Many new providers do not understand the benefits of participating with insurance carriers. Whether or not a provider participates (or joins the panel) can affect not only how much the provider is paid, but can also affect his or her patient load. The doctor who doesn't par with the insurance companies has basically a "cash" practice. Some insurance policies will pay for some of these services, but payments usually go directly to the patient who is expected to pay at the time of service.

Generally speaking, patients tend to go to doctors who participate with their insurance carrier so they know exactly what they will pay out of pocket. This is usually a set amount that is a co-pay or coinsurance. When the provider participates, he or she must then bill the insurance carrier for the service and receive part or all of the payment from the insurance company. The provider is required to accept the amount that the insurance company designates as "allowable".

They must also abide by all the rules of that insurance carrier regarding how and when that claim is filed and how the patient is medically treated. Referrals, authorizations, or treatment plans may be required. Sometimes it seems as if the insurance carrier makes the provider jump through hoops to get paid.

Some providers feel that the insurance companies are unreasonable and make them jump through hoops, but in our experience it is just understanding what is required of you and having a system in place to do it that keeps things running smoothly.

For example, if a patient calls to make an appointment you should obtain their insurance information over the phone. This way you can make sure you do whatever is required by their insurance carrier prior to seeing the patient for the first time.

You must remember, however, that the agreement you made with the insurance carrier is a legally binding contract between the two of you and if you don't follow these rules, in the least you may lose money on unpaid claims and at the worst it may be construed as insurance fraud and you could be prosecuted.

Generally speaking what the insurance companies ask for in their contract is not unreasonable. If you are a beginning provider you can probably build your practice much quicker if you participate with the major insurance companies in your area.

To determine which insurance carriers are the best ones to par with, ask a few of your colleagues who practice nearby about their experience with insurance companies.

Pros of Participating

- You are listed in patient handbooks distributed by the insurance carrier to all the patients who are covered by the insurance
- Knowing exactly what the insurance carrier will pay you and approximately how long it will take you to collect the money
- Most patients look for providers who participate with their insurance
- Payment is made directly to the provider by the insurance carrier
- In many cases, payment to participating providers is higher
- Less likely for the patient to have a deductible to reach

Cons of Participating

- Insurance carriers determine your fees
- You must wait for the payment from the insurance carrier (cannot collect at time of visit from patient)
- You must abide by the insurance company's rules
- Insurance carrier may require extra paperwork
- You may have to obtain or complete referral forms
- You may have to submit treatment notes or plans
- You must complete the credentialing application
- You must fit within the insurance company's guidelines

Pros of remaining Non Participating

- You can collect from the patient at the time of service
- You are not required to submit claims on your patient's behalf (many non par providers just provide the patient with a statement that they can submit on their own)
- You don't have to follow all of the insurance carriers rules

Cons of being Non Participating

- Patients like to go to Participating Providers
- You are not listed in the Insurance Company Directory
- Sometimes the patient will not be reimbursed unless you agree to file treatment plans, or other info (so you end up doing paperwork anyway)
- Some plans have no out-of-network benefits so the patients will not be reimbursed anything
- Payment usually goes directly to the patient (if you don't collect your money up front, this can be a problem)
- Patients may have high out of network deductibles

Overall, for most providers it is beneficial to participate with most insurance plans. There are a few companies that are just more headaches for the provider than it is worth. You need to consider your specialty, your patient base, and each individual carrier's requirements and reimbursement rate when making the decision.

There are actually a few insurance plans that reimburse better when a provider is out of network. It is rare but it does happen. So make sure you do your research with each company before making your decision.

You can request fee schedules from some companies. Medicare's fee schedule is posted on their website.

If you wish to become participating with an insurance plan, then you should call that plan and tell them that you would like to join their network. They will advise you what you need to do to become credentialed.

Credentialing

Credentialing is the process of applying to participate (become par, join the panel, become in network) of an insurance carrier. If the insurance company is accepting new providers in your specialty and your location, an application is completed by the provider and submitted to the insurance company. If accepted into the network, the provider will then be granted specific privileges with that insurance carrier.

Much information is requested as to schooling, licensing, experience, liability insurance coverage, etc on the application. These can be lengthy and vary greatly from insurance carrier to insurance carrier.

The major advantage of going through the process of credentialing and participating with the insurance company is that patients are more likely to use the services of a participating provider.

Some companies have their own applications, but what is becoming very popular with the insurance carriers is the universal CAQH credentialing process. CAQH (Council for Affordable Quality Healthcare) is a non profit organization formed to simply health care administration. The organization works to promote quality interactions between insurance carriers and providers while reducing costs.

Many companies now require that you are registered with CAQH where the insurance carrier can then examine your credentials online to determine if they will accept the provider to participate or to renew their contract.

The CAQH application eliminates the need to complete an application for each individual insurance company. The application can be completed either online or on paper. If you complete it on paper, you mail it in to CAQH where they manually enter the information into the online application. The purpose of the universal application is to eliminate the need for individual credentialing applications for each insurance company.

When a provider notifies an insurance company that he or she would like to apply to become participating, the insurance company can access the CAQH application and find all the information they need without the provider completing yet another application.

You may still be required to fill out some paperwork for the individual insurance companies, but it will be minimal. CAQH is the way of the future so it's a good idea to go ahead and complete the lengthy application. Many insurance carriers require that you have a CAQH application to join their network or even to re-credential.

The application takes about 2 hours to complete. In order to start the process, you must first call an insurance company and request a "CAQH provider ID number. This can take up to 10 days to obtain depending on which insurance company you call. We offer the service of completing the CAQH application for providers who don't want to or can't complete their own applications. You can find application information at http://www.caqh.org/.

National Provider Identification Numbers

The National Provider Identifier or NPI is a unique identification number for all health care providers. Traditionally each insurance carrier issued a provider ID# to each provider who then ended up with ten or twenty different provider ID numbers, one for each insurance company. The NPI number should eliminate the need for all these individual identifiers.

Many people believe that the NPI number was initiated by the HIPAA Act of t996. Actually, the NPI number was initiated by CMS (Centers for Medicare & Medicaid Services) in July of 1993. CIVIS wanted a national identification system for all healthcare providers and many of the existing identifiers did not meet the requirements for national standards.

The I-IIPAA Act of 1996 required the adoption and use of a standard unique identifier for healthcare providers. All covered healthcare providers were required to have an NPI number by May 23, 2007.

The National Provider identifier, or NPI, is a 10 digit numeric identification number assigned by the NPS to uniquely identify a healthcare provider. If you are an individual provider you will need to apply for an NPI number under your individual name, If you belong to a group or bill under an EIN (vs. a SS#) you will need an NPI number for the group and an NPI number for each individual provider in the group.

NPI numbers will replace the healthcare provider's Medicare provider number, Medicaid provider number, Champus provider number, UPIN number, and all other payors unique provider numbers (such as Blue Cross Blue Shield). NPI numbers will not replace tax id number or social security number, DEA number, taxonomy number, CAQH provider ID #or license number,

Once an NPI number is assigned to a covered healthcare provider it will not change. NPI numbers will travel with a healthcare provider if they move from one geographical location to another. NPI numbers can be deactivated if the healthcare provider is deceased or goes out of business. NPI numbers will not be reissued to a different healthcare provider once they have been deactivated.

Any changes in information need to be reported to NPPES (National Plan & Provider Enumeration System, website address listed below) within 30 days of the change. So if you move your office, or leave a group to practice on your own, you need to go into the NPPES website and make the appropriate changes. Your NPI number will not change.

NPI numbers can be obtained by completing an online application which takes about 20 minutes, Information required to obtain an NPI is minimal. You will need the address, date of birth, social security ***#,*** city, state, country of Birth and license ***#,*** and a taxonomy code. Applications for a National Provider Identifier are available online at
https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart.

There is a list of taxonomy codes on the website to choose from. It is important that you choose the correct taxonomy code for your specialty. Taxonomy Codes allow the provider to identify their specialty at the claim level so this can directly affect your reimbursement from insurance companies. For example, taxonomy code Ill N00000X is for Chiropractor and taxonomy code t 1 1NS0005X is for Chiropractor Sports medicine. If you are a chiropractor who specializes in Sports Medicine you will want to pick the more specific taxonomy code.

You can have more than one taxonomy code. You will have to pick a taxonomy code as your primary one, hut you can list others as well, So if you are a general chiropractor who also performs IME's (independent medical exams) you will want to pick general chiropractor taxonomy for your primary taxonomy code, and the chiropractor - independent medical examiner as an additional taxonomy code.

If you have an inaccurate taxonomy code linked to your NPI number then your services may he paid at a lower reimbursement rate, or outright denied by an insurance company.

Some people find the website a little tricky to manage. We offer the service of applying for your NPI number for you. For just $29.95 we will complete your application and send a hard copy of your individual NPI # to you. You can call us for more information at 866.933.1381.

If you require the NPI # of another provider for a referral, there is a website available to obtain NPI numbers. You can look up a provider's NPI on the National Registry at https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do. This is a great option for chiropractors who require referrals on patients. When we first started using NPI numbers, we had to call every referring doctor to get his or her NPI number. This website makes it a lot easier.

It sounds a little creepy that anyone can look up NPI numbers on the web, but the information given is no more than someone can get from the phone book, except that it lists the NPI number.

Fee Schedule

You probably have a pretty good idea of what some of your colleagues charge for their services. If not, there are other ways to determine what is reasonable. What you charge may not be what you actually collect. When you agree to participate with an insurance company, you agree to accept their rates. If you don't participate then you will be collecting your entire charge from the patient and can charge whatever the market will bear.

If you are unsure of what the rate for your specialty is in your area, there are some ways you can find out. Find the website for Medicare for your region. Medicare posts their fee schedule on the website. Look up the Medicare allowance for your codes and add about *25%* to the allowed amount for what you should charge. Some other companies will allow more than Medicare's rates so you don't want to charge less than what is allowed.

Another way to determine an average fee for your area is to check out what the allowance for your specialty is by some of the major insurance carriers. If you are joining any networks they usually provide you with a fee schedule for your specialty.

When you do participate with an insurance company, they will pay a portion of or in a few cases all of the amount due, after you submit an insurance claim to them. It can take between two weeks and three months to receive payment – sometimes longer.

If a co-pay or patient responsibility is a portion of the allowed amount, you are expected and contracted to collect that amount. If you do not charge the patient for the co-pay or the coinsurance you are breaking the terms of your contract with the insurance carrier.

If there are special circumstances for not charging the patient, such as financial hardships, then you need to note that you are not charging the patient and why in the patient's chart. Then if you are audited by the insurance carrier you should be covered.

From the point of view of the insurance carrier, if you are willing to settle for only the $20.00 they pay you instead of collecting the $10 co-pay, then they think you should accept $20.00 for the service instead of $30.00 that they allow. So they would pay you $10 and you would have to get the other $10 from your patient.

This can be used as a tool to take you out of the equation when your patients ask you if they have to pay the deductible or the co-pay. Explain to your patients that you must charge them the patient responsibility or you could be removed from their insurance carrier's provider network. Of course, as we mentioned earlier, you may allow for hardship cases.

One question that we are asked a lot is if it is ok to charge cash patients a different fee than the insurance patients are charged. Technically you must charge all patients the same fees. It is illegal in most states to charge a patient who has insurance more money for the same services that you provide to a cash patient at a lower fee.

However, there are ways to get around charging your cash patients more money than they can afford. One way is to set up a sliding scale for patients without insurance, or whose insurance won't cover your services. Then you set the limit for the lower fee schedule at a fairly high rate and most patients will be eligible. You must have the higher fee schedule in existence though and it should be your regular rates.

For example, your fee schedule could read something like this. If you don't have insurance or if your insurance doesn't cover our ervices then you can pay $30 for a 98941 if your yearly income is less than $150,000. If your yearly income is greater than $150,000 then the charge for the 98941 would be $45.

Basically, you set the lower end of the sliding scale at what you would like to get from cash patients, and you set the higher end at your regular rates for billing insurance companies.

You should check your individual state laws to make sure you are in compliance.

Authorizations and Referrals

Some insurance policies require either authorizations or referrals. It is important to understand the difference between them. Referrals are obtained from the patient's PCP, or primary care physician. Authorization is obtained directly from the patient's insurance carrier.

Different insurance plans require different things. Some will not require any auth or referral. If you are not sure if a patient's insurance requires a referral or an authorization, you should call to make sure prior to seeing the patient.

If an authorization is required you can usually obtain it from the insurance company over the phone. Some companies have special forms that they want faxed in to them. Usually they will issue you a number or a series of numbers and letters which you will enter on the insurance claim in box 23.

Authorizations are usually given for a certain number of visits over a certain period of time. For example, you may be granted 6 visits from January 1 to May 3l. You may also be required to send in your treatment notes.

If a referral is required the patient has to obtain it from the primary care physician. The PCP must determine that the patient requires chiropractic services and complete a referral form for the insurance company. Usually a copy of the referral is sent to the chiropractor and a copy goes directly to the insurance company.

Referrals are usually only required once at the beginning of treatment. In some cases, you may be required to get an updated referral depending on the individual insurance carrier's requirements.

Co-pays, Coinsurance, & Deductibles

Most insurance policies require a portion of the service be paid for by the patient. This may be in the form of a co-pay, coinsurance, or a deductible.

Co-pay information is usually stated on the back of the insured's ID card. Chiropractors are considered specialists and must collect the co-pay amount indicated for a specialist. Co-pays are collected at the time of service.

If the co-pay amount is not listed on the back of the card, you should check on the amount with the insurance company either online, if that option is available, or by phone.

Medicare has an annual deductible and then pays 80% of the allowed amount and the remaining 20% is the coinsurance. The coinsurance is paid by either the patient or a secondary insurance if the patient has one and allows it.

If there is a yearly deductible involved, it usually but not always kicks in at the beginning of the year. This is the amount the patient must pay for any medical services to any providers before the insurance will start paying. It is not unusual to have a $100, $500 or even $1000 deductible that must be paid by the patient before the insurance company will pay anything.

If the remittance states that the charges were applied to the deductible, you must charge your patient that amount that was allowed to the deductible.

Many providers find it difficult to charge their patients the co-pays, coinsurance and deductibles, but when you participate with an insurance company, you have signed a contract that you will collect this. You are breaking your contract if you do not collect it and the insurance carrier can cancel your contract.

The insurance carriers feel that if you are willing to accept what they pay you without the payment from the patient that they are overpaying you. They would rather drop their payment even lower and still expect you to collect the co-pay. If you are not collecting the patient responsibility from the patient, remember to document the case as a hardship to protect yourself.

Patients Charts and Notes

It is important to make sure you keep your patient information organized. It is not uncommon for an insurance carrier to do an audit especially in the chiropractic field. Audits can be done randomly and are not always the result of something that was done incorrectly.

All patients' information including treatment notes should be kept in some sort of a chart that is clearly labeled. All information in the chart should also be clearly labeled with patient's first and last name and date of birth. If the information is ever mixed up, you need to be able to clearly identify what chart it belongs in.

Medicare, for example, requires that a patient's first and last name and date of birth not only be on each paper, but should be on the front and back of each paper, if data or notes are on the front and back.

It doesn't matter what format of note taking you use, as long as you keep treatment notes on each patient's visits. Some providers use the SOAP format. Some prefer to just jot down their own words. If you keep your notes in the computer then you do not need to keep copies in the charts.

Any form that you have the patient sign such as HIPPA policies, assignment of benefits, and release of information forms should be kept in the patient's chart. Also, you should make copies of the patient's insurance identification cards (front and back) and keep those copies in the chart.

It is important that you make sure that all of your patients' charts are kept in a secure location to keep all information confidential as required by HIPAA laws.

Chiropractors should apply the following tips to ensure patient health records are consistent, accurate and contemporaneous:

- Patient records should be legible and indelible
- Each entry in the patient health record should be added chronologically, dated and signed
- Each entry should be made during or shortly after the doctor-patient encounter
- Entries should not be scratched out, erased or deleted. Instead a corrected or change to an entry should be made carefully
- Any necessary treatment consents should be documented
- All professional services rendered in each patient visit should be documented
- Routine record keeping procedures should apply to all individuals treated
- All patient health records, including electronic records need to fulfill all applicable state and federal regulations

GUIDELINES FOR MEDICAL RECORD DOCUMENTATION

Consistent, current and complete documentation in the medical record is an essential component of quality patient care. The following 21 elements reflect a set of commonly accepted standards for medical record documentation. An organization may use these elements to develop standards for medical record documentation. NCQA (National Committee for Quality Assurance) considers 6 of the 21 elements as core components to medical record documentation.

Core elements are indicated by an asterisk (*).

1. Each page in the record contains the patient's name or ID number.

2. Personal biographical data include the address, employer, home and work telephone numbers and marital status.

3. All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier or initials.

4. All entries are dated.

5. The record is legible to someone other than the writer.

*6. Significant illnesses and medical conditions are indicated on the problem list.

