Steps to Modernizing Compliance, Billing, and Patient Treatment

Mind expansion in process...

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Certified Professional Compliance Officer
www.Askmario.com

1

1

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2

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3

3

About Dr. Mario Fucinari, DC, CPCO, CPPM, CIC

- President, Ask Mario DC Consultants, LLC
- Certified Professional Compliance Officer (CPCO)
- Certified Physician Practice Manager (CPPM)
- Certified Insurance Consultant (CIC)
- Post-Graduate Faculty, Palmer College of Chiropractic, Logan College, Northeast College of Health Sciences (NYCC), Life West, NUHS, D'Youville College, Logan College, and Northwestern Chiropractic College
- Member, Medicare Carrier Advisory Committee
- National Speaker's Bureau for NCMIC, CHUSA and Foot Levelers
- Past Recipient Chiropractor of the Year

4

4

- Follow Dr. Fucinari on facebook for the latest in compliance, coding and Medicare.
- Be a friend. "Like" us at **facebook.com/askmario**
- Put us in your notifications

Ask Mario

FOOT LEVELERS

5

5

FOOT LEVELERS

6

Standard of Care

"The type and level of care an ordinary, prudent, health care professional, with the same training and experience, would provide under similar circumstances in the same community."

7

7

STANDARD OF CARE

STANDARD OF CARE APPLIES TO *ALL* PATIENTS – EVEN CASH

8

8

Required Compliance Documents

- **Corporate Compliance Manual**
  - Policies and Procedures
  - Non-Retaliation Policy
  - Non-Harassment Policy
  - Staff Training Required
- **HIPAA Manual**
  - Privacy Policy
  - Business Associate Agreement
  - Staff Training Required

LIVING DOCUMENTS
www.AskMario.com

9

9

OIG GUIDELINES

Seven Elements of Your Compliance Program

1. Designate a compliance officer;
2. Implement Written Policies and Procedures;
3. Conduct comprehensive training and education;
4. Develop accessible lines of communication;
5. Conduct internal monitoring and auditing;
6. Enforcing standards through well publicized disciplinary guidelines; and
7. Responding promptly to detected offenses and undertaking corrective actions.

10

10

Auditing and Monitoring

1. Auditing
   a) Implement risk evaluation and auditing techniques
   b) Best if done by an outside entity so as not to be biased
   c) Must be independent and objective
2. Monitoring
   a) Based on assessment of risk
   b) Used as a management tool
   c) Day-to-day activities within the office
   d) Scalable to the risks and resources

11

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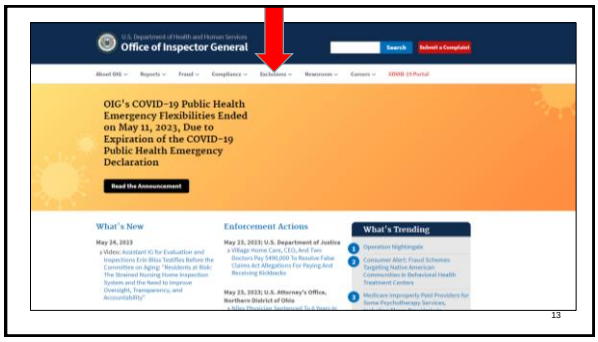
OIG GUIDELINES

The Eighth Element added is that all employees must be checked against the OIG Exclusion Database

12

12



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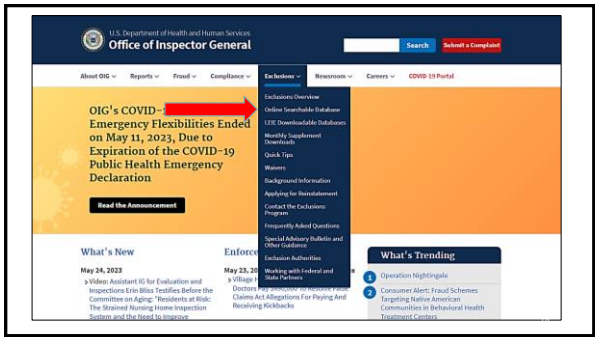

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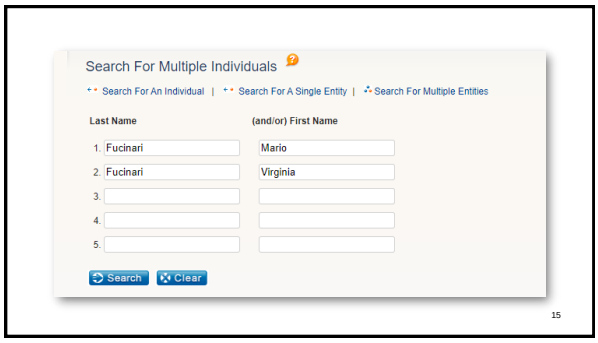

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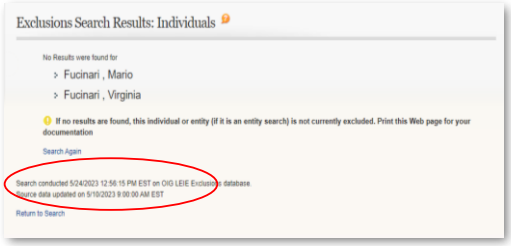

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16

HIPAA Rules

- Congress gave us the law
- HHS gave us Privacy Rules (April 15, 2003) and Security Rules (April 20, 2005).
- **Establish officers in your office:**
  - **Privacy Officer**
  - **Security Officer**
  - **Complaint Officer**

17

17

Compliance Training

- ***ALL*** members of your office are to be trained on the HIPAA, Corporate Compliance, and Cures Act compliance rules.
- This includes admin, doctor(s), staff, volunteers and others who come in contact with patient information
- If you hire someone new, then they must be trained within a *reasonable* time after being hired.

18

18

Compliance Training

Required Compliance Training Documentation:

- Training source
- Date of training
- Notes of training
- Attendees' names must be filed with the Compliance Officer and in the employment file for each person.
- Document your policies and procedures.
  - Customize your policies and procedures
  - Be specific in documentation of the policy and the procedure

19

19

HIPAA – Privacy Policy- General Rule (164.502)

A covered entity may not **use** or **disclose** protected health information except as permitted or required by this subpart or by subpart C of part 160 of this subchapter.