*7. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.

*8. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.

9. For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (for patients seen three or more times, query substance abuse history).

10. The history and physical examination identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.

11. Laboratory and other studies are ordered, as appropriate.

*12. Working diagnoses are consistent with findings.

*13. Treatment plans are consistent with diagnoses.

14. Encounter forms or notes have a notation, regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed.

15. Unresolved problems from previous office visits are addressed in subsequent visits.
16. There is review for under - or overutilization of consultants.

17. If a consultation is requested, there a note from the consultant in the record.

18. Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.

*19. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.

20. An immunization record (for children) is up to date or an appropriate history has been made in the medical record (for adults).

21. There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines.

Personal Injury and Workers Comp Claims

It is not uncommon to get patients who want to file their claims under no fault or workers comp. You want to make sure you will be paid for these services so it's a good idea to check with the individual insurance carrier to make sure they are authorizing payments.

Since these claims are not the same as health insurance claims, the patient will have no identifying ID card with ID number. In the case of no fault, you want to make sure you get the claim number, the policy number, the date of the accident, the proper insurance carrier, phone number, and address. No fault claims can be filed on a CMS 1500 form.

A workers comp claim requires a workers comp board number and a carrier case number. Call the insurance carrier and make sure your services are authorized. Workers comp carriers require that you file on a C4 form. The C4 forms can be found on the workers comp website for your state.

When completing the C4 form it is important that you fill out as much of the information as possible. If the patient's case ever goes for a hearing they will look back at all the previously filed C4 forms for information to support the patient's case.

For example, if you feel the patient is disabled from regular duties but you don't indicate it on the C4 forms when you filed them, the patient may not be able to prove their case. The judge will question why you are saying they are disabled but didn't indicate it on the form.

It is important to ask the patient if they are seeing any other provider for their no-fault or comp case. Insurance will not pay both if the patient is receiving physical therapy and chiropractic care at the same time. If they are also going for PT you may end up being the one who doesn't get paid.

Sometimes workers' comp and no-fault claims are controverted. That means that the insurance carrier is disputing the claim. They may feel that the patient doesn't need any treatment or any further treatment. They may also feel that the injury is unrelated to the auto accident or workers' comp injury.

In either case, if the insurance carrier is disputing the claim then the patient will need to fight it. If they patient agrees with the carrier or doesn't want to fight it then you can bill the patient's regular insurance carrier if they have one. The medical insurance carrier may request documentation from the no-fault or workers' comp carrier showing that the claim is being denied.

If you agree to see a patient under a workers' comp or no-fault claim you cannot collect money from the patient up front. In some cases, depending on why payment is denied, you may not even be able to charge the patient for unpaid services.

For example, if the claim is denied stating the patient reached their no-fault maximum then you can bill the patient. But if the claim is denied stating that due to an IME the patient has reached maximum medical improvement and you didn't agree with the IME and kept on treating the patient, you can't bill the patient. The patient must fight the denial by requesting a hearing.

Workers' comp claims can also be denied stating 'pending hearing.' In this case you have to wait until the judge makes a decision at the hearing to know whether or not you will be paid.

Sometimes workers' comp claims are apportioned. That means that it has been determined that the workers' comp carrier is only responsible for a percentage of the claim. For example, if a patient has a low back injury from a previous car accident and then they injure their low back at work, the workers' comp board may determine that only 50% of the injury is a result of the new accident and 50% is from the old car accident.

In this case you would have to bill the claim out to both the workers' comp carrier and the no-fault carrier. They would each pay 50% of the charges so you would end up being reimbursed 100%. They don't both pay for the entire visit.

In some rare cases the comp board may determine that a certain percent is due to the work related accident but the remaining percent is due to a condition that is not due to an accident. For example, if a patient has a history of low back problems and then injures their low back at work, the comp board may determine that 75% of the condition is due to the accident at work but *25%* was pre-existing.

In that case you would bill the workers' comp carrier for the services. They would reimburse you 75% of the workers' comp fee schedule and the patient would be responsible for the other 25%. If the patient has a medical insurance you may bill the medical insurance for the other *25%*. Most likely they will require a letter from the comp carrier advising they are only paying 75% and then the claims would be submitted with a copy of the explanation of benefits from the comp carrier.

Most states only reimburse chiropractors for certain CPT codes for no-fault and workers' comp. They only allow them to bill a 99203 for the initial visit and a 99213 for each service after the initial. Some states also allow chiropractors to bill a 99214 as a reevaluation every 8 weeks. They do not allow the manipulation codes (98940-98943) or for any modalities.

They also have a set fee schedule for what you are reimbursed. You should check your state's workers' compensation board website to find out the fee schedule for your area. When you bill for workers' comp or no-fault you should bill the allowed amount for the code you are billing. For example, in our local area workers' comp and no-fault allows a chiropractor to bill $44.04 for an initial exam. So you would bill 99203 for $44.04.

If you are going to accept patients with no-fault and workers' comp claims it is important that you do everything that you can to ensure that you will be reimbursed for your services. When the patient comes in for their first visit (or before their first visit if possible) you should contact the insurance carrier for their case to just make sure the case is active, and see if they require anything in the form of pre-notification.

Sometimes patients will come in stating they have a workers' comp case but the injury is from 10 years ago and they haven't received any medical treatment in 3 years. Suddenly they are having symptoms so they decide to get treatment. But the insurance carrier closed their file since no claims had been received.

It is better to be safe than sorry. A quick phone call may save you from having a bill for several hundred dollars (or more) that you suddenly find out will not be paid.

Following is a copy of an Irrevocable Assignment of Proceeds that can be used for third party personal injury claims. This form is to be completed by the clinic, signed and dated by the patient and provider and notarized.

IRREVOCABLE ASSIGNMENT OF PROCEEDS AND CONVEYANCE LIEN INTEREST

Re: Medical Reports and Lien for _______________________________________
Patient

I do hereby authorize ______________________________ and/or _______________________________________ who is my treating doctor and, (hereafter "the treating facility"), to furnish my attorney, and/or insurance carrier, with complete report of any medical examination, treatment, prognosis, etc (including x-rays, and other medical data, as determined necessary by my treating doctor), relating to my health care treatment in regard to the automobile accident or other contributing incident giving rise to my need for such heath care services.

ASSIGNMENT AND CONVEYANCE OF LIEN INTEREST

I do hereby execute and provide this **Irrevocable Lien Interest and Assignment of Proceeds** in favor of the above named doctor and/or doctor's designated treating facility. This **Irrevocable Lien Interest and Assignment of Proceeds** shall apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance policy to which I am entitled, and from which I am paid in the form of an insurance settlement(s), claim(s), judgment(s), or verdict(s) resulting from the above identified accident (collectively the 'insurance proceeds").

The Insurance Carrier is instructed that pursuant to this **Irrevocable Lien Interest and Assignment of Proceeds** the total dollar amount of all sums which I owe on account to the above named doctor and treating facility, as evidenced by the medical bills submitted by the doctor and/or treating facility, shall be paid directly to the above named doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled, or withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to the above named doctor and/or treating facility.

As consideration for my execution of this **Irrevocable Lien Interest and Assignment of Proceeds**, I represent that said doctor and/or treating facility has provided me professional services upon my request, that I am aware of the nature and expense of all such services so provided and that as consideration for his forbearance of his legal right to require payment by me at the time such services were rendered, said doctor and treating facility relied upon my express declaration and intention to execute and instruct that this **Irrevocable Lien Interest and Assignment of Proceeds** shall apply to all insurance proceeds to which I am entitled and direct that the amount of such proceeds required to satisfy my outstanding balance with said doctor and/or treating facility be remitted directly to the doctor and/or treating facility, at such time as I received an insurance settlement or other monetary settlement/award.

In event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to such named doctor and treating facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt of my settlement award(s).

I fully understand and stipulate that I am ultimately and directly responsible to the doctor and/or treating facility for all medical bills incurred by me for those services rendered to me, or on my behalf or request, and that this agreement is made solely for the benefit of the doctor and treating facility, as additional protection and in consideration of the treating facility's agreement to forgo immediate collection of payment for such services rendered.

Printed Name of Patient: ____

Signed: _________________________________ Date: ________________________

For or On Behalf of the Minor Child: ____________________________, I do hereby assume full financial responsibility.

Signed: _________________________________ Date: ________________________

I, the undersigned do accept the above assignment of proceeds.

Signed: _________________________________ Date: ________________________

below to be filled out by the notary:

____
Notaries Signature

This sworn before me on this the _______day of ______, ___________

My commission expires: __________________________

Submitting Insurance Claims

In order to get paid by an insurance carrier for a claim for chiropractic services, an insurance claim must be submitted to the carrier on a CMS 1500 form (unless it is a workers comp claim) within a certain time frame of the visit. Claims can be denied for timely filing in as little as 45 days after the date of service.

It is important that they are filed quickly, correctly and with all the required information to the correct insurance carrier. The best way to do this is to make sure you obtain good information from the patients on the first visit.

- Make a photocopy of the front and back of the insurance card and keep it in their file.
- Ask the patient to complete a patient intake sheet.
- Determine whether or not a referral or authorization is required and follow the proper course of action.
- Get a signed release of information from the patient such as this:

I authorize the release of any medical or other information necessary to process insurance claims.

- If you participate with the insurance company and want payment made directly to you get a signed release of payment statement such as this:

I authorize payment of medical benefits to the provider for services of these insurance claims. ________

Keep these forms in the patient's files. You are not required to have the patient sign a form each time they come in. Have them sign the form once and keep it on file.

Here is an example of an intake sheet you could use for information you require from the patient along with the necessary releases.

PATIENT INTAKE FORM

Name ____ Soc. Sec. # ______________________________
Last Name First Name Initial

Address ____
_

City____ State _________ Zip ________

Sex M F Age _______ Birth date _________________ Single Married Divorced Widowed Separated

Patient Employed By Occupation _ _______ __________________ _

Home Phone Work/Mobile phone __________ _______ __________________ _

Whom may we thank for referring you? ________________ __________________________ _______ __________________ _

In case of emergency, who should be notified? __________ ___________________________

Person Responsible for Account____
Last Name First Name Initial

Relationship to Patient __________________________Birth date _________________Soc. Sec. # ______________________ _

Address (if different from patient's) Phone ____ _

City ____ State ________________Zip _________________ _

Person Responsible Employed by _____________________________________ Occupation ______ ____________________ _

Business Address Business Phone _____ ____________________ _

Insurance Company Ins. ID No. ___ ____________________ _

Names of other dependents covered under this plan ____________________________________ ___ ____________________ _

Is patient covered by additional insurance?

Subscriber Name ____ Relation to Patient _ _________________ Birth date

Address (if different from patient's) ____________________________________ ______________________ Phone

City ____State ________________Zip __________________

Subscriber Employed by _______________________________________ _ Business Phone ______ ____________________ _

Insurance Company Ins. **ID** No. ____ ____________________ _

Names of other dependents covered under this plan ____ ____________________ _

I, the undersigned, certify that I (or my dependent) have insurance coverage with ____
Name of Insurance Company(ies)

and assign directly to my provider all insurance benefits otherwise payable to me for services rendered. I understand that I am ultimately responsible for all charges accumulated. I hereby authorize the doctor to release all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions.

Responsible Party Signature Relationship Date

I give permission for treatment of myself/my dependent to my assigned provider.

Responsible Party Signature Relationship Date

Once you have all the necessary information from the patient, you will need to call or use the website of the insurance carrier (if this is an option) to obtain benefits and authorization if necessary. You will call the phone number for customer service on the back of the insurance card and ask for benefit information for chiropractic services.

On this call you can expect to be told if there is any co-pay or coinsurance – in other words, what the patient is expected to pay and if authorization or a referral is required. If an authorization is required they will tell you how to obtain it. Sometimes that person you are talking to will give you an authorization number or will give you the phone number of where you can obtain the authorization.

If a referral is required by their insurance plan, the patient must get their primary care physician to complete a referral before you will be paid by the insurance company. Each insurance carrier has its own process for referrals but the PCP's office should be aware of what needs to be done. Make sure the referral is in place before seeing the patient.

It's also a good idea to ask if the patient has a yearly deductible and if it has been met for the year. They may advise you of both an individual deductible and a family deductible. Each individual in a family must meet a separate deductible. All individual deductibles are added together and count towards the family deductible. Once the family deductible is met, no more individual family members have to meet the deductible (if they haven't already).

Example:

> John Smith has a policy where they have a $200 individual deductible and a $500 family deductible. If John's wife Sue met her individual deductible, $200, and his daughter Jill met her individual deductible, $200, that is $400 towards the family deductible. John would only have to meet $100 of his individual deductible which puts the family deductible at $500.

Once you have all the information necessary, it is easier to submit the claims to the insurance carriers completely and correctly. Following is a sample of an Insurance Verification Form.

INSURANCE VERIFICATION

Clinic ______________________ Fax ____________________

Tax ID_____________________________ NPI _________________________________

Name of Patient: _________________________________ Date: _______________ Time: ______________

Primary Ins. Co.: ______________________________________ Ins Phone #: _______________________ Spoke To:__________ Send Claims To: _____________________________________ ____ **INSURED**: ____ Relationship to patient: _________________________________ ID#: __________________________ Group #: ______________ SS#: ____________________ D.O.B.: _____/_____/_________ Eff. Date of Policy: ___________ Pre-Existing? _____________ Out-Of-Network Benefits? Yes / No; Pre-Authorization? Yes/No Pre-Authorization Phone Number: ________________________ Self-Funded? ___________ Cal/plan year? ________________ **Percentage of Coverage?** ______________________________ **Copay: IN $**_________ **OUT$** __________ **Deductible: IN $**_________ **OUT $**__________ Met? _______ **Family Deductible**: **IN $**_______ **OUT $**______ Met? ______ **Last Qtr Carry-Over?** Yes/No **Out of Pocket:** ______/Met_____ **Family** ______/Met ______ Does out of Pocket include deductible or co-pay? ____________	**Secondary** Ins. Co.: ______________________________________ Ins Phone #: _______________________ Spoke To:__________ Send Claims To: _____________________________________ ____ **INSURED**: ____ Relationship to patient: _________________________________ ID#: __________________________ Group #: ______________ SS#: ____________________ D.O.B.: _____/_____/_________ Eff. Date of Policy: ___________ Pre-Existing? _____________ Out-Of-Network Benefits? Yes / No; Pre-Authorization? Yes/No Pre-Authorization Phone Number: ________________________ Self-Funded? ___________ Cal/plan year? ________________ **Percentage of Coverage?** ______________________________ **Copay: IN $**_________ **OUT$** __________ **Deductible: IN $**_________ **OUT $**__________ Met? _______ **Family Deductible**: **IN $**_______ **OUT $**______ Met? ______ **Last Qtr Carry-Over?** Yes/No **Out of Pocket:** ______/Met_____ **Family** ______/Met ______ Does out of Pocket include deductible or co-pay? ____________
Chiropractic Benefits: $Amt/Visit: ________________ $Amt/Yr: _______/Used______ #Visits/Yr: ______/Used______ #Visits/DX: ______/Used_____ Limitations: ____ **Physical Therapy Benefits**: $Amt/Visit: ________________ $Amt/Yr: _______/Used______ #Visits/Yr: ______/Used______ #Visits/DX: ______/Used_____ Limitations: ____	**Chiropractic Benefits**: $Amt/Visit: ________________ $Amt/Yr: _______/Used______ #Visits/Yr: ______/Used______ #Visits/DX: ______/Used_____ Limitations: ____ **Physical Therapy Benefits**: $Amt/Visit: ________________ $Amt/Yr: _______/Used______ #Visits/Yr: ______/Used______ #Visits/DX: ______/Used_____ Limitations: ____
PROCEDURES: 99201 – 99215 –Patient E/M _________ X-rays _________ DME _________ Other Notes: ____ ____ ____	**PROCEDURES:** 99201 – 99215 –Patient E/M _________ X-rays _________ DME _________ Other Notes: ____ ____

I understand that the above information was obtained directly from my insurance company and they have explained that it is not a guarantee of benefits or payment. This office has suggested that I personally call my insurance company to verify my benefits as well, since this will enable me to understand my own benefits better. This office will cooperate with any additional, reasonable requests by my insurance company. Lengthy reports or copies of records may incur an additional charge. I understand that my insurance coverage is a contract between me and my insurance company and that I will be responsible for any and all charges not paid by my insurance company.

_______________________________ _______________________________

Signature of Patient Signature of Chiropractic Assistant

Medicare

If you are going to accept Medicare patients then you will need to become either a participating or non-participating Medicare provider. If you choose to participate then that means that you agree to accept what Medicare allows for your services and follow all of Medicare's guidelines. Medicare will make payment directly to you.