20

20

Uses and Disclosures (160.103)

- **Uses** – information shared within the covered entity.
- **Disclosures** – sending information outside of the entity
- A covered entity may use/disclose PHI to carry out essential health care functions for TPO
  - **T**reatment
  - **P**ayment
  - Health Care **O**perations

21

21

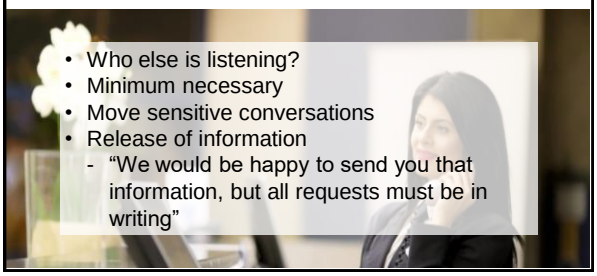
Patient Sign-in Process

- Confidentiality is key.
- HIPAA concerns
- Are Sign-in Sheets confidential?
- Do you mark through the name with a dark marker?
- Do you use a label?
- Electronic sign-in?
- Assign patient a number and call them back by number?

22

22

HIPAA Telephone Considerations



- Who else is listening?
- Minimum necessary
- Move sensitive conversations
- Release of information
  - "We would be happy to send you that information, but all requests must be in writing"

23

Office Photography

Formulate a policy to *not* allow photography in the office

24

Patient Photography

- Why?
- In Office Notices
- Marketing
- Children

25

Open Adjusting and The Therapy Bay Requirements

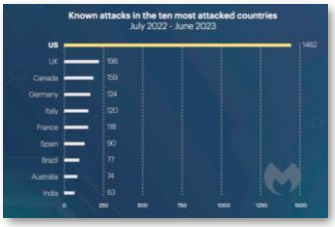
26

27

Ransomware Attacks in 2023

- A new report from the Malwarebytes Threat Intelligence shows 1,900 total ransomware attacks within just four countries—the US, Germany, France, and the UK—in 2023.
- The report shows that the US shouldered a hefty 43 percent of all global attacks.

2023 State if Ransomware, August 2023, Malwarebytes.



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28

Ransomware Risk Analysis

Where is your vulnerability?

- Networks, systems, or applications

Sources of ransomware

- Phishing emails (#1)
- Facebook
- Drive-by downloading – user unknowingly visits an infected website and malware is unknowingly installed

An example of a ransomware attack prompt.

29

29

Ransomware Policies and Procedures:

1. Set your operating system and antivirus software for automatic updates
2. Note, learn and train staff about how Ransomware originates
3. No Facebook on office computers
4. If an incident occurs, immediately disconnect from the network, put your device in airplane mode, turn off wifi and Bluetooth, reboot to safe mode, and alert the clinic director. Scan system for the malware, restore the computer to previous state, then report all incidents to the Curis Compliance Officer
5. Determine how the incident occurred (e.g., tools and attack methods used, vulnerabilities exploited).
6. **Document everything**

30

30

Security Risk Analysis (SRA)

- All HIPAA covered entities and business associates are required to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by their organization.
- Download the HHS SRA Tool to help with this foundational element upon which the security activities necessary to protect ePHI are built.

31

31

Security Risk Analysis (SRA)

- Download the Windows version of the tool at https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool

NEW

Required: The downloadable SRA Tool is a desktop application that walks users through the security risk assessment process using multiple-choice questions, threat and vulnerability assessments, and asset and vendor management. References and additional guidance are given along the way. Reports are available to save and print after the assessment is completed.

32

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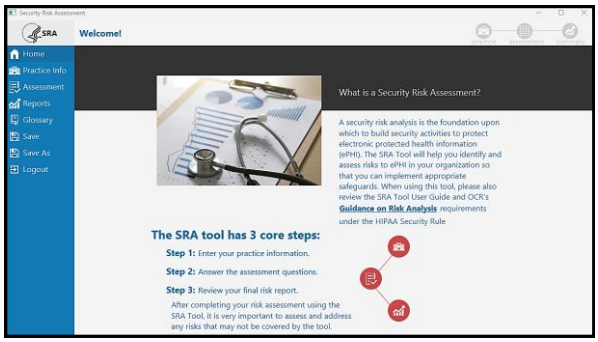

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Discrimination Awareness

34

Section 1557 of PPACA

- Section 1557 is intended to promote equity in health care and prevent discrimination on the basis of **race, color, national origin, religion, sex, age, or disability** in health programs or activities that receive federal financial assistance.
- Compliance requires posting certain notices in your office and there are consequences for failure to do so if you are not exempt.

35

35

Section 1557 of PPACA

Section 1557 Requirements are as follows:

- Having a Section 1557 compliance coordinator;
- Having a Section 1557 grievance process;
- **Posting new notices** - in your building, on your website and in certain publications/communications - on nondiscrimination, available assistance and patient rights;
- **Posting taglines** - in your building, on your website and in certain publications/communications - on the availability of language services in the top 2 non-English languages spoken in your state;
- Treating patients in a manner consistent with their gender identity;
- Not denying care to a patient based on sex, which includes their gender identity and sex stereotyping; and
- Providing equal access to communications and electronic and information technology for individuals with disabilities.

36

36

Discrimination Based on Sex

Section 1557 of the ACA makes it clear that sex discrimination is prohibited. This includes discrimination based on:

- An individual's sex or sexual orientation
- Pregnancy, childbirth and related medical conditions

Protections against Sex Discrimination

- Individuals cannot be denied health care or health coverage based on their sex.
- Women must be treated equally with men in the health care they receive and the insurance they obtain.
- Sex-specific health programs or activities are permissible only if the entity can demonstrate an exceedingly persuasive justification.

37

37

Discrimination Based on Disability

- Section 1557 of the ACA ensures that an individual is not excluded from participating in, denied benefits because of, or subjected to discrimination as prohibited under Section 504 of the Rehabilitation Act of 1973 (disability),

38

38

Discrimination Based on Age

OCR enforces the Age Discrimination Act of 1975 (Age Act), which prohibits discrimination on the basis of age in HHS-funded programs and activities.

- Under the Age Act, recipients may not exclude, deny, or limit services to, or otherwise discriminate against, persons on the basis of age.

39

39

Non-Discrimination Notice

Our office does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, religion, disability, sex, or age in admission to, or receipt of the services and benefits.

40

40

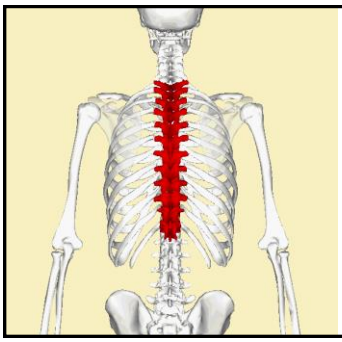
NEW!

www.Askmario.com

REQUIRED CORPORATE COMPLIANCE AND HIPAA MANUAL BUNDLE USE PROMO CODE BUNDLEIT FOR DISCOUNT PRICE ON CHECKOUT

41

41



Just as the spine works in unison to achieve function, so must the office TEAM.

42

42

43

Intake Form Assessment

Date:_____Name:_____

Permanent Address: _____

City:_____State:_____Zip:_____

Phone: Home:_____Cell:_____Work:_____

Birth Date:_____Sex: M F SS#_____E-mail:_____

Marital Status: S M W D # of Children:_____Spouse Name:_____

Your Employer:_____Occupation:_____

How did you find out about our office? _____

(If referred by someone, please give us their name so we can thank them!)

Who is your Primary M.D.?_____Phone # _____

Emergency Contact Name:_____Phone #_____

Please indicate how you would prefer to be reached for appointment reminders:

_____*Text message 1 to 2 days prior to my appointment: Cell phone provider*

_____*Email 1 to 2 days prior to my appointment*

44

44

Intake Form Assessment

Date:_____Name:_____

Permanent Address: _____

City:_____State:_____Zip:_____

Phone: Home:_____Cell:_____Work:_____

Birth Date:_____Sex: M F SS#_____E-mail:_____

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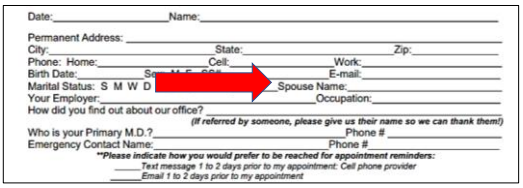
Intake Form Assessment



Date:_____Name:_____

Permanent Address: _____

City:_____State:_____Zip:_____

Phone: Home:_____Cell:_____Work:_____

Birth Date:_____Sex M F GSS_____E-mail:_____

Marital Status: S M W D _____Spouse Name:_____

Your Employer:_____Occupation:_____

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_____Email 1 to 2 days prior to my appointment

46

46

The HIPAA Privacy Notice

HIPPA PRIVACY POLICY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated. If you have further questions, please contact Mario Fuciarati D.C.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results

47

47

Required Elements of the Privacy Notice

b. Header - Must use the specific language in the header as provided by the law.

   "This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully."

c. Uses and Disclosures – Describe all the uses of the information for which you are not required to have an authorization.

48

48

The Provision of the Privacy Notice

- The notice must be posted "**in a prominent location**."
- The notice *must* be posted on your **web site**.
- The covered entity must provide a notice upon the request from *any* person.
- The patient will sign an acknowledgment that they were offered the privacy policy to read.
- If the acknowledgment is not signed, you must document why the acknowledgement was not obtained.

49

49

HIPAA Notice Acknowledgement

HIPAA Acknowledgement of Receipt of Notice of Privacy Practices

This authorization is prepared according to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191, 42 U.S.C. Section 1320d, et. seq. and regulations thereunder, as amended from time to time (collectively referred to as "HIPAA"). This authorization affects your rights in the privacy of your personal healthcare information.

By signing this authorization, you acknowledge and agree that this Chiropractic ("Practice") or its Business Associates may use or disclose your Protective Health Information (PHI) to provide treatment, for purposes of relating to the payment of services rendered, and for the Practice's healthcare operations purposes.

Further, by signing this authorization, you acknowledge that you have been provided a copy of and have read and understood this Chiropractor's Privacy Notice containing a complete description of your rights and the permitted uses and disclosures under HIPAA. While this office has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available and can be received by sending a written request with the return address to the center where you were seen.

By signing below, you are acknowledging that you have received, reviewed, understand and agree to the Notice of Privacy Practices of this Chiropractic office, which describes the Practice's policies and procedures regarding the use and disclosure of any of your Personal Health Information created, received, or maintained by the Practice.

Acknowledged and agreed to by:

50

50

HIPAA COMPLIANCE

- Patient Emergency Contact Information
  - –Update at least annually
- Alternate Contacts?
- Voice Mail Restrictions
- **Permission to Text**
- **HIPAA Privacy Acknowledgement**

51

51

In case of emergency, who may we contact or release information to on your behalf? Do you give permission to the doctor or staff to discuss your medical condition and information about your care with any family members or friends? If yes, please provide names and contact information below.

NAME	RELATIONSHIP	TELEPHONE NUMBER

52

52

HIPAA COMPLIANCE

Security Cameras in the Office

- Security cameras at the front and back entrances are generally acceptable as these are considered public areas. Nonetheless these should be accompanied with a highly visible notice that the areas are being monitored by video surveillance.
- When using security cameras, you must ensure that they don't compromise patients' protected health information (PHI). Keep in mind that PHI not only encompasses information in the clinical records, but also biometric identifiers including voice prints and full-face photographic images.

Source: NCMIC. www.ncmic.com/insurance/malpractice/risk-management/what-dcs-should-know-about-security-cameras-and-hipaa/

53

53

HIPAA COMPLIANCE

Security Cameras in the Office

To mitigate a HIPAA violation or allegation of a PHI breach, make sure not to install the video cameras in private areas (such as exam rooms). Additionally, take care that there is no possibility of the public viewing any recorded information. Create a policy and procedure for your staff regarding the use of, management and disposal of the cameras/recordings. It also can be beneficial to identify:

- Who will have access to the recordings
- How long the recordings will be kept
- Where the recordings will be kept
- How the recordings will be disposed of (disposal must be consistent with disposing other PHI, if present)
- How recordings will be released in the event of a request to prevent the unintentional release of other PHI
- How to prevent hacking
- What encryption is used if video is stored
- When to obtain a business associate agreement If cameras will be monitored by a third party
- What HIPAA training is needed for staff who has access to PHI in the recordings

Source: NCMIC. www.ncmic.com/insurance/malpractice/risk-management/what-dcs-should-know-about-security-cameras-and-hipaa

54

54

Permission to Treat a Minor

CONSENT TO TREATMENT OF MINOR

I(We), the undersigned, parent(s)/person having legal custody/legal guardianship of _____ (name of minor), a minor, do hereby authorize _____ (name of agent) _____ as agent(s) for the undersigned to consent to any x-ray examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

This authorization shall remain effective until _____ (month and day), 20___, unless sooner revoked in writing delivered to the agent(s) noted above.