If you choose to accept Medicare patients, but be a non-participating provider then you can see Medicare patients, and you can charge up to the limiting charge set my Medicare. Medicare will make payment directly to the patients if you are non participating and you don't accept assignment.

You can be a non-participating Medicare provider but still choose to accept assignment. You do this by checking yes in box 27 on the CMS 1500 form. If you choose to accept assignment then you must accept Medicare's non-participating allowed amount for your services, but payment will be sent directly to you.

Medicare billing can be a little different than other insurance carriers. Medicare only reimburses chiropractors for manipulation codes (98940 - 98942) and they only reimburse those if the diagnoses warrant it.

For example, Medicare will only reimburse chiropractors if they have a valid primary diagnosis and a valid secondary diagnosis for the visit. Not only do you have to use valid diagnosis codes, they have to be in the right order on the claim.

Medicare requires that the primary diagnosis code for a manipulation code be either 739.0, 739.1, 739.2, 739.3, 739.4 or 739.5. If you have any other diagnosis code in the first spot of the claim the services will be denied.

In addition to having the primary diagnosis code one of the nonallopathic lesion codes (739.0-739.5) you must have a valid secondary diagnosis code. Medicare posts a list of the valid codes on their website. Medicare also decides how many visits a year will be allowed based on the secondary diagnosis code.

They list the valid secondary diagnosis codes based on categories. Category I will allow approximately 12 visits per year. Category II will allow approximately 18 visits per year. Category III allows approximately 24 visits per year.

Medicare ICD-9 Coding for Chiropractors

PRIMARY	SECONDARY AND/OR COMPLICATIONS: Short Duration	Medium Duration	Long Duration
Cervical Region 739.1 Cervical	723.1 Cervicalgia 784.0 Headache 721.91 Spondylosis Un spec. w/ Myelopathy 721.90 Spondylosis Un spec. w/o Myelopathy 307.81 Tension Headache	738.4 Acquired Spondylolisthesis 723.4 Brachial Neuritis 353.0 Brachial Plexus Lesions Cerv. 721.0 Spondylosis w/o Myelopathy 723.3 Cervicobrachial Syndrome 723.2 Cervicocranial Syndrome 722.91 Disc Disorder 729.4 Fasciitis, Unspec. 729.1 Myalgia & Myosi tis, Unspec. Root 353.2 Lesions Spinal 720.1 Enthesopathy 847.0 Sprain/Strain 723.0 Stenosis 723.5 Torticollis, unsp. 724.8 Facet Syndrome	722.4 Disc Degeneration 722.0 Disc Displacemnt w/o Myelopathy 722.81 Postlaminectomy 721.7 Traumatic Spondylopathy
Thoracic Region 739.2 Thoracic	724.5 Backache Unspec. 724.1 Pain in Spine 721.91 Spondylosis Un spec. w/ Myelopathy 721.2 Thor. Spondylosis 721.90 Spondylosis Un spec. w/o Myelopathy	738.4 Acquired Spondy lolisthesis 723.4 Brachial Neuritis 353.0 Brachial Plexus lesions 723.3 Cervicobrachial Syndrome 722.92 Disc Disorder 729.4 Fasciitis, Unspec. 729.1 Myalgia & Myosi tis, Unspec. 353.8 Nerve Root and Plexus Disorder 724.4 Neuritis or Radiculitis 353.3 Root Lesions 720.1 Spinal Enthesopathy 756.12 Spondylolisthesis w/o Myelopathy 847.1 Sprain/Strain 724.01 Stenosis 724.8 Facet Syndrome 724.9 Unspec. Back Disorder	722.51 Disc Degeneration 722.11 Disc Displacement 722.82 Postlaminectomy 721.7 Traumatic Spondy

MEDICARE ICD-9 CODING FOR CHIROPRACTORS

PRIMARY	SECONDARY AND/OR COMPLICATIONS		
	Short Duration	Medium Duration	Long Duration
Lumbar Region 739.3 Lumbar	724.5 Backache Unspec. 724.2 Lumbago 721.91 Spondylosis Un Spec w/Myelopathy 721.90 Spondylosis Un spec. w/o Myelopathy 721.3 Spondylosis, LumboSacral w/o Myelopathy	738.4 Acquired Spondy lolisthesis 724.6 Ankylosis or instability 722.93 Disc Disorder 729.4 Fascitis Unspec 720.1 Enthesopathy 729.1 Myalgia 353.8 Nerve Root and Plexus Disorder 724.4 Neuritis/Radiculitis 353.1 Plexus Lesions 353.4 Root Lesions 756.12 Spondylolisthesis 847.2 Sprain/Strain Lumbar 846.0 Sprain/Strain Lumbosacral 724.02 Stenosis 724.8 Facet Syndrome 724.9 Unspec Back Disorder	722.52 Disc Degeneration 722.10 Disc Displacement 722.83 Postlaminectomy 721.7 Traumatic Spondylopathy
Sacral/Pelvic Region 739.4 Sacral 739.5 Pelvic	724.5 Backache Unspec. 721.91 Spondy w/Myelopathy 721.90 Spondylosis Unspec w/o Myelopathy 721.3 Spondylosis, Lumbo Sacral w/o Myelopathy	738.4 Acquired Spondy Lolisthesis 724.6 Ankylosis 724.79 Coccygodynia 720.1 Enthesopathy 729.4 Fascitis, Unspec 729.1 Myalgia & Myositis, Unspec 353.8 Nerve Root & Plexus Disorder 756.12 Spondylolisthesis 847.4 Sprain/Strain Coccyx 847.3 Sprain/Sprain Sacrum 846.1 Sprain/Strain Sacroiliac 846.2 Sprain/Strain Sacrospinatus 846.3 Sprain/Strain Sacrotuberous 724.8 Facet Syndrome 724.9 Unspec Back Disorder	724.3 Sciatica 721.7 Traumatic Spondylopthy

One of the diagnoses from the lists above must be in the second spot on the claim in order to be reimbursed by Medicare. You cannot just have the correct diagnoses on the claim, but they must also be in the correct order. It is important that you understand the impact that the diagnoses have. I'm not telling you how to diagnose your patients, I'm just telling you what Medicare requires to reimburse for chiropractic services.

Another requirement Medicare has is that the services be performed due to an acute condition. The AT modifier indicates acute treatment and must be on all services to be considered for reimbursement. Medicare does not allow for maintenance. So you must indicate that the condition is acute by using the AT modifier.

Some people think that Medicare is a pain, but if you just understand and follow their guidelines, they really are not that bad. If you submit your claims electronically they will pay you in 14 days and they post all of their requirements and guidelines on their website.

Following is information taken directly from CMS website with regards to billing and filing Medicare claims.

Chiropractic Services

Published September 2011

Part B

IMPORTANT

The information provided in this manual was current as of August 2011. Any changes or new information superseding the information in this manual, provided in MLN Matters® articles, eBulletins, listserv notices, Local Coverage Determinations (LCDs) or CMS Internet-Only Manuals with publication dates after August 2011, are available at:

http://www.trailblazerhealth.com/Medicare.aspx

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Provider Outreach and Education
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IMPORTANT

Chiropractic Services

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INTRODUCTION TO CHIROPRACTIC SERVICES

A chiropractor must be licensed or legally authorized to furnish chiropractic services by the state or jurisdiction in which the services are furnished. In addition, a licensed chiropractor must meet uniform minimum standards to be considered a physician for Medicare coverage. Coverage extends only to treatment by means of manual manipulation of the spine to correct a subluxation provided such treatment is legal in the state where performed. All other services furnished or ordered by chiropractors are not covered.

If a chiropractor orders, takes or interprets an X-ray or other diagnostic procedure to demonstrate a subluxation of the spine, the X-ray can be used for documentation. However, there is no coverage or payment for these services or for any other diagnostic or therapeutic service ordered or furnished by the chiropractor.

Chiropractic service, which is eligible for reimbursement, is specifically limited by Medicare to the treatment by means of manual manipulation (i.e., by use of the hands or use of manual devices that are hand-held, with the thrust of the force of the device being controlled manually) of the spine for the purpose of correcting a subluxation. Other services such as lab tests, X-rays, nutritional supplements, modalities, traction, office visits, examinations, supports, etc., are services that Medicare will not consider for payment when performed by a chiropractor.

Payment is based on the physician fee schedule. The fee schedule can be found online at:

http://www.trailblazerhealth.com/Payment/Fee Schedules/Default.aspx

HCPCS CODES

98940©	Chiropractic manipulation
98941©	Chiropractic manipulation
98942©	Chiropractic manipulation
98943©	Chiropractic manipulation

Note: CPT code 98943©, CMT, extraspinal, one or more regions, is not a Medicare benefit.

INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY

For the purpose of Medicare, subluxation means a motion segment in which alignment, movement integrity and/or physiological function of the spine are altered although contact between joint surfaces remains intact. A subluxation usually falls into one of two categories:

- Acute, such as strains and sprains.

- Chronic, such as loss of joint mobility.

Note: No other diagnostic or therapeutic service furnished by a chiropractor or under his order is covered under the Medicare program.

Acceptable terminology for the Chiropractic Manipulative Treatment (CMT) being provided includes:

- Spinal adjustment by manual means.
- Spinal manipulation.
- Manual adjustment or manipulation.
- Vertebral manipulation or adjustment.

Manual devices (those devices that are hand-held with the thrust of the force of the device being controlled manually) may be used by a chiropractor in performing manual manipulation of the spine. However, no additional payment is allowed for the use of the device or for the device itself.

The five spinal regions referred to in this policy on CMT are:

- Cervical region.
- Thoracic region.
- Lumbar region.
- Sacral region.
- Pelvic.

MEDICAL NECESSITY

Refer to the "Chiropractic Services" Local Coverage Determination (LCD) on the TrailBlazer Health Enterprises® Web site at:

http://www.trailblazerhealth.com/Tools/LCDs.aspx

LOCATION OF SUBLUXATION

The mere statement or diagnosis of "pain" is not sufficient to support medical necessity for the treatments. The precise level of the subluxation must be documented by the chiropractor in the medical records.

Area of Spine	Names of Vertebrae	Number of Vertebrae	Short Form or Other Name
Neck	Occiput Cervical Atlas Axis	7	Occ, CO C1 through C7 C1 C2
Back	Dorsal or Thoracic Costovertebral Costotransverse	12	D1 through D12 T1 through T12 R1 through R12 R1 through R12
Low Back	Lumbar	5	L1 through L5
Sacral	Sacrum, Coccyx		S, SC
Pelvic	Ilii, R and L		I, Si

In addition to the vertebrae and pelvic bones listed, the ilii (R and L) are included with the sacrum as an area where a condition may occur that would be appropriate for CMT.

There are two ways the level of the subluxation may be specified:

- The exact bones may be listed, for example, C5, C6, etc.
  Or,
- The area may suffice if it implies only certain bones such as:
  - Occipito-atlantal (occiput and C1 (atlas)).
  - Lumbosacral (L5 and sacrum).
  - Sacroiliac (sacrum and ilium).

Below are some common examples of acceptable descriptive terms for the nature of the abnormalities. Other terms may be used if they clearly refer to the bone or joint space or position (or motion) changes of vertebral elements.

- *Off-centered.*
- *Misalignment.*
- *Malpositioning.*
- *Spacing – abnormal, altered, decreased, increased.*

- *Incomplete dislocation.*
- *Rotation.*
- *Listhesis – anterior, postero, retro, lateral, spondylo.*
- *Motion – limited, lost restricted, flexion, extension, hypermobility, hypomotility, aberrant.*

There are three categories of conditions:

- Acute – A patient's condition is considered to be acute when the patient is being treated for a new illness or injury. The result of chiropractic treatment is expected to be an improvement in, arrest or retardation of the patient's condition.
- Chronic – A patient's condition is considered chronic when it is not expected to completely significantly improve or be resolved with further treatment (as is the case with an acute condition), but where continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition without expectation of additional functional improvement, further manipulation treatment is considered maintenance therapy and is not covered.
- Maintenance Therapy – A treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life or maintain or prevent deterioration of a chronic condition is not a Medicare benefit. Once the maximum clinical benefit has been achieved for a given condition, ongoing maintenance therapy is not considered to be medically reasonable or necessary and is not payable under the Medicare program. An Advance Beneficiary Notice of Noncoverage (ABN) is required.

BILLING FOR ACTIVE/CORRECTIVE TREATMENT

Chiropractic services that provide acute or chronic active/corrective treatment must be billed with the AT modifier. However, the presence of the AT modifier may not in all instances indicate the service is reasonable and necessary.

If codes 98940–98942 are billed without the AT modifier, the treatment will be considered maintenance therapy and will not be covered.

BILLING FOR MAINTENANCE THERAPY

Maintenance therapy is not a Medicare benefit. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life or therapy, which is performed to maintain or prevent deterioration of a chronic condition. Once the maximum therapeutic benefit has been achieved for a given condition, ongoing maintenance therapy is not covered under the Medicare program. Chiropractic maintenance therapy is not medically reasonable or necessary and is not payable under the Medicare program.

Chiropractic Services

The AT modifier **must not** be placed on the claim when maintenance therapy has been provided. Claims without the AT modifier are considered maintenance therapy and will be non-covered.

Since maintenance therapy is not a Medicare benefit and is considered not medically necessary, the beneficiary will need to sign an ABN form. Complete instructions regarding the ABN may be found on the TrailBlazer® Web site at:

http://www.trailblazerhealth.com/Publications/Training Manual/abn.pdf

DOCUMENTATION REQUIREMENTS

A subluxation may be demonstrated by an X-ray or by physical examination. (If the X-ray is used to demonstrate the subluxation, it is required on the claim form. Refer to the "Claim Requirements" section of this manual.) If the X-ray is to be used to document the subluxation, it must have been taken at a time reasonably proximate to the initiation of a course of treatment. Unless more specific X-ray evidence is warranted, an X-ray is considered reasonably proximate if it was taken no more than 12 months prior to or three months following the initiation of a course of chiropractic treatment. In certain cases of chronic subluxation (e.g., scoliosis), an older X-ray may be accepted provided the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding the condition is permanent.

A previous Computed Tomography (CT) scan and/or MRI are acceptable evidence if a subluxation of the spine is demonstrated.

INITIAL VISIT

The following documentation requirements apply whether the subluxation is demonstrated by X-ray or physical examination:

1. **History:**
   - Family history if relevant.
   - Past health history (general health, prior illness, injuries or hospitalizations, medications, surgical history).
   - Chief complaint including the symptoms present that caused the patient to seek chiropractic treatment.
   - Mechanism of trauma.
   - Quality and character of symptoms/problem.
   - Onset, duration, intensity, frequency, location and radiation of symptoms.
   - Aggravating or relieving factors.
   - Prior interventions, treatments, medications, secondary complaints.

2. **Description of the present illness including:**
    - Mechanism of trauma.
    - Quality and character of symptoms/problem.
    - Onset, duration, intensity, frequency, location and radiation of symptoms.
    - Aggravating or relieving factors.
    - Prior interventions, treatments, medications, secondary complaints.
    - Symptoms causing patient to seek treatment.

    These symptoms must bear a direct relationship to the level of subluxation. The symptoms refer to the spine (spondyle or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal) and joint (arthro) and would be reported as pain (algia), inflammation (itis), or as signs such as swelling, spasticity, etc. Vertebral pinching of spinal nerves may cause headaches, arm, shoulder and hand problems as well as leg and foot pains and numbness. Rib and rib/chest pains are also recognized symptoms, but in general other symptoms must relate to the spine as such. The subluxation must be causal, i.e., the symptoms must be related to the level of the subluxation that has been cited. A statement on a claim that there is “pain” is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.

3. **Evaluation of musculoskeletal nervous system through physical examination (*PART* exam) is required to identify:**
    - ***P***ain/tenderness evaluated in terms of location, quality and intensity.
    - ***A***symmetry/misalignment identified on a sectional or segmental level.
    - ***R***ange of motion abnormality (changes in active, passive and accessory joint movements resulting in an increase or a decrease in sectional or segmental mobility).
    - ***T***issue tone changes in the characteristics of contiguous or associated soft tissues, including skin, fascia, muscle and ligament.

    To demonstrate a subluxation based on the physical examination, two of the four described criteria (pain/tenderness, asymmetry/misalignment, range of motion abnormality and tissue tone changes) are required, one of which must be asymmetry/misalignment or range of motion abnormality.

4. **Diagnosis:**

    The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named.

5. **Treatment plan:**
   - The treatment plan should include the following:
     - Recommended level of care (duration and frequency of visits).
     - Specific treatment goals.
     - Objective measures to evaluate treatment effectiveness.

6. **Date of the initial treatment.**

SUBSEQUENT VISITS

The following documentation requirements apply whether the subluxation is demonstrated by X-ray or physical examination:

1. **History:**
   - Review of chief complaint.
   - Changes since last visit.
   - System review if relevant.

2. **Physical exam:**
   - Exam of area of spine involved in diagnosis.
   - Assessment of change in patient condition since last visit.
   - Evaluation of treatment effectiveness.

3. **Documentation of treatment given on day of visit.**

   Failure to document the medical necessity of the chiropractor's manual spinal manipulation(s) may result in denial of claim(s).

NECESSITY FOR TREATMENT

A. 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. The patient must have a subluxation of the spine as demonstrated by X-ray or physical exam, as described above.

   Most spinal joint problems may be categorized as follows:

   - Acute Subluxation: A patient's condition is considered acute when the patient is being treated for a new injury identified by X-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, arrest or retardation of the patient's condition.
   - Chronic Subluxation: A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the

case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

B. Maintenance Therapy: A treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. Once the maximum therapeutic benefit has been achieved for a given condition, ongoing chiropractic treatment is not considered to be medically reasonable or necessary and is not payable under the Medicare program.

C. Contraindications: Dynamic thrust is the therapeutic force or maneuver delivered by the physician during manipulation in the anatomic region of involvement. A relative contraindication is a condition that adds significant risk of injury to the patient from dynamic thrust but does not rule out the use of dynamic thrust. The doctor should discuss this risk with the patient and record this in the chart. The following are relative contraindications to dynamic thrust:

- Articular hypermobility and circumstances where the stability of the joint is uncertain.
- Severe demineralization of bone.
- Benign bone tumors (spine).
- Bleeding disorders and anticoagulant therapy.
- Radiculopathy with progressive neurological signs.

Dynamic thrust is absolutely contraindicated near the site of demonstrated subluxation and proposed manipulation in the following:

- Acute arthropathies characterized by acute inflammation and ligamentous laxity and anatomic subluxation or dislocation, including acute rheumatoid arthritis and ankylosing spondylitis.
- Acute fractures and dislocations or healed fractures and dislocations with signs of instability.
- An unstable os odontoedeum.
- Malignancies that involve the vertebral column.
- Infection of bones or joints of the vertebral column.
- Signs and symptoms of myelopathy or cauda equina syndrome.
- For cervical spinal manipulations, vertebrobasilar insufficiency syndrome.
- A significant major artery aneurysm near the proposed manipulation.

TREATMENT PARAMETERS

The patient's condition should be arrested, improve or retard deterioration within a reasonable and generally predictable period of time. Acute subluxation problems may require as many as three months of treatment, but some require very little treatment. In the first several days, treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained.

Chronic spinal joint condition implies the condition has existed for a longer period of time and that, in all probability, the involved joints have already "set" and fibrotic tissue has developed. This condition may require a longer treatment time but not with higher frequency.

Some patients have been identified as being treated with an "intensive care" concept. This approach provides multiple daily visits given in the office or clinic, and so-called room or ward fees are charged since the patient is confined to the bed, usually for the day. The room or ward fees are not covered and payment under Medicare is limited to one treatment per day.

COMMON DOCUMENTATION ERRORS

Required Documentation That Was Deficient	Component of the Documentation That Was Missing or Incomplete
Physical exam	The missing information included: • Previous diagnosis. • An exam of the area of the spine involved in the diagnosis. • Assessment of change in the patient's condition since the last visit and an evaluation of treatment.
Plan of care	The plan of care was incomplete in that it lacks specific treatment goals and objective measures to evaluate treatment effectiveness.
Documentation to support chiropractic manipulation	• Document the service rendered in the medical record. • If non-standard abbreviations or acronyms are used, a legend needs to be submitted with medical records.
PART exam	• Exam did not document either the Range of Motion (ROM) or asymmetry/misalignment, one of which must be documented in the PART exam.

ASK YOURSELF SOME QUESTIONS ABOUT YOUR DOCUMENTATION

Ask yourself the following questions to avoid the common documentation errors:

- Does the record show a significant neuromusculoskeletal condition?
- Is there a precise subluxation documented?
- Does the exam substantiate the condition and the subluxation?
- Is there a primary and secondary diagnosis that bears a direct relationship to the primary level of subluxation?
- Is there a treatment plan?
- In order to substantiate the need and frequency of ongoing care, does your documentation note a response to treatment (e.g., increased range of motion, increased function, decreased pain)?

X-RAYS ORDERED/REFERRED BY A CHIROPRACTOR

Coverage of chiropractic services is specifically limited to treatment by means of manual manipulation. No other diagnostic or therapeutic service furnished by a chiropractor or under his order is covered. The X-ray may be used for documentation, but Medicare will make no payment to the Doctor of Medicine (MD) or Doctor of Osteopathy (DO) if the chiropractor orders the X-ray.

This clarifies the current policy regarding payment of diagnostic X-rays either ordered by or referred by a chiropractor. If a chiropractor directs or refers the patient to the radiologist to obtain an X-ray to demonstrate a subluxation prior to beginning treatment, and the radiologist performs the X-ray based upon the chiropractor's evaluation of the patient, the radiologist should report the chiropractor as the ordering provider on the claim form. Medicare will deny the service as non-covered, the beneficiary will be responsible for payment, the ABN will not apply, and advance written notice will not be required.

If the patient is referred by the chiropractor to the radiologist, and the radiologist then determines that an X-ray is appropriate, the radiologist assumes responsibility for ordering the X-ray and enters his name and ID number as the ordering physician on the claim form; Medicare will not deny the claim. The radiologist is not precluded from ordering a diagnostic X-ray. However, in this case, we would expect the radiologist to maintain adequate documentation to substantiate the medical necessity of the services he has ordered based upon his evaluation of the patient. In the event of a postpayment review of claims, we would request this documentation to validate payments made to the radiologist. In addition, no other diagnostic or therapeutic service performed by a chiropractor or ordered by a chiropractor is covered (e.g., physical therapy).

CHIROPRACTORS BILLING FOR PHYSICAL THERAPY

Chiropractors billing for physical therapy services (CPT codes 97001–97799 and HCPCS code G0283) must bill with the appropriate modifier.

- GN – Services delivered under an outpatient speech-language pathology plan of care.
- GO – Services delivered under an outpatient occupational therapy plan of care.
- GP – Services delivered under an outpatient physical therapy plan of care.

Even though physical therapy billed by a chiropractor is a program exclusion, if one of the above modifiers is omitted from any of the codes referenced, the service will be rejected. This rejection would require the claim to be corrected and resubmitted.

CODING GUIDELINES

- The level of subluxation must be specified on the claim and must be listed as the primary diagnosis, i.e., cervical region (7391). The neuromusculoskeletal condition necessitating the treatment must be listed as the secondary diagnosis.
- Non-covered services provided by a chiropractor need not be billed to Medicare unless the patient requests the services be billed to obtain a denial for his supplemental insurance. The chiropractor may bill the services with specific procedure codes for the non-covered services, e.g., X-rays, laboratory tests, physical examinations or physical therapy. One exception to this situation exists: A chiropractor will still be required to bill Medicare for manipulations that exceed the norm and maintenance therapy.

CLAIM REQUIREMENTS

- The initial date of treatment must be documented in Item 14 of the CMS-1500 claim form or the electronic equivalent.
- If the subluxation is demonstrated by an X-ray, the X-ray date must be placed in Item 19 of the CMS-1500 claim form or the electronic equivalent.

Complete claim form instructions can be found at:

http://www.trailblazerhealth.com/Publications/Training Manual/claim form instructions.pdf

REASONS FOR DENIAL

- When the number of manipulations exceeds the norm. (This type of denial will still require a claim be submitted to Medicare.)
- Excluded Services: An excluded service from Medicare coverage is any service other than manual manipulation for treatment of subluxation of the spine. The chiropractor is not required to bill excluded services; however, the provider may bill these services to Medicare to obtain a denial for secondary insurance purposes. The following are examples (not an all-inclusive list) of services that, when performed or ordered by the chiropractor, are excluded from Medicare

coverage and for which the beneficiary is responsible for payment:
  - Therapy for a chronic condition that does not meet the definition as described in the “Indications and Limitations and/or Medical Necessity” section of this policy.
  - Laboratory tests.
  - X-rays.
  - Office visits (history and physical).
  - Physical therapy.
  - Supplies.
  - Injections.
  - Drugs.
  - EKGs or any diagnostic study.
  - Acupuncture.
  - Orthopedic devices.
  - Nutritional supplements/counseling.
  - Any service ordered by the chiropractor.
- Any manipulation, including low-force technique, where one of the absolute contraindications listed in this policy exists.
- Mechanical or electric equipment that is used for manipulations and does not meet the definition of “manual device” as specified in the “Description” section of this policy.
- Coverage will be denied for lack of reasonable expectation that the continuation of treatment would result in long-term improvement of the patient’s condition; continued repetitive treatment without an achievable and clearly defined goal is considered maintenance therapy and is not covered.
- The service is considered an extraspinal CMT.
- The service does not follow the guidelines of this policy.

SUPPLIES

Supplies (such as braces, corsets, supports, etc.) and Durable Medical Equipment (DME) may be coverable when ordered by an MD or DO and supplied by a chiropractor. Supplies must be billed to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) and the chiropractor must have a DME supplier number with the DME MAC.

FREQUENTLY ASKED QUESTIONS

Question:

What is the difference between the GP and GY modifiers? Do we use GP, GY and GA for physical therapy charges?

Chiropractic Services

Answer:
Yes, it is possible that physical therapy services could be billed with all three modifiers. (Remember that the patient does not have to sign an Advance Beneficiary Notice of Noncoverage (ABN) to be held financially responsible.)

- GP: Services delivered under an outpatient physical therapy plan of care.

  Chiropractors billing for physical therapy services (CPT codes 97001–97799 and HCPCS code G0283) must bill with the appropriate modifier. Even though physical therapy billed by a chiropractor is a program exclusion, if one of the above modifiers is omitted from any of the codes referenced, the service will be rejected. This rejection would require the claim to be corrected and resubmitted.
- GY: Used to indicate an item or service statutorily excluded or it does not meet the definition of any Medicare benefit.

  This modifier can be used when billing for a non-covered service to later bill to the patient's secondary insurance for consideration (e.g., X-rays or physical therapy).
- GA: Used to indicate that an ABN is on file.

  A copy of the ABN does not have to be submitted with the claim but must be made available upon request.

Question:
Do we need an ABN on file for physical therapy, X-rays and exams if we are not billing Medicare? Or is it voluntary?

Answer:
The only Medicare Part B benefit for chiropractors is the spinal manipulation. All services other than spinal manipulation, such as X-rays, office visits, physical therapy services, supplies or extra-spinal manipulations, are considered excluded services and are not a Medicare Part B benefit. These types of excluded services are never covered and are always the patient's financial responsibility. Therefore, the ABN is not required to hold the patient financially responsible.

Question:
Do we have to bill Medicare for physical therapy, X-rays and exams even though we know Medicare will not cover them?

Answer:
These types of services do not have to be billed to Medicare because they are program exclusions. In some cases, the patient might request that you bill all services provided to Medicare for the purpose of supplemental insurance or for their records, and in this case, they should be billed.

Chiropractic Services

Question:
Is there a limit for the number of modifiers used?

Answer:
Paper claim submitters only have the ability to bill four modifiers. However, electronic billers sometimes have the capability to bill up to eight modifiers.

Question:
Does the number of visits allowed reset if there is a change in the diagnosis (i.e., the patient suffers a new injury)?

Answer:
The answer is per episode. If the patient had an acute exacerbation of a current diagnosis or had a new episode (with a new diagnosis) that was well documented in the record, consideration for the new episode/acute exacerbation would be given when the claim is reviewed by the Medical Review department.

Question:
There were concerns about the physical therapy codes being rejected when billed with the GP and GY modifier.

Answer:
These situations need to be evaluated on a claim-by-claim basis. Please contact the Part B Provider Contact Center at (866) 280-6520 for assistance.

REVISION HISTORY

Date	Revision
June 2007	• Removed limited coverage and added the link to the "Chiropractic Services" LCD on the TrailBlazer Web site. • Updated the loops and segments for the claim requirements for electronic claims submission.
March 2009	• Updated Web site links. • Removed loops/segments of the electronic claim form and added a link to the CMS-1500 claim form manual.
April 2010	Added the term PART exam to the initial visit documentation requirements.
August 2010	• Added Common Documentation Errors chart (based on Medical Review audit results – J4). • Added "Ask Yourself Some Questions About Your Documentation" section. • Added "Frequently Asked Questions" section.
September 2011	• *Added "acceptable descriptive terms" under the "Location of Subluxation" section (IOM 100-02, Chapter 15, Section 240.1.4).* • *Added "Treatment Parameters" section (IOM 100-02, Chapter 15, Section 240.1.5).*

TrailBlazer
HEALTH ENTERPRISES, LLC

Redetermination/
Appeals Number:

Part B Reconsideration Request Form

Directions: If you wish to appeal this decision, please fill out the information below and mail this form to the address shown below. *At a minimum, **you must complete/include information for items 1, 2a, 6, 7, 11 and 12,** but to help us serve you better, please include a copy of the redetermination notice with your reconsideration request.*

Q2 Administrators
Part B Operations
P.O. Box 183092
Columbus, OH 43218-3092

1. Name of Beneficiary:______________________________

2a. Medicare Number:______________________________

2b. Claim Number (ICN/DCN, if available):______________________________

3. Provider Name:______________________________

4. Person Appealing: ☐ Beneficiary ☐ Provider of Service ☐ Representative

5. Address of the Person Appealing: ______________________________

____

6. Item or Service You Wish to Appeal: ______________________________

____

7. Date of the Service: From _____/_____/_____ To _____/_____/_____

8. *Does this appeal involve an overpayment?* ☐ Yes ☐ No

9. Why do you disagree? Or what are your reasons for your appeal? (Attach additional pages, if necessary.) ______________________________

____

10. You may also include any supporting material to assist your appeal. Examples of supporting materials include:
    - Medical Records
    - Copy of the Claim
    - Office Records/Progress Notes
    - Treatment Plan
    - Certificate of Medical Necessity

11. Name of Person Appealing: ______________________________

12. Signature of Person Appealing: ______________________________ Date:____/____/____

Published November 2009

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** ____________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** ____________ below.

D.	**E. Reason Medicare May Not Pay:**	**F. Estimated Cost**

WHAT YOU NEED TO DO NOW:

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

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

G. OPTIONS: Check only one box. We cannot choose a box for you.
☐ **OPTION 1.** I want the **D.** ____________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ **OPTION 2.** I want the **D.** ____________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.
☐ **OPTION 3.** I don't want the **D.** ____________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	**J. Date:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form Instructions
Advance Beneficiary Notice of Noncoverage (ABN)
OMB Approval Number: 0938-0566

Overview

The ABN is a notice given to beneficiaries in Original Medicare to convey that Medicare is not likely to provide coverage in a specific case. “Notifiers” include physicians, providers (including institutional providers like outpatient hospitals), practitioners and suppliers paid under Part B (including independent laboratories), as well as hospice providers and religious non-medical health care institutions (RNHCIs) paid exclusively under Part A. They must complete the ABN as described below, and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice. (Note that although Medicare inpatient hospitals and home health agencies (HHAs) use other approved notices for this purpose, skilled nursing facilities (SNFs) must use the revised ABN for Part B items and services.) Beginning March 1, 2009, the ABN-G and ABN-L will no longer be valid; and notifiers must begin using the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131).

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. Employees or subcontractors of the notifier may deliver the ABN. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the notifier must retain the original notice on file.

ABN Changes

The ABN is a formal information collection subject to approval by the Executive Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (PRA). As part of this process, the notice is subject to public comment and re-approval every 3 years. The revised ABN included in this package incorporates: suggestions for changes made by notifiers over the past 3 years of use, refinements made to similar liability notices in the same period based on consumer testing and other means, as well as related Medicare policy changes and clarifications occurring in the same interval. We have made additional changes based on suggestions received during the recent public comment period.

This version of the ABN continues to combine the general ABN (ABN-G) and the laboratory ABN (ABN-L) into a single notice, with an identical OMB form number. As combined, however, the new notice will capture the overall improvements incorporated into the revised ABN while still permitting pre-printing of the lab-specific key information and denial reasons used in the current ABN-L.
Also, note that while previously the ABN was only required for denial reasons recognized under section 1879 of the Act, the revised version of the ABN may also be used to provide

voluntary notification of financial liability. Thus, this version of the ABN should eliminate any widespread need for the Notice of Exclusion from Medicare Benefits (NEMB) in voluntary notification situations.