Date: _____

Signature: _____ (parent/legal guardian/person having legal custody) (circle relationship)

Signature: _____ (parent)

55

55

Financial Policies

OFFICE FINANCIAL POLICY

Our policy is that following a preliminary exam, any services rendered by this office on the initial visit shall be paid for at that time unless other arrangements have been made in writing. Our office is pleased to accept your insurance assignment as soon as the responsible party verifies your exact coverage. However, it must be fully understood that the contract is between you and your insurance company. You are fully responsible for any amounts not paid by your insurance.

Our office policy is as follows:

1. Since we have to await payment by taking your insurance assignment, this courtesy may be withdrawn if warranted.
2. The deductible amount must be paid in full before billing.
3. Insurance payments should be made every 30 days; the maximum time limit we extend is Sixty days, then fees must be paid in full by the patient.
4. You are required to sign an "Authorization to Pay Physician" form and any other documents required by your insurance company.
5. Our office without guarantee that your insurance company will pay. At the beginning of your healthcare, we will make every attempt to receive verification of your policy coverage. However, if your claim is denied for any reason, you are responsible for the total amount due to this office.
6. This office will not enter into a dispute with your insurance company over your claim. It is your responsibility and obligation. We will, however, assist you in any way that we can.
7. You, the patient, must keep current with your insurance co-payment.
8. A 1.5% finance charge will be added to all accounts over 90 days old.
9. If your account is past due, it may be turned over to a collection agency. If our account is not paid in full and this account is turned over to a collection agency and/or attorney, then you agree to be responsible for all reasonable fees necessary for the collection agency fees of 33% of the balance due and costs and reasonable attorney's fees of 33% of the balance.
10. If the insurance company sends you payment for our services, it is your responsibility and obligation to bring to us a payment in full.

I have fully read and agree to this financial policy as written.

Signed: _____

Date: _____

Witness: _____

56

56

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4. You are required to sign an "Authorization to Pay Physician" form and any other documents required by your insurance company.
5. Our office **will not** guarantee that your insurance company will pay. At the beginning of your healthcare, we will make every attempt to receive verification of your policy coverage. However, if your claim is denied for any reason, you are responsible for the total amount due to this office.
6. This office will not enter into a dispute with your insurance company over your claim. It is your responsibility and obligation. We will, however, assist you in any way that **we can.**
7. You, the patient, must keep current with your insurance co-payment.
8. A 1.5% finance charge will be added to all accounts over 90 days old.
9. If your account is past due, it may be turned over to a collection agency. If our account is not paid in full and this account is turned over to a collection agency and/or attorney, thim you agree to be responsible for all reasonable fees necessary for the collection agency fees of 50% of the balance due and costs and reasonable attorney's fees of 33% of the balance.
10. If the insurance company sends you payment for our services, it is your responsibility and obligation to bring to us a payment in full.

58

58

Credit Card Policies

- If your practice collects patient billing information, you are considered a 'merchant' and are subject to federal and state laws and regulations that protect consumer credit card information.
- These laws and regulations include Health Insurance Portability and Accountability Act (HIPAA); Federal Trade Commission Act (FTCA); and Payment Card Industry Data Security Standard (PCI DSS), which was not devised by the federal or state government.
- Health Insurance Portability and Accountability Act (HIPAA) and state privacy laws require providers to implement 'reasonable' security measures to protect payment information.
- Using HIPAA-compliant encrypted storage programs (for electronic storage) are examples of 'reasonable' security measures.

59

59

Credit Card Policies

- Federal law requires all businesses to delete a card's expiration date and shorten the account information to include no more than the last 5 digits of the card number that is printed on all sales receipts.
- FTCA also requires businesses to get prior authorization from individuals before charging their credit cards. For example, if a patient previously used a credit card to pay for a session, the psychiatrist cannot later use the credit card to charge for a missed appointment without notifying the patient and getting their authorization.
- Payment Card Industry Data Security Standard (PCI DSS) applies to entities that store, process, and/or transmit cardholder data. Examples of the PCI DSS rules include using firewalls to protect cardholder data and restricting access to cardholder data to a 'need-to-know' basis. Businesses that do not comply with PCI DSS can be subjected to fines and/or have their contracts terminated by credit card companies.

60

60

61

61

Informed Consent

- **State Controlled. Mich. Admin. Code R. 330.7003**
- Prior to treating a patient, the doctor must provide adequate information concerning the **possible risks, benefits and alternatives** to a particular procedure.
- Doctors must properly and clearly communicate with their patients.
- If called into question, documentation of the communication is vital.
- A general informed consent is recommended.

62

62

Informed Consent

- Describe the procedures to be employed.
- **Disclose the risks of treatment**
  - **Inherent – foreseeable**
- Answer any questions for the patient

63

63

The Informed Consent

From a risk management perspective, there are two important elements in the informed consent process: (1) communication between the physician and the patient, with the physician giving the patient appropriate information so that the patient understands the options for care and can make an informed decision regarding treatment; and (2) appropriate documentation. Informed consent is not just obtaining a signature on a form.

64

64

The Informed Consent

Key Points to Consider:

- All new and existing patients should complete the Informed Consent. Advise all existing patients that you are simply updating their information. (medical history, medications, supplements)
- Standardize your intake process.
- Obtain Informed Consent *before* services are rendered.
- Be open and informative with patients.
- Consult your malpractice carrier and state association.