Instructions for completion of the form are set forth below. Once the new ABN approval process is completed, CMS will issue detailed instructions on the use of the ABN in its on-line Medicare Claims Processing Manual, Publication 100-04, Chapter 30, §50. Related policy on billing and coding of claims, as well as coverage determinations, is found elsewhere in the CMS manual system or website (www.cms.hhs.gov).

Completing the Notice

OMB-approved ABNs are placed on the CMS website at: http://www.cms.gov/BNI . Notices placed on this site can be downloaded and should be used as is, as the ABN is a standardized OMB-approved notice. However, some allowance for customization of format is allowed as mentioned for those choosing to integrate the ABN into other automated business processes. In addition to the generic ABN, CMS will also provide alternate versions, including a version illustrating laboratory-specific use of the notice.

ABNs must be reproduced on a single page. The page may be either letter or legal-size, with additional space allowed for each blank needing completion when a legal-size page is used.

Sections and Blanks:
There are 10 blanks for completion in this notice, labeled from (A) through (J), with accompanying instructions for each blank below. We recommend that the labels for the blanks be removed before use. Blanks (A)-(F) and blank (H) may be completed prior to delivering the notice, as appropriate. Entries in the blanks may be typed or hand-written, but should be large enough (i.e., approximately 12-point font) to allow ease in reading. (Note that 10 point font can be used in blanks when detailed information must be given and is otherwise difficult to fit in the allowed space.) The Option Box, Blank (G), must be completed by the beneficiary or his/her representative. Blank (I) should be a cursive signature, with printed annotation if needed in order to be understood.

A. Header

Blanks A-C, the header of the notice, must be completed by the notifier prior to delivering the ABN.

Blank (A) Notifier(s): Notifiers must place their name, address, and telephone number (including TTY number when needed) at the top of the notice. This information may be incorporated into a notifier's logo at the top of the notice by typing, hand-writing, pre-printing, using a label or other means.

If the billing and notifying entities are not the same, the name of more than one entity may be given in the Header as long as it is specified in the Additional Information (H) section who should be contacted for questions.

Blank (B) Patient Name: Notifiers must enter the first and last name of the beneficiary receiving the notice, and a middle initial should also be used if there is one on the beneficiary's Medicare (HICN) card. The ABN will not be invalidated by a misspelling or missing initial, as long as the beneficiary or representative recognizes the name listed on the notice as that of the beneficiary.

Blank (C) Identification Number: Use of this field is optional. Notifiers may enter an identification number for the beneficiary that helps to link the notice with a related claim. The absence of an identification number does not invalidate the ABN. An internal filing number created by the notifier, such as a medical record number, may be used. Medicare numbers (HICNs) or Social Security numbers **must not** appear on the notice.

B. Body

Blank (D): The following descriptors may be used in the header of Blank (D):

- Item
- Service
- Laboratory test
- Test
- Procedure
- Care
- Equipment

- The notifier must list the specific items or services believed to be noncovered under the header of Blank (D).
- In the case of partial denials, notifiers must list in Blank (D) the excess component(s) of the item or service for which denial is expected.
- For repetitive or continuous noncovered care, notifiers must specify the frequency and/or duration of the item or service. See § 50.14.3 for additional information.
- General descriptions of specifically grouped supplies are permitted. For example, "wound care supplies" would be a sufficient description of a group of items used to provide this care. An itemized list of each supply is generally not required.
- When a reduction in service occurs**,** notifiers must provide enough additional information so that the beneficiary understands the nature of the reduction. For example, entering "wound care supplies decreased from weekly to monthly" would be appropriate to describe a decrease in frequency for this category of supplies; just writing "wound care supplies decreased" is insufficient.

Blank (E) Reason Medicare May Not Pay: In this blank, notifiers must explain, in beneficiary friendly language, why they believe the items or services described in Blank (D) may not be covered by Medicare. Three commonly used reasons for noncoverage are:

- "Medicare does not pay for this test for your condition."
- "Medicare does not pay for this test as often as this (denied as too frequent)."
- "Medicare does not pay for experimental or research use tests."

To be a valid ABN, there must be at least one reason applicable to each item or service listed in Blank (D). The same reason for noncoverage may be applied to multiple items in Blank (D).

Blank (F) Estimated Cost: Notifiers must complete Blank (F) to ensure the beneficiary has all available information to make an informed decision about whether or not to obtain potentially noncovered services.

Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed in Blank (D). In general, we would expect that the estimate should be within $100 or 25% of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted. Thus, examples of acceptable estimates would include, but not be limited to, the following:

<u>For a service that costs $250</u>:

- Any dollar estimate equal to or greater than $150
- "Between $150-300"
- "No more than $500"

<u>For a service that costs $500:</u>

- Any dollar estimate equal to or greater than $375
- "Between $400-600"
- "No more than $700"

Multiple items or services that are routinely grouped can be bundled into a single cost estimate. For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). Average daily cost estimates are also permissible for long term or complex projections. As noted above, providers may also pre-print a menu of items or services in Blank (D) and include a cost estimate alongside each item or service. If a situation involves the possibility of additional tests or procedures (such as in reflex testing), and the costs associated with such tests cannot be reasonably estimated by the notifier at the time of ABN delivery, the notifier may enter the initial cost estimate and indicate the possibility of further testing. Finally, if for some reason the notifier is unable to provide a good faith estimate of projected costs at the time of ABN delivery, the notifier may indicate in the cost estimate area that no cost estimate is available. We would not expect either of these last two scenarios to be routine or frequent practices, but the beneficiary would have the option of signing the ABN and accepting liability in these situations.

CMS will work with its contractors to ensure consistency when evaluating cost estimates and determining validity of the ABN in general. In addition, contractors will provide ongoing education to notifiers as needed to ensure proper notice delivery. Notifiers should contact the appropriate CMS regional office if they believe that a contractor inappropriately invalidated an ABN.

C. Options

Blank (G) Options: Blank (G) contains the following three options:

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

This option allows the beneficiary to receive the items and/or services at issue and requires the notifier to submit a claim to Medicare. This will result in a payment decision that can be appealed. *See Ch. 30, §50.14.1 of the online Medicare Claims Processing Manual for instructions on the notifier's obligation to bill Medicare.*

Note: Beneficiaries who need to obtain an official Medicare decision in order to file a claim with a secondary insurance should choose Option 1.

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

This option allows the beneficiary to receive the noncovered items and/or services and pay for them out of pocket. No claim will be filed and Medicare will not be billed. Thus, there are no appeal rights associated with this option.

☐ **OPTION 3.** I don't want the (D) ___________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

This option means the beneficiary does not want the care in question. By checking this box, the beneficiary understands that no additional care will be provided and thus, there are no appeal rights associated with this option.

The beneficiary or his or her representative must choose only one of the three options listed in Blank (G). Under no circumstances can the notifier decide for the beneficiary which of the 3 checkboxes to select. Pre-selection of an option by the notifier invalidates the notice. However, at the beneficiary's request, notifiers may enter the beneficiary's selection if he or

she is physically unable to do so. In such cases, notifiers must annotate the notice accordingly.

If there are multiple items or services listed in Blank (D) and the beneficiary wants to receive some, but not all of the items or services, the notifier can accommodate this request by using more than one ABN. The notifier can furnish an additional ABN listing the items/services the beneficiary wishes to receive with the corresponding option.

If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: “beneficiary refused to choose an option”.

D. Additional Information

Blank (H) Additional Information: Notifiers may use this space to provide additional clarification that they believe will be of use to beneficiaries. For example, notifiers may use this space to include:

- A statement advising the beneficiary to notify his or her provider about certain tests that were ordered, but not received;
- Information on other insurance coverage for beneficiaries, such as a Medigap policy, if applicable ;
- An additional dated witness signature; or
- Other necessary annotations.

Annotations will be assumed to have been made on the same date as that appearing in Blank J, accompanying the signature. If annotations are made on different dates, those dates should be part of the annotations.

E. Signature Box

Once the beneficiary reviews and understands the information contained in the ABN, the Signature Box is to be completed by the beneficiary (or representative). This box cannot be completed in advance of the rest of the notice.

Blank (I) Signature: The beneficiary (or representative) must sign the notice to indicate that he or she has received the notice and understands its contents. If a representative signs on behalf of a beneficiary, he or she should write out “representative” in parentheses after his or her signature. The representative’s name should be clearly legible or noted in print.

Blank (J) Date: The beneficiary (or representative) must write the date he or she signed the ABN. If the beneficiary has physical difficulty with writing and requests assistance in completing this blank, the date may be inserted by the notifier.

Disclosure Statement: The disclosure statement in the footer of the notice is required to be included on the document.

CPT and ICD9 Codes

CPT codes (Current Procedural Terminology) are services and procedures performed by physicians which are described on claim forms by the use of CPT codes. The CPT codes are identifying the service you performed. The following is a list of the current most common CPT codes used by chiropractors:

Office Visit Codes - Evaluation and Management

New Patient

99201	minor severity, usually 10 minutes face to face
99202	low to moderate severity, usually 20 minutes face to face
99203	moderate severity, usually 30 minutes face to face
99204	moderate to high severity, usually 45 minutes face to face
99205	moderate to high severity, usually 60 minutes face to face

Established Patient

99211	minor severity, usually 10 minutes face to face
99212	low to moderate severity, usually 20 minutes face to face
99213	moderate severity, usually 30 minutes face to face
99214	moderate to high severity, usually 45 minutes face to face
99215	moderate to high severity, usually 60 minutes face to face

Manipulation Codes

98940	Chiropractic manipulative treatment, spinal, 1-2 regions
98941	spinal, 3-4 regions
98942	spinal, five regions
98943	extraspinal, one or more regions

Modalities

97010	hot or cold packs, to one or more areas
97012	traction, mechanical
97014	electrical stimulation unattended (some companies do not use this code, Medicare for example requires that you bill electrical stimulation using G0283, other companies are now also using the G0283 code)
97032	electrical stimulation manual, each 15 minutes
97140	manual therapy techniques, one or more regions, each 15 minutes
97535	Self-care/home management training, each 15 minutes

If a cpt code indicates that it is used to report each 15 minutes then you would indicate the time spent with the units. For example, if you did a spinal manipulation of 3 regions of the spine along with 10 minutes of unattended electrical stimulation and 20 minutes of manual therapy (trigger point therapy can be billed under this code) then you would bill the following:

CPT Code	Units
98941	1
97014	1
97140	2

So if you charge $20 per 15 minutes of manual therapy, you would charge $40 for the 20 minutes in the example above.

Not all insurance carriers reimburse chiropractors for all codes. For example, our local BCBS only allows chiropractors a global fee of $30 per visit. No matter what charges you bill out, they only allow the $30 per visit.

Medicare will only reimburse chiropractors for manipulation codes, 98940-98942. Medicare also only reimburses the manipulation codes when the AT modifier is used. The AT modifier stands for Acute Treatment.

Workers' comp and no-fault only will reimburse chiropractors for 99203 for an initial evaluation and 99213 for subsequent visits. They also allow a chiropractor to bill for a reevaluation using CPT code 99214 every 8 weeks.

I have also seen some workers' comp and no-faults allow a chiropractor to bill using a consultation code (99241-99245). These codes would only be used if the patient were referred to you by another provider for a consultation or second opinion. For example, if a patient's primary care physician wants to see if the patient's condition can be helped by chiropractic treatment prior to trying something more involved like surgery. They will refer the patient for a consultation. The chiropractor will do an examination, and review any x-rays and/or medical records sent over by the primary care doctor. The advantage to billing these out using the consultation codes of 99241-99245 is that the allowed amount for these codes is much higher than the 99203 code.

Other insurance carriers will reimburse for office visits, manipulations and modalities. If you want to be reimbursed for all of your work then you will need to bill all CPT codes.

If you are going to bill for modalities, you should bill for them across the board, meaning to all insurance carriers. You can't bill out modalities only to the insurance carriers that will reimburse for them and not to the ones that don't. That is considered illegal in most states because you are charging the patient based on their insurance coverage.

The only exception to this is workers' comp and no-fault. Claims to workers' comp and no-fault should only be billed using the appropriate workers' comp and no-fault codes.

ICD9 Codes are the diagnosis codes used to determine the diagnosis of the patient. Both ICD9 codes and CPT codes are updated every year and sometimes change. The following are a list of diagnosis codes that are ***commonly*** used by chiropractors for the first quarter of 2008. There are many more diagnosis codes than these that can be used, but these are the most common. You may find that you want to purchase a current ICD9 Code book to have a more complete list of diagnosis.

There are online sites that keep the diagnosis codes updated. We recommend that you check the code on a current website to make sure no changes were made to the code you are using.

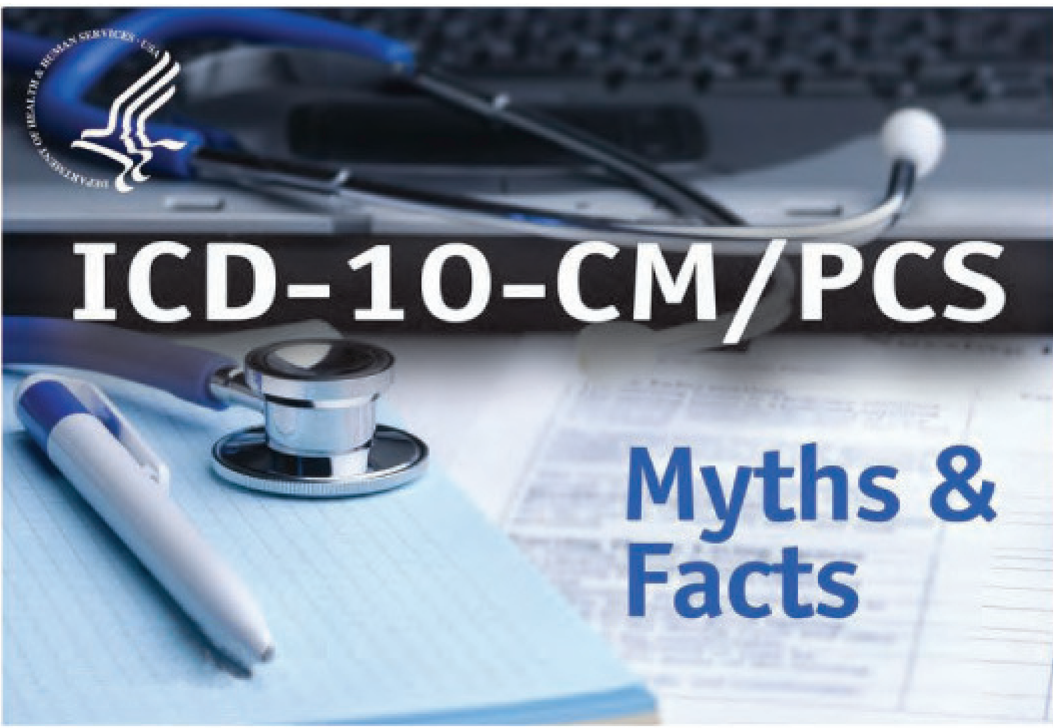
Online Site:

http://icd9coding.com/

If this site is not available you should google 'free online icd9 codes'.

When choosing a diagnosis code, make sure you code it to the highest level of specificity. That means that if there is a fourth or fifth digit for the code that you are using, you must use it. For example, degeneration of thoracic or lumbar intervertebral disc, 722.5 must have a fifth digit of 1 or 2 to indicate whether it is lumbar or thoracic. 722.51 is degeneration of thoracic intervertebral disc and 722.52 is degeneration of lumbar intervertebral disc. So if you sent in a claim with diagnosis 722.5 it would be denied. You must have the fifth digit. However, low back pain, 724.2 has no fifth digit that applies so you just use four digits.

Following is information on ICD-10. These codes will become effective on or after October 1 2014 and will replace the current ICD-9 codes.



The purpose of this fact sheet is to present correct information in response to some myths regarding the ICD-10-Clinical Modification/Procedure Coding System (ICD-10-CM/PCS).

MYTH

The October 1, 2013 compliance date for implementation of ICD-10-CM/PCS should be considered a flexible date.

FACT

All Health Insurance Portability and Accountability Act (HIPAA) of 1996 covered entities MUST implement the new code sets with dates of service, or date of discharge for inpatients, that occur on or after October 1, 2013.

MYTH

Implementation planning should be undertaken with the assumption that the Department of Health and Human Services (HHS) will grant an extension beyond the October 1, 2013 compliance date.

FACT

HHS has no plans to extend the compliance date for implementation of ICD-10-CM/PCS; therefore, covered entities should plan to complete the steps required in order to implement ICD-10-CM/PCS on October 1, 2013.

MYTH

Noncovered entities, which are not covered by HIPAA such as Workers' Compensation and auto insurance companies, that use ICD-9-CM may choose not to implement ICD-10-CM/PCS.

FACT

Because ICD-9-CM will no longer be maintained after ICD-10-CM/PCS is implemented, it is in noncovered entities' best interest to use the new coding system. The increased detail in ICD-10-CM/PCS is of significant value to noncovered entities. The Centers for Medicare & Medicaid Services (CMS) will work with noncovered entities to encourage their use of ICD-10-CM/PCS.

Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

MYTH FACT

State Medicaid Programs will not be required to update their systems in order to utilize ICD-10-CM/PCS codes.

HIPAA requires the development of one official list of national medical code sets. CMS will work with State Medicaid Programs to ensure that ICD-10-CM/PCS is implemented on time.

MYTH FACT

The increased number of codes in ICD-10-CM/PCS will make the new coding system impossible to use.

Just as an increase in the number of words in a dictionary doesn't make it more difficult to use, the greater number of codes in ICD-10-CM/PCS doesn't necessarily make it more complex to use. In fact, the greater number of codes in ICD-10-CM/PCS make it easier to find the right code. In addition, just as it isn't necessary to search the entire list of ICD-9-CM codes for the proper code, it is also not necessary to conduct searches of the entire list of ICD-10-CM/PCS codes. The Alphabetic Index and electronic coding tools will continue to facilitate proper code selection. It is anticipated that the improved structure and specificity of ICD-10-CM/PCS will facilitate the development of increasingly sophisticated electronic coding tools that will assist in faster code selection. Because ICD-10-CM/PCS is much more specific, is more clinically accurate, and uses a more logical structure, it is much easier to use than ICD-9-CM. Most physician practices use a relatively small number of diagnosis codes that are generally related to a specific type of specialty.

MYTH FACT

ICD-10-CM/PCS was developed without clinical input.

The development of ICD-10-CM/PCS involved significant clinical input. A number of medical specialty societies contributed to the development of the coding systems.

MYTH FACT

There will be no hard copy ICD-10-CM and ICD-10-PCS code books. When ICD-10-CM/PCS is implemented, all coding will need to be performed electronically.

ICD-10-CM and ICD-10-PCS code books are already available and are a manageable size (one publisher's book is two inches thick). The use of ICD-10-CM/PCS is not predicated on the use of electronic hardware and software.

MYTH

ICD-10-CM/PCS was developed a number of years ago, so it is probably already out of date.

FACT

ICD-10-CM/PCS codes have been updated annually since their original development in order to keep pace with advances in medicine and technology and changes in the health care environment. The coding systems will continue to be updated until such time that a decision is made to “freeze” the code sets prior to implementation. For instance, the health care community may request that ICD-9-CM and ICD-10-CM/PCS codes not be updated on October 1, 2012 and be frozen with the October 1, 2011 updates. If the freeze is approved through formal rulemaking, it would provide a year or more of stability and an opportunity to develop coding products and training materials. ICD-10-CM/PCS could then be updated again on October 1, 2014, after providers have had a year of experience under the new coding system.

MYTH

Unnecessarily detailed medical record documentation will be required when ICD-10-CM/PCS is implemented.

FACT

As with ICD-9-CM, ICD-10-CM/PCS codes should be based on medical record documentation. While documentation supporting accurate and specific codes will result in higher-quality data, nonspecific codes are still available for use when documentation doesn’t support a higher level of specificity. As demonstrated by the American Hospital Association/American Health Information Management Association field testing study, much of the detail contained in ICD-10-CM is already in medical record documentation but is not currently needed for ICD-9-CM coding.

MYTH

Implementation of ICD-10-CM/PCS can wait until after electronic health records and other health care initiatives have been established.

FACT

Implementation of ICD-10-CM/PCS cannot wait for the implementation of other health care initiatives. As management of health information becomes increasingly electronic, the cost of implementing a new coding system will increase due to required systems and applications upgrades.

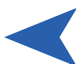
MYTH

ICD-10-CM-based super bills will be too long or too complex to be of much use.

FACT

Practices may continue to create super bills that contain the most common diagnosis codes used in their practice. ICD-10-CM-based super bills will not necessarily be longer or more complex than ICD-9-CM-based super bills. Neither currently-used super bills nor ICD-10-CM-based super bills provide all possible code options for many conditions. The super bill conversion process includes:

- Conducting a review that includes removing rarely used codes; and
- Crosswalking common codes from ICD-9-CM to ICD-10-CM, which can be accomplished by looking up codes in the ICD-10-CM code book or using the General Equivalence Mappings (GEM).



MYTH

The GEMs are intended to facilitate the process of coding medical records.

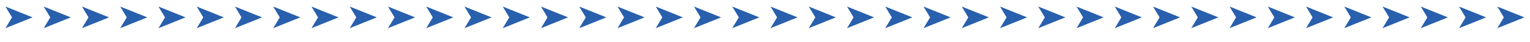
FACT

Mapping is not the same as coding:

- Mapping links concepts in two code sets without consideration of patient medical record information; and
- Coding involves the assignment of the most appropriate code based on medical record documentation and applicable coding rules/guidelines.

The GEMs can be used to convert the following databases from ICD-9-CM to ICD-10-CM/PCS:

- Payment systems;
- Payment and coverage edits;
- Risk adjustment logic;
- Quality measures; and
- A variety of research applications involving trend data.

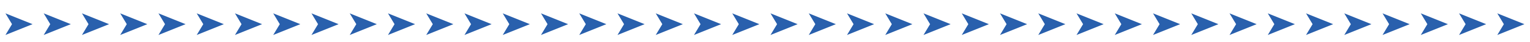


MYTH

Each payer will be required to develop their own mappings between ICD-9-CM and ICD-10-CM/PCS, as the GEMs that have been developed by CMS and the Centers for Disease Control and Prevention (CDC) are for Medicare use only.

FACT

The GEMs are a crosswalk tool developed by CMS and CDC for use by ALL providers, payers, and data users. The mappings are free of charge and are in the public domain.

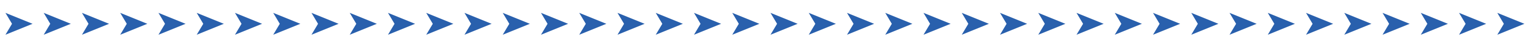


MYTH

Medically unnecessary diagnostic tests will need to be performed in order to assign an ICD-10-CM code.

FACT

As with ICD-9-CM, ICD-10-CM codes are derived from documentation in the medical record. Therefore, if a diagnosis has not yet been established, the condition should be coded to its highest degree of certainty (which may be a sign or symptom) when using both coding systems. In fact, ICD-10-CM contains many more codes for signs and symptoms than ICD-9-CM, and it is better designed for use in ambulatory encounters when definitive diagnoses are often not yet known. Nonspecific codes are still available in ICD-10-CM/PCS for use when more detailed clinical information is not known.



MYTH

Current Procedural Terminology (CPT) will be replaced by ICD-10-PCS.

FACT

ICD-10-PCS will only be used for facility reporting of hospital inpatient procedures and will NOT affect the use of CPT.

To find additional ICD-10-CM/PCS information, including the GEMs and educational resources, visit **http://www.cms.gov/ICD10** on the CMS website.

Using Modifiers To Get Paid For Services

Sometimes it is necessary to use modifiers on insurance claims. Modifiers are 2 digits that are used to further describe a service or procedure. There are not a lot of modifiers that pertain to chiropractic but there are a couple that in some cases can increase the reimbursement by an insurance carrier.

Modifiers go in box 24D on the CMS 1500 claim form, right after the CPT code. There is room for up to 4 modifiers. Usually you will only need to use one, but sometimes there is a need to use multiple modifiers. The following is a list of modifiers that are applicable to chiropractors.

25 - Significant, Separately Identifiable E&M Service by the Same Physician on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E&M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E&M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E&M service to be reported. The E&M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting the E&M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E&M service.

59 - Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E&M services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

52 - Reduced services. Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's direction. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service

MEDICARE MODIFIERS

AT Acute treatment. This modifier should be used when reporting a spinal manipulation service (codes 98940, 98941, and 98942).

GA Waiver of liability statement on file. (Advance Beneficiary Notice (ABN).)

GW Service not related to the hospice patient's terminal condition. (If you see a patient who has hospice but you are treating a different condition you must have this modifier to indicate that to Medicare.)

An example of an appropriate use of the 25 modifier would be if a patient came in and had neck pain, thoracic pain and low back pain. The patient had been being seen for the thoracic and low back pain, but the neck pain is a new complaint. A manipulation is down to 3 areas of the spine, but you also do an exam, 99212 due to the neck pain. You would indicate that this is separate from the 98941 using the 25 modifier. So your claim might look like this:

1 724.23. 3 728.85
2 724.14. 4 723.1

99212 -25 4
98941 12
97140 -59 3

As mentioned in the Medicare chapter, the AT modifier is used to indicate acute treatment.

Modifiers are not as common with chiropractic as they are with other specialties, but they are still needed in certain situations. It is good to know what they stand for and how they should be used.

List of common codes used in Chiropractic (for reference only)

ICD-9 Codes

Symptoms:

723.1	Cervicalgia
724.1	Thoracic Spine Pain
724.2	Lumbalgia
648.70	Pregnancy Backache
724.5	Vertebrogenic Pain Syndrome
726.90	Tendinitis/Capsulitis
727.00	Synovitis/Tenosynovitis
727.3	Bursitis
729.1	Myofascitis of Upper or Extremity Musculature
729.4	Fascitis
728.87	Muscle Weakness
728.85	Muscle Spasm
780.4	Dizziness
438.85	Vertigo
780.4	Dizziness And Giddiness/Light-headedness/Vertigo
780.5	Sleep Disturbance
780.7	Fatigue
787.2	Dysphagia
784.5	Dysarthria/Dysphasia/Slurred speech
784.9	Choking Sensation
784.49	Hoarseness of Speech/Dysphonia/Hypernasality/Hyponasality
787.0	Nausea
782.0	Paresthesia/Tingling/Burning/Prickling
354.8	Nerve Inflammation/Compression (Upper Limb)
443.0	Raynaud's Syndrome
354.4	Causalgia of Upper Limb
355.71	Causalgia of Lower Limb
355.9	Causalgia of (WHATEVER)
780.2	Syncope
726.0	Adhesive Capsulitis of Shoulder
726.11	Calcific Tendinitis of Shoulder
726.12	Bicipital Tenosynovitis
905.6	Late Effects of Subluxation [Late effect of injury classifiable to 830-839]
905.7	Late Effects of Sprain or Strain

The MEDICARE listings for Subluxation (the 739 series):

739.0	Occipital Subluxation
739.1	Cervical Subluxation
739.2	Thoracic Subluxation
739.3	Lumbar Subluxation
739.4	Sacrum or Coccyx Subluxation
739.5	Pelvic (Ilia or SI) Subluxation

Cervical Spine:

839.08	Multiple Cervical Subluxation
722.0	Cervical Disc Disorder w/o Myelopathy
722.71	Cervical Disc Disorder with Myelopathy
723.0	Cervical Spinal Stenosis (usually Disc-related)
729.4	Ligament laxity (observed on flexion/extension films)
723.2	Cervicocranial Syndrome (Barre-Lieou syndrome; Posterior cervical sympathetic syndrome)
723.3	Cervicobrachial Syndrome (diffuse)

723.4	Brachial Neuritis; Cervical Radiculitis; Radicular Syndrome of Upper Extremity
723.5	Torticollis; Contracture of Neck
722.4	Degeneration of Cervical Disc(s)
353.2	Cervical Nerve Root Lesion
724.9	Foraminal Encroachment (Compression) of Nerve Root, Cervical
722.81	Postlaminectomy Syndrome Of Cervical Region
354.1	Median Nerve Neuritis
354.2	Ulnar Nerve Lesion
354.3	Radial Nerve Lesion
719.08	Edema of Cervical Facet Joint
719.48	Arthralgia of Cervical Spine
719.58	Stiffness of Cervical Spine
847.0	Cervical Sprain/Strain
723.2	Cervicocranial Syndrome
351.0	Bell's Palsy
723.8	Occipital Neuralgia
723.3	Cervicobrachial Syndrome
353.0	Thoracic Outlet Syndrome
726.1	Rotator Cuff Syndrome
726.10	Supraspinatus Syndrome
354.0	Carpal Tunnel Syndrome
524.6	TMJ Dysfunction Syndrome
847.0	Acute post-traumatic torticollis

Thoracic Spine:

839.21	Subluxation of the Thoracic Vertebrae
722.11	Thoracic Disc Disorder w/o Myelopathy
722.72	Thoracic Disc Disorder with Myelopathy
722.51	Degeneration of Thoracic Disc(s)
724.9	Foraminal Encroachment (Compression) of Nerve Root, Thoracic
722.82	Postlaminectomy Syndrome Of Thoracic Region
353.3	Thoracic Nerve Root Lesion
724.4	Thoracic Or Lumbosacral Neuritis Or Radiculitis
719.08	Edema of Thoracic Facet Joint
847.1	Thoracic Sprain/Strain
719.48	Arthralgia of Thoracic Spine
719.58	Stiffness of Thoracic Spine

The Lumbar Spine:

839.20	Subluxation of the Lumbar Vertebrae
722.10	Lumbar Disc Disorder w/o Myelopathy
722.73	Lumbar Disc Disorder with Myelopathy
722.52	Degeneration of Lumbar Disc(s)
738.4	Spondylolysis/Spondylolisthesis (Acquired)
756.12	Spondylolysis (Congenital)
756.11	Prespondylolisthesis (Congenital)
724.3	Sciatica; Neuralgia of Sciatic Nerve
724.9	Foraminal Encroachment (Compression) of Nerve Root, Lumbar
722.83	Postlaminectomy Syndrome Of Lumbar Region
724.4	Thoracic Or Lumbosacral Neuritis Or Radiculitis
353.4	Lumbosacral Nerve Root Lesion
719.08	Edema of Lumbar Facet Joint
847.2	Lumbar Sprain/Strain
719.48	Arthralgia of Lumbar Spine
719.58	Stiffness of Lumbar Spine

The Pelvis:

839.42	Subluxation of the Sacroiliac Joint
847.3	Sacroiliac (SI) Sprain/Strain
353.1	Lumbosacral Plexus Lesion
720.2	Sacroilitis
719.08	Edema of Sacroiliac Joint
719.48	Arthralgia of Sacroiliac Joint
719.58	Stiffness of Sacroiliac Joint
839.41	Subluxation of the Coccyx
724.71	Hypermobility Of Coccyx
847.4	Coccyx Sprain/Strain
353.1	Lumbosacral Plexus Lesion

The Peripheral Joint Codes:

831.01	Anterior Subluxation of Humerus
831.02	Posterior Subluxation of Humerus
832.12	Subluxation of Elbow
833.03	Subluxation of Carpal Bone
836.53	Medial Subluxation of Tibia
836.54	Lateral Subluxation of Tibia
838.01	Subluxation of Tarsal Bone

Sprains and Strains of Shoulder and Upper Arm:

840.0	Acromioclavicular (joint) (ligament)
840.1	Coracoclavicular (ligament)
840.2	Coracohumeral (ligament)
840.3	Infraspinatus (muscle) (tendon)
840.4	Rotator cuff (capsule)
840.5	Subscapularis (muscle)
840.6	Supraspinatus (muscle) (tendon)

Various Other Codes:

733.1	Collapsed Vertebra
805.2	Compression Fracture
805.4	Compression Fracture Lumbar
381.00	Acute Nonsuppurative Otitis Media
381.10	Chronic Serous Otitis Media, Simple Or Unspecified
382.00	Acute Suppurative Otitis Media W/O Spontaneous Rupture Of Eardrum
724.9	Ankylosing Sponylitis (Ankylosis of Spine)
736.81	Acquired Unequal Leg Length
755.30	Congenital Unequal Leg Length
781.2	Abnormality of Gait (Ataxic, Paralytic, Spastic, Staggering)
719.7	Difficulty in Walking
781.3	Lack of Coordination
781.9	Abnormal Posture
737.10	Kyphosis (Acquired)
737.20	Lordosis (Acquired)
738.2	Hypolordosis of the Cervical/Lumbar Spine (Acquired)
738.2	Reversal of the Cervical Curve
737.30	Scoliosis (Idiopathic)
715.9	Degenerative Joint Disease (Osteoarthritis)
715.95	Degenerative Joint Disease of the Hip
715.96	Degenerative Joint Disease of the Knee
715.09	Osteoarthrosis of Multiple Sites
716.9	Chronic Arthritis
734	Pes Planus, Acquired
754.61	Pes Planus, Congenital

736.41	Genu Valgus
733.0	Osteoporosis
733.01	Osteoporosis Senile
733.02	Osteoporosis Idiopathic
339.10	Tension-type headache, unspecified
339.11	Episodic tension-type headache
339.12	Chronic tension-type headache
307.81	Tension Headache
784.0	Headache (Facial pain; Pain in head NOS)

CPT Codes

98940	CMT 1-2 Areas
98941	CMT 3-4 Areas
98942	CMT 5 Areas
98943	CMT Extra-Spinal
99201	Initial Exam
99202	Expanded Serv/Exam
99203	Detailed Serv/Exam
99211	Non-Physician Off Visit
99212	Limited Off/Serv Exam
99213	Expanded Serv/Exam
97110	Therapeutic Exercise
92040	Cervical, Spine 2, 3 Views
72050	Cervical XRay Min 4 Views
72052	Cervical XRay 6, 7 Views
72070	Thoracic XRay 2 Views
72100	Lumbar XRay 2 Views
72110	Lumbar XRay 4 Views
97026	Infrared
97014	Unattended Electrical Stimulation
97035	Ultrasound
97140	Myofascial Release/TPT
97112	Neuromuscular Reeducation
97530	Kinetic Therapeutic Activity

Modifiers

21	Prolonged E&M Code
25	Separately Identifiable E&M Service
26	Professional Component
50	Bilateral Procedure
51	Multiple Procedures
52	Reduced Services
59	Distinct Procedural Service
76	Repeat Procedure by Same Physician
77	Repeat Procedure by Another Physician
79	Unrelated Procedure by Same Physician
99	Multiple Modifiers
AT	Medicare Chiropractic Manipulation
GA	Medicare Maintenance Care
GP	Medicare Medical/PT Modalities
GY	Services Not Covered by Medicare
KX	Medicare PT Cap Auto Exception
RR	Rental
TC	Technical Component
RT	Right
LT	Left

Modalities – To bill or not to bill

Most chiropractors do modalities on their patients but only about 50% of them actually bill for them. Some just figure it is part of the treatment, and others figure that if the insurance carriers don't pay for them why bill them. In my opinion it is better to bill for all of the services that are being performed.