65

65

The Informed Consent

- A "process" of informing the patient of the risks and benefits of care, so that they may make a decision and control their care.
- Many patients are new to chiropractic.
- Ideally presented over a course of consultation and report of findings.
- it gives you the opportunity to dispel misconceptions
- **Consultation** – what we are going to do in general
- **Report of Findings** – what we are going to do specifically

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The Informed Consent

- When to get the informed consent:
  - The new patient consultation AND report of findings PROCESS.
  - Established patient with a new area of complaint

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CLEAR COMMUNICATION of the Informed Consent

- Must be in plain language. If the average lay person cannot understand the terms used in the consent, a judge may throw the informed consent out.
- Must be separate from other documents. Do not mix it in with HIPAA notices and the Financial Policy. *"Shrouded Importance"*
- Must be addressed verbally with the patient to give them the opportunity to address questions
- Elicit engagement of the patient and family

68

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Components of the Informed Consent

- Without a consent form, charges may be levied that the touching was unwanted – sexual abuse.
- With an improper informed consent, it may be alleged that you caused injury and were guilty of neglect.

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The "Reasonable Standard" Law

- Physicians are held to a "reasonable standard."
- A doctor is required to tell a patient what another reasonable doctor would tell the patient under similar circumstances.

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Patients Must have The Mental Capacity to Decide

- The patient must realize that they have the ability and the right to make a decision.
- If a patient is unable to make decisions the legal designee needs to be identified. Policies and procedures must be made to assess the patient capacity and how to identify a legal designee.
- Is the patient able to make and communicate a choice?
- Is the patient able to understand key information about their condition, the treatment options, benefits, harms, and risks; and is not required by law or court order to undergo treatment.
- Does the minor have the right to consent?

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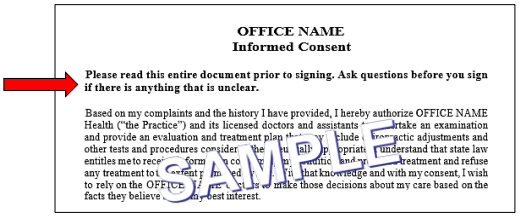

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RISKS

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those that relate to [illegible] aberrant [illegible] unknown or reasonably undetectable by the doctor. [illegible] have been associated with injuries to the arteries [illegible] to or resulting to serious complications including stroke. Some [illegible] soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if I have a condition that would otherwise not come to the Doctor's attention, I understand that it is my responsibility to inform the Doctor before treatment.

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I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand the care and treatment I may receive to my satisfaction. My signature below acknowledges my consent to the Practice's examination, evaluation, and proposed course of care and treatments.

Witness

Patient's Printed Name

Patient's Signature

Signature of Doctor

74

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Special Circumstances Informed Consent

- Decompression Therapy
- Acupuncture
- Dry Needling
- Laser
- Shock wave
- If you don't take x-rays

75

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Revenue Cycle Management

The Journey begins *before* the Check in… Pre-Check

Ask Questions

Collect as much information as possible

Communicate costs and collect if possible

Pre-Service for the scheduled patients

Insurance Verification

Explain financial obligations and plans if necessary

76

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- It is important to be as detailed and specific as possible.
- I have seen cases in which a patient verified coverage indicating that chiropractic is covered but failed to inquire about the need for being in-network.
- In that case, the insurer did not give misinformation; the company stated correctly that chiropractic was covered.
- However, the inquiring party did not go any further with questions about in- or out-of-network limitations.

Insurance verification

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CHIROPRACTIC INSURANCE VERIFICATION

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Verify Insurance and Identity

The Medicare Card
- Name
- Medicare Number
- Effective date of entitlement

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- Photocopy/scan the front and back of the member's ID card.
- Check eligibility and benefits

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- Some cards may feature an employer's name or logo
- Copay amounts are not shown on the card.
- If present, a QR code on the BCBS ID cards will link to the members Schedule of Benefits Summary. This will tell you about in-network and out-of-network deductibles and out-of-pocket maximums.

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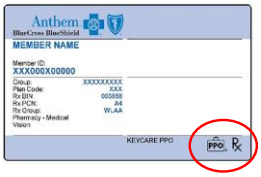

- The PPO suitcase logo indicates that the member is enrolled in either a preferred provider organization (PPO) plan or an exclusive provider organization (EPO) plan.
- In either case, you will be reimbursed according to your network provider agreement.

- The EMPTY SUITCASE logo indicates the member is enrolled in one of the following types of plans: traditional HMO or POS.
- No suitcase for Medicaid, SCHIP, Medicare Supplement

82

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Insurance Definitions

- **Deductible** – A *contractual* obligation the patient pays for covered health care services before the insurance plan starts to pay.
- **Co-insurance** - The percentage of costs of a covered health care service the patient pays (20%, for example) after they meet their deductible.
- **Co-pay** – A *contractual* obligation the patient pays each visit. Usually a fixed amount ($20, for example) they pay for a covered health care service. The patient *must* pay it at the time of service.

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Opting out of Medicare

"Opting out of Medicare is not an option for Doctors of Chiropractic. Note that opting out and being non-participating are not the same things. Chiropractors may decide to be participating or non-participating with regard to Medicare, but they may not opt out."

MedLearn Matters SE0479

84

Filing of Medicare Claims

Medicare Processing Manual §70.8.6 – Time Limitation for Filing Part B Reasonable Charge and Fee Schedule Claims (Rev. 170, 05-07-04)

- Medicare law prescribes specific time limits within which claims for benefits may be submitted with respect to physician and other Part B services payable on a reasonable charge or fee schedule basis
- For these services, the terms of the law require that the **claim be filed no later than one year from which the service was furnished.**

85

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Timely Filing Deadlines

- Medicare Part B – one year from the date of service
- Medicare Part C – 90 days from the date of service
- BCBS – 6 months from the date of service

86

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NEW!

Are you in compliance with Qualified Medicare Beneficiary (QMB) billing requirements?

People with Medicare who are in the QMB program are also enrolled in Medicaid and get help with their Medicare premiums and cost-sharing. **Medicare providers may not bill people in the QMB program for Medicare deductibles, coinsurance, or copays, but state Medicaid programs may pay for those costs.** Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. *(Released by CMS January 17, 2019)*

87

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Offering Gifts and Other Inducements to Beneficiaries

A person who offers or transfers to a Medicare or Medicaid beneficiary any remuneration that the person knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services may be liable for civil money penalties (CMPs) of **up to $10,000 for each wrongful act.** The statute defines "remuneration" to include, without limitation, waivers of copayments and deductible amounts (or parts thereof) and transfers of items or services for free or for other than fair market value.