It is true; some insurance carriers do not reimburse chiropractors for modalities (i.e. Medicare). But some do. And if you are not billing for them you are just giving the ones that don't more ammunition to support their stance on not paying for them.

If an insurance carrier only allows $30 for a chiropractic visit and most chiropractors only bill that amount out to them, then their stats will show them that they are reimbursing what most DC's are billing. But if you are billing your regular fees and your modality charges, their stats will show them that they are underpaying. Now I'm not going to say that it will make a difference, but I still think it makes a statement.

Also, if you have some carriers that do allow for modalities in addition to the manipulation codes then you are missing out on reimbursement for services that you are performing. You are not supposed to only bill the modalities out to the insurance companies that reimburse for them. You are supposed to bill consistently across the board.

So if you bill modalities to Aetna patients because Aetna pays for them, then you should be billing out modalities to BCBS even though they don't. If you bill out the modalities to an insurance carrier that doesn't allow them then you just adjust that amount off after the explanation of benefits statement is received.

You may be able to increase your reimbursement by $75-$100 per visit and you are giving the service away by not properly billing. Here are some examples:

Example of services with high RVU (Relative Value Units):

- 97110 Therapeutic exercises to develop strength, endurance, range of motion and flexibility – RVU .90
- 97112 Neuromuscular Re-education of movement, balance, kinesthetic sense, and posture – RVU .94
- 97140 Manual therapy as defined by CPT, manual lymphatic drainage – RVU .84
- 97530 Therapeutic activities – RVU .99
- 97760 Orthotic Management/Training – RVU 1.08

These codes are billed per unit. One unit is equivalent to 15 minutes. Be sure that you document the time spent on each serice. You must also use the -59 modifier on some codes (i.e. 97140) when billing these services with a manipulation code (98940-98943).

Now add this to your Manipulation Codes:

- 98940 – RVU .76
- 98941 – RVU 1.06
- 98942 – RVU 1.35
- 98943 – RVU .70

These are RVUs for 2011. Be sure that your fee schedule is appropriate for your geographical region. Having an outdated or inappropriate fee schedule could be costly. To find out RVUs for other services visit:

https://commerce.ama-assn.org/ocm/index.jsp

Practice Management Systems

Many chiropractors make the mistake of selecting software or a practice management system based entirely on price, while others base their decision on the number of "bells and whistles" a system is equipped with. Neither of these scenarios make good sense. Doctors who base their decision on price alone are often left with an out-dated system lacking in the necessary features to properly and efficiently manage their office. Those who base their decision on the number of "bells and whistles" a system is equipped with often pay too much for a system consisting of features they will never use or require. The truth is a balance of the two is ideal. When looking for practice management software, consider these three primary areas price, features and support.

Software Price

The software you choose for your chiropractic office should be reasonably priced and fit within your budget. Just because a vendor is offering a special discount or an attractive leasing plan on their software, doesn't mean that you should purchase it. Practice management systems can range in price from a low of about $500.00 to more than $8,000.00. Many companies also charge additional fees for technical support, updates, upgrades, multi-user access, network-ready versions and other services. Hardware requirements are another area of concern as well. Some vendors may require the purchase of special hardware such as servers, additional monitors, kiosks, Tablet PCs, and so on. This can increase the cost of the software significantly.

Before considering a specific system, you should always consider the TOTAL cost of ownership and not just the price a vendor's sales department quotes you. Always ask what you are getting for your money, especially when it comes to the more expensive systems. Don't be fooled by all the fancy computer jargon. Ask the sales person to explain the features of their software in a verbiage that YOU can understand. Additionally, you ask about any special offers or discounts up front. Many vendors offer discounts on their software to new graduates and doctors who may be just starting out in practice.

Features for YOUR Office

The software you select should provide you with the essential features required to run YOUR office efficiently. At the very least, this should include an appointment scheduler and an integrated billing module with the capability to submit claims electronically. Again, these are the basic and essential features of any chiropractic or medical practice management system. It's important that you select a system with the capability to submit claims electronically.

Other features to consider include automated reporting capabilities for creating notes and reports on the fly. As a doctor, your time should be spent caring for your patients and marketing your practice - not spending countless hours writing notes and reports. The time wasted writing reports could be better utilized caring for your patients, scheduling seminars and screenings to market your practice, and having some free time to just relax and enjoy yourself.

One catch-phrase you've probably been hearing a lot about lately is EMR. EMR stands for electronic medical record. EMRs are capable of converting your paper documents to digital files, and storing and managing them appropriately. Many of the chiropractic software systems on the market today are equipped with EMR capabilities. Imagine never having to retrieve or replace a paper file again. How about never having to buy paper folders again! This saves both time and money and in many cases, pays for itself within the first year or two. Last but not least, the system you select should comply with HIPAA regulations and offer user defined access levels to prevent tampering with records or system settings by a staff member, especially a disgruntled one.

As with price, you should demand that the sales staff explain to you in clear verbiage all the features included in the office software system you are considering purchasing.

Software Support
One of the most important considerations of any software vendor is the level of support they offer their clients. In other words, how well do they back their software after the sale? What good is office software if you can't figure out how to use it or get it to run properly? Most vendors offer a combination of phone and web-based support. Some even offer in-house or off-site training for the doctor and office staff for an additional fee.

Most software companies do charge for support, so expect to pay for it. Some charge by the incident, while others offer an unlimited annual plan that also includes updates and upgrades. The truth is, there are a lot of individuals who are not computer proficient. It takes a considerable amount of time and resources to train these individuals and their staff, and to address questions that may arise along the way. Think of a software support plan as health care insurance. You are required to pay a monthly premium whether or not you utilize the benefits of the plan. Most software support plans will run you between $500 and $800 per year. You will find vendors offering free or low cost options when it comes to support, but in the end, will your expectations be met? Probably not.

It has been our experience to go with a reliable vendor who offers an annual support plan that includes unlimited phone and email support, and all software maintenance including updates and upgrades. Training for staff should also be included in this plan. If you opt out of the vendor's support plan, it will likely cost you more in the end. Remember, your software is the backbone of your office and should remain a priority for you and your staff.

Reading Payment Remittances (EOBs)

You need to become proficient at reading explanation of benefits statements or EOBs in order to make sure you are paid correctly for all your visits. Each insurance carrier will issue a form with their payment or denial of payment explaining how they processed the claim. Each company's statement is different than the next.

The explanation of benefits statements or EOBs will show:

- the patient's name
- the date of the visit, or date of service
- the charge you billed
- the amount the insurance policy allowed
- the amount the insurance policy doesn't allow

- the amount they are paying
- the amount the patient owes
- if the claim is denied, the reason for the denial

You must look them over carefully to make sure that the payment made was what you expected to get when you first determined benefits when you originally called the insurance company. If you don't understand any part of the payment process, you should call the member services department and ask them to explain why the payment is not what you expected.

Be sure to read the 'legend' that is generally located on the very last page of the EOB. This legend will be your guide as to how the claim was processed. Following is a sample of an EOB from Healthsmart.

HealthSmart
SMARTER HEALTHCARE SOLUTIONS

How to Read an Explanation of Benefits (EOB)

Below is a description of your Explanation of Benefits (EOB). The numbers correspond with the numbers on the sample copy of the EOB (see the last page for an example of an EOB).

(1) Claim processing office: This is the location of the claims processing office. You can write to customer service at this location.

(2) Address: The name and address where the EOB is being mailed.

(3) Customer Service: Number to call with questions regarding your claim and the hours for calling.

(4) Claim Number: The unique identification number assigned to this claim. Please refer to this number if you call or write about this claim.

(5) Group Number: The identification number for your Group. Please refer to this number if you call or write about your claim.

(6) Group Name: The name of your Group. (In most cases, this is your employer.)

(7) Location: The number assigned to your location within the Group.

(8) Location Name: The name or description of the location.

(9) Enrollee: Name of the employee.

(10) Enrollee ID: Employee's social security number (last 4 digits only) or identification number. Refer to this ID if you call or write about your claim.

(11) Plan Number: The identification number for your plan of benefits.

(12) Patient: Name of the individual for whom services were rendered or supplies were furnished.

(13) Relationship: Relationship of the patient to the employee.

(14) Patient Acct: Number assigned by the service provider, i.e. doctor's chart number, hospital number.

HealthSmart
SMARTER HEALTHCARE SOLUTIONS

(15) Paid Date: If a check was issued, the date it was issued.

(16) Plan Sponsor: Name of the plan sponsor. (In most cases, this is your employer.)

(17) Provider: The name of the person or organization who rendered the service or provided the supply.

(18) Dates Of Service: The date(s) (Month, Day, Year) on which services were rendered.

(19) Proc Code: The Current Procedural Terminology (CPT) codes listed on the provider's bill.

(20) Charge Amount: The charge for each service as indicated on the bills submitted.

(21) Charges Not Covered: Amount that is not eligible for benefits under the plan, or more information is needed to process the claim.

(22) Reason Code: Code relating to the "Charges Not Covered" amount. Also used to request additional information or provide further explanations of the claim payment.

(23) Provider Discount: Identifies the savings received from a Preferred Provider Organization (PPO). The corresponding reason code will appear in this field. The explanation will appear in the "Checks Issued" box (see #41).

(24) Maximum Benefit: Allowable charges to be considered by your plan after subtracting Charges Not Covered and the Provider Discount from the Charge Amount.

(25) Copay: The amount of charges specified by your plan that you must pay before benefits are paid.

(26) Deductible Amount: The amount of charges that apply to your deductible specified by your plan that you must pay before benefits are payable.

(27) Covered Expenses: Amount of eligible charges to be considered by your plan after subtracting Charges Not Covered, Provider Discounts, Copays and Deductible amounts from the Charge Amount.

(28) Paid At: The percentage that the Covered Expenses will be considered as determined by your plan.

(29) Total Payable Amount: Benefits payable for services provided.

(30) Column Totals: The sum of each column.

(31) Benefit Deductible: The amount that is not eligible for benefits as determined by your plan, such as precertification penalties.

(32) Adjusted Payment / Other Insurance: Represents adjustments based upon the benefits of other health plans or insurance carriers, including Medicare.

(33) Total Paid: The sum of the "Total Amount Payable" column.

(34) You are entitled to a review: Statement explaining your entitlement of a review of the benefit determination on the Explanation of Benefits (EOB).

(35) Reason code: Description for the Reason code (s box 22) will appear in this section.

(36) Satisfied Amounts After This Claim: Dollar amount satisfied for the current year. (Note: If dates of service are in two calendar years, (2007 and 2008) the current year's (2008) amounts is shown.

(37) Payee Name: Individual or organization to whom benefits are paid.

(38) Check Number: The unique number assigned to the check.

(39) Check Amount: Total benefit amount paid on this claim.

(40) Enrollee Responsibility: After all benefits have been calculated, this is the amount of the enrollee's responsibility.

(41) Provider Discount Code: The reason for negotiated savings.

Check Section (Items 42-52)

This section contains the check portion of the EOB. If benefits are assigned, a provider will receive an EOB and check, if applicable. The employee will receive an EOB showing all providers for the claim on one EOB with a non-negotiable check. Much of the information here is a repeat of the descriptions for the EOB.

(42) Group Name: The name of your Group. (In most cases this is your employer.)

(43) Enrollee: Name of the Employee.

(44) Patient: Name of the individual for whom services were rendered or supplies were furnished.

(45) Patient Acct: Number assigned by patient's provider of services.

(46) Group Number: The identification number for your Group. Please refer to this number if you call or write about your claim.

(47) Date: The date the check was issued.

(48) Claim Number: The unique identification number assigned to this claim. Please refer to this number if you call or write about this claim.

(49) Check Number: The unique number assigned to this check.

(50) Check Amount: Total benefit amount paid on this claim.

(51) Pay Exactly: The amount of this check in words.

(52) Pay To The Order Of: Name and address of the person or organization to whom benefits were paid.

(1) P.O. BOX XXXX
XXXX XXXXX

RETURN SERVICE REQUESTED

(2) Dr. Robert Jones
123 Main Street
ANYTOWN, ST 12345-6789

EXPLANATION OF BENEFITS - EOB
THIS IS NOT A BILL

(3) For Customer Service, please call (800) XXX-XXX between the hours of X:XX am and X:XX pm central time

(4)	Claim #:	70577697-01
(5)	Group #:	2000000
(6)	Group Name:	ABC COMPANY
(7)	Location:	003
(8)	Location Name:	HAWARDEN, IA
(9)	Enrollee:	JOSEPH SAMPLE
(10)	Enrollee ID:	*****6789
(11)	Plan #:	08861
(12)	Patient:	JOSEPH SAMPLE
(13)	Relationship:	EMPLOYEE
(14)	Patient Acct:	001234
(15)	Paid Date:	05/23/2007
(16)	Plan Sponsor:	ABC COMPANY

(17) Provider: ROBERT JONES

DATES OF SERVICE FROM THRU	PROC CODE	CHARGE AMOUNT	MINUS CHARGES NOT COVERED	REASON CODE	MINUS PROVIDER DISCOUNT	MAXIMUM BENEFIT	MINUS COPAY	MINUS DEDUCTIBLE AMOUNT	EQUALS COVERED EXPENSES	PAID AT	TOTAL PAYABLE AMOUNT
(18)	(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)	(28)	(29)
04/16-04/16/2007	73620	66.00	0.00		J3 29.94	36.06	0.00	0.00	36.06	80%	28.85
COLUMN TOTALS	(30)	66.00	0.00		29.94	36.06	0.00	0.00	36.06		28.85

Your cooperation is needed to stop fraud! If these services were not rendered, please contact AAG immediately at the number above.

BENEFIT DEDUCTIBLE	(31)	.00
ADJUSTED PAYMENT/ OTHER INSURANCE	(32)	.00
TOTAL PAID	(33)	28.85

DESCRIPTION OF REMARKS/MESSAGES

* (34) You are entitled to a review of this benefit determination if you have questions or do not agree. To obtain a review, submit your request in writing to the office to which you submitted your initial request for benefits. Your request should include your name, Enrollee ID and other identifying information shown above, the issues, and any data, documents and comments you would like to have considered. Written requests for review must be mailed or delivered within the time limit required by your Plan. Please consult your Plan Document for more information about claim review procedures. If a claim is denied, or partially denied, because of lack of medical necessity or an experimental treatment exclusion, internal rules, guidelines, protocol or an explanation of the clinical judgment for determination will be provided without charge, upon request.

(35) When applicable, description of Reason Code appears here.

(36) SATISFIED AMOUNTS AFTER THIS CLAIM

YOU HAVE MET ALL YOUR INDIVIDUAL IN NETWORK DEDUCTIBLE FOR 2007.
YOU HAVE MET $92.96 OF YOUR $1,000.00 INDIVIDUAL IN NETWORK OUT OF POCKET FOR 2007.
YOU HAVE MET ALL OF YOUR FAMILY IN NETWORK DEDUCTIBLE FOR 2007.
YOU HAVE MET $1,092.96 OF YOUR $2,000.00 FAMILY IN NETWORK OUT OF POCKET FOR 2007.