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Offering Gifts and Other Inducements to Beneficiaries

The OIG has interpreted the prohibition to permit providers to offer beneficiaries inexpensive gifts (other than cash or cash equivalents) or services without violating the statute. For enforcement purposes, inexpensive gifts or services are those that have a retail value of not more than **$15** individually, and no more than **$75** in the aggregate annually per patient.

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Verify the Insurance Information **when making the appointment, *before*** the patient comes in for the first visit

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According to your insurance carrier…

there is NO guarantee of coverage!!

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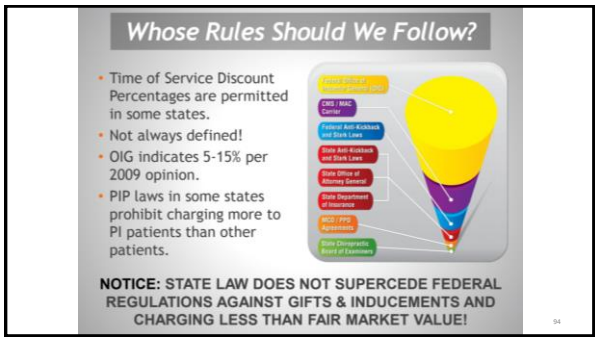

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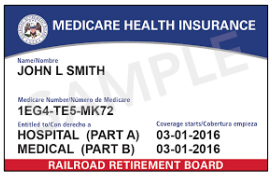
- The Railroad Retirement Board (RRB) is also mailing new Medicare cards with the MBI.
- The RRB logo will be in the upper left corner and "Railroad Retirement Board" at the bottom



97

Verify Identity

The Medicare Card
- Name
- Medicare Number
- Effective date of entitlement

98

Medicare Beneficiary Identifier (MBI)

- MBIs are numbers and upper-case letters. We'll use numbers 0-9 and all letters from A to Z, except for S, L, O, I, B, and Z. This will help the characters be easier to read.
- The MBI will contain letters and numbers. Here's an example:

1EG4-TE5-MK73

99

Medigap PLAN F

- Both Part A and Part B deductibles are covered by the plan
- Best if you've got serious or chronic health conditions and have a lot of medical expenses each year.
- Phased out unless previously owned

100

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Medigap PLAN G

- Same coverage as Plan F except for the Part B deductible, which is $240
- Part F and G are the only Medicare Supplement Plans that offer coverage for Part B excess charges
- There are no plans to phase out Plan G

101

101

Medigap PLAN N

- No coverage for Part B deductible
- No coverage for Part B excess charges
- You may have a copay of up to $20 for doctor visits and $50 for hospital visits that don't result in admission.
- You must collect the co-pay each visit

102

102

103

Medicare Part B (Original Medicare)
- Medigap
  - Plan F
  - Plan G
  - Plan N

Medicare Advantage (Part C)

104

Medicare Advantage Plans (Part C) are offered by *private* companies approved by Medicare.
This is a Part B *replacement* plan.

105

MEDICARE ADVANTAGE

- Medicare Advantage plans must cover at least the same chiropractic services as original Medicare, but copayments and deductibles may vary. The representative typically quotes benefits with the disclaimer that there is no guarantee of benefits.
- Medicare Advantage may require the patient to use an in-network provider.
- It Is a PRIVATE CONTRACT.

106

106

UHC Medicare Advantage Plan

- In most Part C plans, as long as you are a provider for Medicare, you are in their program.
- Plans must cover all medically necessary services and supplies that Original Medicare covers. However, the representative typically quotes benefits with the disclaimer that there is no guarantee of benefits.
- **Specific plans within the Part C Medicare Advantage plans may cover maintenance care.** Plans such as AARP® Medicare Advantage, UnitedHealthcare® Dual Complete, and UnitedHealthcare® Group Medicare Advantage may cover maintenance spinal manipulation. There may be additional UnitedHealthcare plans as well that have this benefit. Since Medicare Advantage plans are private contracts within the Medicare system, the benefits must be verified before services are rendered.

107

107

UHC Medicare Advantage Plan

- When the provider verifies benefits for any UnitedHealthcare Medicare member, **they must ask the representative if the member has the "*routine benefit*," and if so, how many routine visits are covered.** If the member has these benefits, they are there to utilize when the care is not deemed active treatment by the Medicare definition.
- Essentially, these plans have a benefit that allows for a certain number of visits for non-active treatment.

108

108

Some UHC Part C Plans

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Part C Benefit Questions to Ask

1. Do you follow the Medicare fee schedule?
2. Do you cover services other than spinal manipulation in a chiropractic office?
3. Do you accept the AT modifier?
4. Use GFE or other forms.

110

110

Medicare (Part B) Modifiers

MODIFIER	INDICATION
GY	Used when an item or service is statutorily not covered. Do not use on CMT.
GP	Services delivered under an outpatient physical therapy plan of care.
GPGY	Used on physical therapy services in Medicare .
GZ	Used on CMT codes, when you expect Medicare to deny the service, but you did not get an ABN.
GA	**Used on CMT codes, when you expect Medicare to deny the service, and you have a signed ABN on file.**
AT	Used on CMT codes (spinal) to indicate active care.
Q6	Locum tenen is performing the service

111

111

Medicare Advantage (Part C) Modifiers

MODIFIER	INDICATION
25	Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service.
GP	Services delivered under an outpatient physical therapy plan of care.
AT	Used on CMT codes (spinal) to indicate active care.

112

112

- **L3020** -- Foot insert, molded to patient model, longitudinal/metatarsal support, each Guideline: Prescription Custom Fabricated Foot insert, each, removable. **This type of device is fabricated from a three-dimensional model of the patient's own foot (e.g. cast, foam impression, or virtual true 3-D digital image). Use Modifier RT and Lt and bill separately per foot.**
- **L3030** -- Foot insert, removable, formed to patient foot, each Guideline: Prescription Custom Fabricated Foot insert, each, removable. This type of device is **formed directly to the patient's foot through the use of an external heat source**. The heat source should sufficiently and permanently alter the shape of the device, activating a resin, or other method by which the shape of the device is sufficiently and permanently altered in order to provide continuous contact with the unique characteristics of the plantar aspect of the patient's foot.
- Billing: L3020 Rt, L3020 Lt

FOOT LEVELERS

113

- In **Medicare Part B, we have the ABN form** that informs patients that they are responsible for payment and transfers liability to them.
- For ALL others paying out of pocket, the No Surprises Act (NSA) mandates that a **Good Faith Estimate (GFE)** be given to the patient *before* services are rendered.

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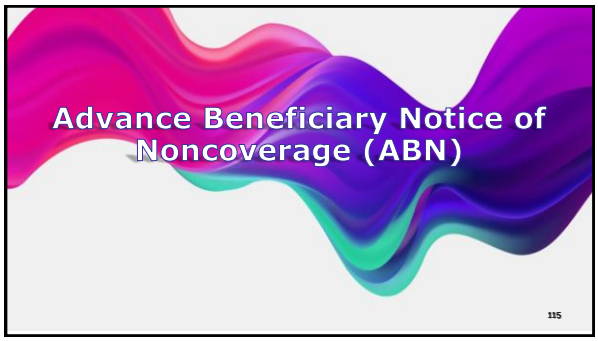

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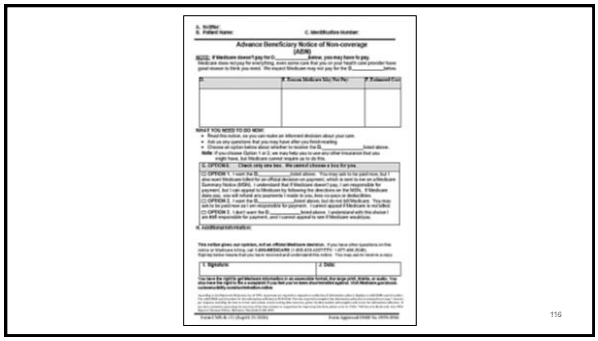

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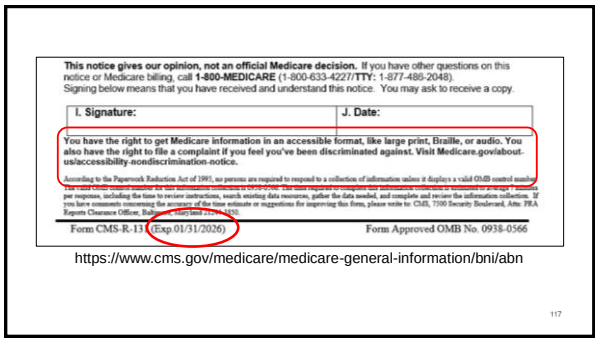

https://www.cms.gov/medicare/medicare-general-information/bni/abn

117

For Medicare Part B Non-Covered Services

Clinic/Doctor Name
Clinic Address
City, State, Zip, Telephone

Please be advised that your Medicare coverage for chiropractic only covers spinal manipulation that is deemed medically necessary. You are personally responsible for payment for services that are statutorily not covered. Services have been deemed medically necessary by the doctor but are not covered by your Medicare insurance. Those services include:

Examination (CPT 99202-99215)	$XX – $XXX
X-rays	$XXX
Electric muscle stimulation (G0283)	$XX
Ultrasound (97035)	$XX

Signature: _____ Date: _____

118

118

Clinic Name or Doctor Name, Clinic Address, City, State, Zip, Telephone Number

A. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for the services 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 services below.

Services	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.

119

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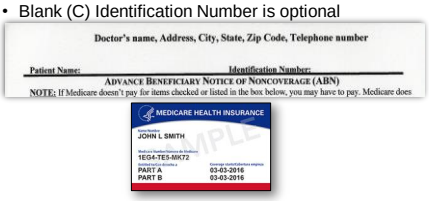
Patient Name:

- Notifiers must enter the first and last name of the beneficiary receiving the notice, and middle initial should also be used if on the beneficiary's Medicare (HICN) card.
- Blank (C) Identification Number is optional


Doctor's name, Address, City, State, Zip Code, Telephone number

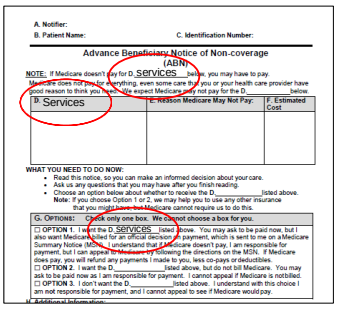
Patient Name: Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box below, you may have to pay. Medicare does

120

120



A. Notifier:
B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D, services 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. Services	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 services 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.

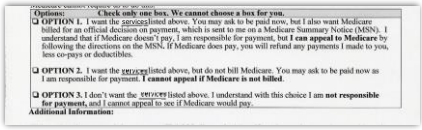
H. Additional Information:

121

121

Options:

- These 3 checkboxes represent the beneficiary's possible choices regarding the potentially non covered care described in the body of the ABN.
- The beneficiary or representative must select only 1 of the 3 checkboxes. **Under no circumstances can the notifier decide for the beneficiary or representative which of the 3 checkboxes to select.**
- If a beneficiary chooses to receive some, but not all of the items or services that are subject of the notice, the items and services listed under Blank (D) that they do not wish to receive may be crossed out.



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

❑ **OPTION 1.** I want the services 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 services 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 services listed above. I understand with this choice I am **not responsible for payment,** and I cannot appeal to see if Medicare would pay.

Additional Information:

122

122

Signature Box

- The beneficiary or representative must sign the notice, with his or her own name, in this box simply labeled "Signature", to allow maximum space for making the written entry. The signature indicates that he or she has received the notice and understands its contents.

Date:

- The beneficiary or representative must enter the date he or she signed the ABN.

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 may ask to receive a copy.

I. Signature:	J. Date:
John L. Smith	8/21/2024

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

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 [illegible] per response, including the time to review instructions, search existing data resources, gather the data needed, 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 CMS-R-131 (Exp 01/31/2026) Form Approved OMB No. 0938-0566

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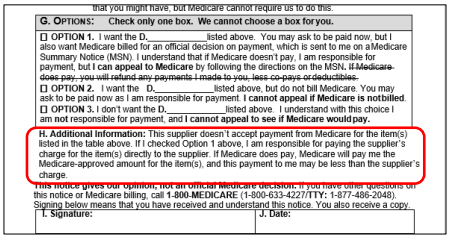
The Non-Par ABN



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 supplier doesn't accept payment from Medicare for the item(s) listed in the table above. If I checked Option 1 above, I am responsible for paying the supplier's charge for the item(s) directly to the supplier. If Medicare does pay, Medicare will pay me the Medicare-approved amount for the item(s), and this payment to me may be less than the supplier's charge.