CHECK(S) ISSUED			ENROLLEE
(37) PAYEE NAME	(38) CHECK NUMBER	(39) CHECK AMOUNT	RESPONSIBILITY (40)
DR. ROBERT JONES	00000111	28.85	7.21
(41) J3 PATIENT NOT LIABLE PPO DISCOUNT			

BANK OF AMERICA

NO. 00000111 (49)
32-2/7717 TX

(42)	GROUP NAME:	ABC COMPANY	(46)	GROUP #:	2000000
(43)	ENROLLEE:	JOSEPH SAMPLE	(47)	DATE:	05/23/2007
(44)	PATIENT:	JOSEPH SAMPLE	(48)	CLAIM #:	70577697-01
(45)	PATIENT ACCT:	001234			

(50) $28.85

(51) **PAY EXACTLY** *** TWENTY-EIGHT DOLLARS AND EIGHT-FIVE CENTS

(52) PAY TO THE ORDER OF
DR. ROBERT JONES
123 MAIN STREET
ANYTOWN, ST 12345

Authorized Signature
VOID AFTER 90 DAYS

||00000111|| |071922777| 06080572602||

Insurance Denials

When a claim is denied it must be acted upon as soon as possible to determine where the payment is coming from and what action must be taken to achieve that result. Sometimes the payment is applied to the deductible and you must bill the patient. Sometimes the claim is denied for lack of authorization or referral. At any rate each non payment of a claim requires further action.

Start by looking the denial over carefully. Look for a denial code that may include numbers, letters, or a combination. Now search for the explanation of the denial codes, usually found at the bottom of the remittance. It may not make sense to you, but that does not matter. Right now you just want to know the reason for denying the claim.

Once you determine the insurance company's reason for the denial, you have a better idea what to do. Here is a list of common denials and the process to follow to get the services paid.

If the claim is denied for no authorization or referral first determine if you did have the required authorization or referral. If you did have the required documentation, you need to call member services and explain. If you didn't have it, you still need to call member services.

Sometimes they will still grant you the auth or backdate the referral. You may find that you think an auth or a referral are not required and the claim is then denied. In some cases the claims are denied in error and the auth was not needed. In any case if you call member services you can usually straighten this out.

You may run into a few companies that absolutely will not allow services not properly authorized. That is another reason to call before you treat the patient.

If the claim is denied for member terminated, your patient probably has new insurance and has neglected to tell you. Contact the patient and request the new information. If it is an error and the patient does still have the same insurance, the patient should call the insurance company to straighten this out. If the patient has lost his job and his insurance was cancelled, you'll have to bill the patient.

If the claim was denied for timely filing it must be resubmitted with proof of timely filing. Many companies have a filing deadline for claims. If you originally submitted the claim in a timely fashion, this can be appealed with a patient ledger or an electronic report when you use a practice management system.

If the claim has been denied for an incorrect ID# the ID# must be corrected and the claim resubmitted. If you have a photocopy of the ID card, check to see if the ID number was entered incorrectly. You may have to contact the patient or the insurance company. Some insurance companies have websites where you can look up identification numbers.

If the claim was denied for an incorrect diagnosis, look up the diagnosis code and see if it requires a fourth or fifth digit. Once corrected, resubmit the claim with a note "corrected claim" handwritten on the front of the claim form.

It is very unusual, but if your claim is denied for the procedure code check to see what you have for a procedure code. Maybe there was a typo, but with the few codes used for chiropractic billing denial for procedure code is very uncommon. If you are using a practice management system, make sure the procedure codes were entered into the computer correctly and are printing correctly on the claims.

If the claim is denied because the patient has maxed his or her benefits, the patient is then liable for payment of the services. When you first started seeing the patient and checked benefits you would have learned how many visits were allowed before the insurance would no longer pay. If the claim is not denied but applied to the deductible and no payment made to you, the charge is then billed to the patient.

If you must call the insurance company to resolve the problem, calmly explain the situation to the customer service representative. These representatives have to deal with calls like this all day, so it is much better to treat them respectfully. Remember, if a mistake was made, it wasn't necessarily this person who made it: they are going to correct it for you. Be nice.

If your claim has been denied and you understand the reason, but disagree, call the insurance company. Explain why you disagree to the representative and ask what it will take to get this claim paid.

If the denial is for a reason which can be remedied, ask the representative exactly what you must do to correct the situation. Sometimes it is necessary to resubmit the claim.

It is very common for an insurance company to deny a claim incorrectly or because there was not enough information on the claim form. If they have denied the claim incorrectly, many times the representative can fix the problem while you are on the phone.

If the claims were submitted with all the required information as instructed in the CMS 1500 instructions they will not be denied for lack of information.

Some companies allow you to request adjustments on the internet via their website. Many companies have specific adjustment forms that must be used when requesting that a previously processed claim be adjusted.

Make sure you keep good notes of everyone you talk to or write concerning the problem when you do have to call an insurance company. This can be the key to getting your claim paid.

The bottom line is that if a medical insurance claim is denied, it does not necessarily mean that the insurance company won't pay. It may involve following the proper procedures to get a desirable end result.

Insurance Appeals

When an insurance claim has been denied and can no longer be corrected by resubmitting a corrected claim, you may have to file an insurance appeal. This does not have to be a complicated process.

Each company may have different requirements for filing an appeal. Usually the instructions for an appeal are indicated on the denial. Some appeals can be initiated with a phone call and others require a written request.

When submitting a written request, we attach the claim to a letter of appeal and send it to the appropriate address which may be different than the one the claim is filed to. You may have to call the insurance carrier's member services to get the address for the appeal letter.

Whether filing an appeal by phone or in writing, clearly state your reason for disagreeing with the denial. Don't hesitate to file an appeal if necessary. A large percentage of claims are paid after an appeal.

KMK Consultants offers an appeal workbook. Each appeal letter is a fully customizable, copyright-free Microsoft Word template that you can modify with a few clicks.

To order: http://www.thechirobuzz.com/store-2/download-product/appeals-solution

Perfecting Your Billing System

It is no secret, for many chiropractors it has become harder and harder to obtain payment for your care. Because of this, your practice budget can become constricted and the dollars available to you to provide services is shrinking. In order to sustain your practice, you must learn how to obtain reimbursement for the care you provide. Effective insurance collection procedures are the lifeblood of your practice. A well-run insurance department will support your cash flow and ensure your profitability. This section includes a step-by-step procedure for creating a successful insurance department. When systems are in place and it's running smoothly stress is decreased throughout the practice. Without a system, chaos will reign and accountability is non-existent.

Let's Start at the Very Beginning…

- To implement this system, we'll take the step by step approach:
- Insurance Verification
- Billing
- Accounts Receivable Aging follow
- Tickler Follow Up Systems
- Tying it all together with a schedule.
- Doctor's responsibility to know what's going on!

Step One: Verification

- The first step of the insurance process is insurance verification.
- Every type of insurance must be verified…health, PI, WC, Medicare.
- Always copy the front and back of the patient's insurance card on the first visit.

Personal Injury Verification

- Any auto case should also be verified for Med-Pay/PIP/No-Fault.
- Make sure the medical case is open.
- Verify with the attorney that he/she is handling the case and let them know your procedures...DON'T LET THEM DICTATE TO YOU!!

Medicare and Supplement Verification

- Don't think you can skip Medicare!!
- Find out the details of the secondary insurance.
- Assure that your patient hasn't chosen a Medicare 'replacement' plan
- Beat the odds by knowing what your patient's supplemental insurance will support beyond Medicare.

Worker's Compensation Verification and Authorization

- Worker's Compensation insurance is verified with the employer.
- Get authorization to treat.
- Use your state specific requirements as well.
- Don't send bills to employer whenever possible...you're in control!

Step Two: Billing

- We've all heard the saying...Garbage in-Garbage Out. (GIGO)
- Same applies to billing…in order to get paid quickly and accurately, you must bill precisely.
- This includes proper modifiers, diagnosis codes, CPT codes, attachments, and CMS-1500 form filled out properly.

Proper Billing Techniques

- Send claims at least once a week.
- All practices must bill according to provider. (DC/PT/MD)
- Make sure any attachments that are required go with the bills.

Scrutinize…then scrutinize again!!

- The secret is in the review!!
- No bills should ever go out without a careful review.
- This one step, which should not take longer than 15-20 minutes per week, will do more to improve your bottom line than anything else.

Make your list and check it twice!!

- Carefully review the following on the CMS-1500 form:
- Diagnosis codes listed in proper hierarchy (or as required by Medicare on Medicare claims)
- Diagnosis codes properly linked to CPT codes in Box 24E where appropriate
- CPT codes properly modified where appropriate
- Proper provider listed in Box 31
- All appropriate boxes filled in with no blanks

Step Three: AR Aging and Follow Up

AR Aging and Follow Up

- This is, by far, the single step that most practices miss the most is Accounts Receivable Aging and Follow Up!!
- Without a set procedure and system for this step, your accounts receivable will be in shambles and your cash flow will be erratic.

A Word About EOBs

- The most ineffective way to run your Insurance Department is to only respond to those requests for information generated by the Explanations of Benefits (EOBs) sent by an insurance carrier.
- Without making pro-active calls to insurance carriers, you are assuming that when you send an insurance claim form into an insurance company that they are anxious to pay your claims.
- The fact is that many insurance claims reviewers are motivated to find a reason not to pay your claims!

Be Proactive!

- When making accounts receivable calls, you must be proactive!
- “Hello. This is Diane calling from Dr. XYZ’s office. I am calling to check on the status of the claim … and to find out when the payment check will be cut.”
- This is where the fun starts.
- He who has the most information wins!

Breakdown Accounts Receivable By Payor Class

- Print out your accounts receivable (AR) on a monthly basis. Make it consistent!!
- Have your computer break down the various cases by payor class.
- In other words, print of all of your Medicare patients together on the same sheet; print of all of your Workers’ Compensation on another; another with all of your personal injuries; another with all of the major med insurance; one with HMO’s, and another with all of the cash accounts receivable.

List Payor Classes In Descending Dollar Order

- Have each payor class on the list sorted in descending order, with the largest dollar amount at the top of that list and the smallest dollar amount at the bottom of the list.
- You would rather not have your insurance staff pursue a $200.00 claim when there is a $2,000.00 claim waiting to be collected.
- It is also helpful to sort the AR list by insurance carrier. This way, when you contact an insurance carrier, you can address all of the outstanding claims to that carrier at the same time.

Three-Ring Color-Coded Binders

- Purchase a series of three-ring binders at your local office supply store.
- Color-code the three-ring binders so that each payor class has its own colored binder. For example, green for cash, blue for Medicare, orange for health insurance, red for workers’ comp, and black for personal injury.

• There is no secret to the colors selected, simply choose a variety of colors based upon what is available from your supplier.

Two Kinds of Calls

• Proactive calls that are generated by your aging report. You're not sure why it's not paid….you just know it isn't paid!

• Reactive calls generated by receiving a denial, a check in the wrong amount, or a request you don't understand.

Sort and Categorize

• Have a separate location where you keep those things needing reactive calls.

• Build time into the schedule each week for those calls.

• Don't stop what you're doing to handle them!! Times-a-wastin!!

The Trouble Shooting Log

• A "Trouble Shooting Log" is a form that enables you and your Insurance Department to track the action steps that are being taken in the collections process.

• When making calls, it's most inefficient to stop what you're doing every time you have to resubmit, send notes, etc.

• List these requests on a troubleshooting log to be handled later in the day away from "prime time" calling time!!

Black Check Mark = Status Quo

• When working through the aging report, if everything is status quo on a particular claim – this means that payment is pending and has been confirmed with the insurance carrier - make a black checkmark in the right hand margin of the insurance printout.

• A black check mark indicates that everything is status quo with the claim and that no further action is required.

• Make sure you are listing your conversation notes in your computer or in the file to refer to them later.

Status Quo – Not!

• If everything is not status quo with the claim, then the Rainmaker should record the comments on the Trouble Shooting Log and in the conversation notes in the file or the patients account.

• For example: "1/4-1/9/03, Mary Smith, Acct # 202, mail office notes and treatment plan to Fred Jones".

• The Trouble Shooting Log is reviewed later and the action steps that have been requested are completed. For example, go to the patient's file, photocopy the office notes, attach the treatment plan, and send into Mr. Jones

• Don't forget to log it in the account and the notes when completed.

Follow up!

- Without follow-up, all your efforts up to now are a moot point!
- You must have some type of a follow up system...either electronic or paper.
- Just because someone says a check will be here in 10 days, you can't bank on that!! You must follow up and hold them accountable.

Paper/Card File

- Get pressboard dividers 1-31 to represent days of the month.
- When someone says they will pay by a certain date, put a card in to remind you to make sure the check arrived.
- If you need a reminder to call a patient, an attorney, or an adjuster, make the reminder card in this system.

Write brief details on the card…

- Your detailed notes go in your patient's account or file.
- Write brief notes on the index card to remind you that follow up is necessary.
- Then, check it daily!

Electronic Follow Up

- Electronic follow up can be done with a calendar program like Outlook.
- List the items needed on each date.
- Check or print it out daily.
- Move unfinished items to the next date.

Step Four: Tie it all together with a schedule

- You must allot a proper amount of time to each duty with none being shortchanged.
- It's too easy to get overwhelmed and let things slip through the cracks.

The 2 Role Insurance Department

- We recommend that a practice generating over $50,000 per month in collections divide the labor of the Insurance Department into two roles.
- In practices generating less than this amount, one team member may perform both roles.

Role 1: The Rainmaker

- The first position is called the "Rainmaker".
- This team member's job description is to perform the pro-active, follow up calls to insurance carriers.
- Unfortunately, this is a step that many practices do not have in place resulting in tremendous inefficiency.

Role 2: The Paper Pusher

- The second position in the well-run Insurance Department is called the "Paper Pusher".
- The Paper Pusher is the person who gathers the information, office notes, treatment plans, etc., that the Rainmaker requests.

How many CA's does it take…?

- Whether your practice devotes one, two, or even a part time worker to the insurance area, you must have dedicated time for each and every duty in the department.

Step Five: Doctor's Monthly Review

- At the end of each month, without exception – there are no excuses – the doctor should receive all of the color-coded, three-ring binders, with the Trouble Shooting Logs completed for that month.

Canvas Tote Bag

- A canvas tote bag is a handy way to collect and transport the binders.
- Hang it on the back of a doorknob in your private office and have your insurance staff tuck the colored binders in it at the end of the month.
- Take the bag home with you to review at the end of the month.
- This is a procedure that doctors should not delegate! It should take you no more than an hour to review all of the binders at home.

Look For Patterns

- Review the work that was done. As the doctor, you will be able to recognize patterns of reimbursement or denial, which may be difficult for your insurance staff to pick up.
- For example, you might catch it when all of a sudden a certain insurance carrier stops accepting a particular code. Now you can be proactive in your insurance collections.
- The doctor should make any notations or comments on the Trouble Shooting Logs and the insurance printouts in red pen to easily catch the attention of the Insurance Department's team members.

Reimbursement Chess

- Insurance reimbursement is essentially a game of chess, and staying several move ahead in the game is essential.
- The only difference between insurance reimbursement and chess is that the rules of chess don't change and that the rules of reimbursement change every time you master them!
- These procedures enable you to see reimbursement patterns develop and to stay a step ahead in the game.

Monthly Baseline Comparison

• At the end of the next month, the Paper Pusher prints the accounts receivable by payor class and places them in the color-coded insurance binders on top of the previous month's printout and Trouble Shooting Log. By comparing this printout to the baseline established by the previous month's printout, you can readily determine if the accounts receivable for a particular payor class have gone up or down.

Monitor Your AR

- If all of a sudden you see that last month you had $28,000.00 outstanding in Medicare, and that this month you have $35,000.00, it alerts you to look at Medicare.
- It doesn't necessarily mean that your insurance procedure has broken down.
- You may all of a sudden have had a large influx of Medicare patients that has temporarily inflated your Medicare accounts receivable.
- However, it could also mean that there was a breakdown in your in-office insurance procedures, or that there was a breakdown on the part of the insurance carrier.

Watch For Trends

- By monitoring the fluctuation of the accounts receivable by payor class on a monthly basis you will know where to focus your energy and efforts.
- What you desire to see is that the accounts receivable for a particular payor class is stable or trending downward.
- You don't want your accounts receivable to trend sharply upward. This will occur only when your practice is experiencing rapid growth, because you are rendering a quantity of services that is greater than you have in the past and it takes time for those claims to be processed.

Quality Control

- This procedure provides you with a quality control feedback mechanism for the performance of your Insurance Department.
- If your review of the Trouble Shooting Logs reveals requests that were not fulfilled, or you see a patient's account consistently appearing on the insurance printouts without change, you will know that someone has dropped the ball.
- You can instantly go to that team member and correct the situation.