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:

124

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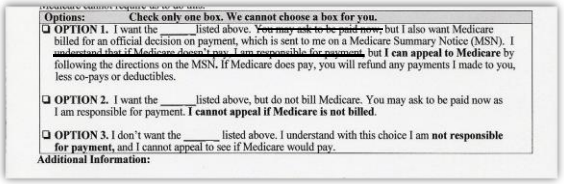
The Medicare QMB Patient



Options:	Check only one box. We cannot choose a box for you.
❑ **OPTION 1.** I want the _____ 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 _____ 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 _____ listed above. I understand with this choice I am **not responsible for payment,** and I cannot appeal to see if Medicare would pay.	

Additional Information:

125

125

ABN Effectiveness Period

B. Period of Effectiveness

An ABN can remain effective as long as there is no change in the patient's health status. ABNs may describe treatment as long as no other triggering event occurs. If a new "triggering event" occurs within the 1-year period, a new ABN must be given.

See § 50.5 – Triggering Events.

126

126

NO ABN Form for Part C Medicare Advantage Plans

- **CMS *expressly prohibits* providers from using the Advance Beneficiary Notice (ABN) or similar notices for Medicare Advantage (Part C) members.**
- CMS recommends that providers use the determination process established by the member's health plan. If there is a question about whether a Medicare Advantage plan will cover an item or service, members or their provider can request prior authorization/precertification before services or items are provided. If the request is denied, written determinations provide denial reasons and set forth appeal rights. If a provider chooses to provide a service to a Medicare Advantage member without first ensuring the service is covered, the provider must hold the member harmless.

127

127

Medicare Advantage (Part C) Modifiers

MODIFIER	INDICATION
25	Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service.
GP	Services delivered under an outpatient physical therapy plan of care.
AT	Used on CMT codes (spinal) to indicate active care.

128

128

NO SURPRISES ACT (NSA)

The No Surprises Act was passed with a goal to ensure that patients do not receive health care bills that far exceed their awareness or expectations.

129

129

NO SURPRISES ACT (NSA)

Who does the NSA protect?

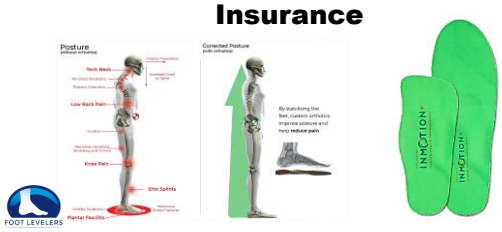
If the patient does not have insurance or they elect to self-pay for care, in most cases, these new rules make sure the patient gets a good faith estimate of how much their care will cost *before* they receive it.

- **Uninsured, Cash, Part C, PI, and Self-Pay Patients**

130

130

Not All Services the DOCTOR Recommends May be Covered by Insurance



131

131

NSA Patient *Notification*

132

NO SURPRISES ACT

How you must inform your patients of their rights

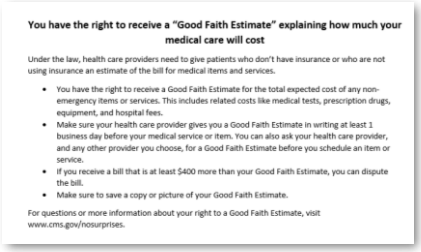
- Providers or facilities must post the "No Surprises Act Notice" prominently at the location of the facility and website in ***three*** **specific, clear, and understandable ways:**
  1. A **notice prominently displayed in the office** where patients can see the posting (Office Poster)
  2. A notice prominently displayed (and easily searchable from a public search engine) on your **website**, and
  3. **Orally** when a patient schedules an item or service or when questions about costs occurs.

(See templates)

133

133

The NSA Notice



You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

134

134

Examples of *LINKS* on your website for the
- No Surprises Act
- HIPAA Privacy Policy
- Anti-Discrimination Notice

135

135

How Do I Know What I Will Do on the First Visit?

- The GFE for the first visit could be the examination only, for example. However, if your GFE only estimated an evaluation, prudent policy would be not to do the service until the patient signs off on it.
- You do not want accusations of bait and switch.

136

136

NO SURPRISES ACT (NSA)

Your GFE must be accurate

- For services provided, the actual amount charged must be within $400 of the GFE estimate you quote.
- If it appears that the final charges will be $400 or greater than the good faith estimate, then issue an additional GFE before the services are rendered.

137

137

GOOD FAITH

ELEMENTS

138

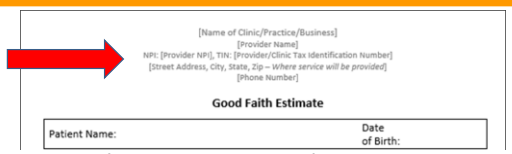
138

The NSA Good Faith Estimate (GFE)

139

139

NSA Good Faith Estimate

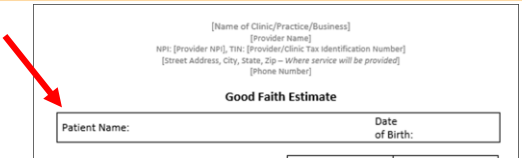


1. Enter in the first name, last name, and title of providers and the legal name of the corporation or facility as written on their business license.
2. Enter in the physical address, city, state, and zip code for all providers and facilities involved in the expected period of care.
3. List the tax identification number and the NPI number of the provider or facility

140

140

NSA Good Faith Estimate

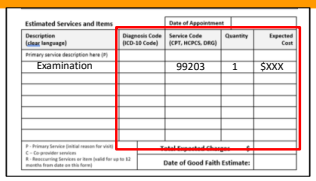


4. First name, last name, and date of birth for the uninsured (or self-pay) individual receiving items or services.

141

141

NSA Good Faith Estimate



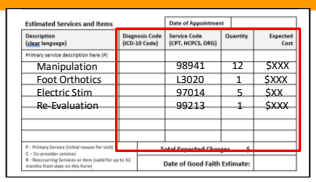
Estimated Services and Items		Date of Appointment		
Description (clear language)	Diagnosis Code (ICD-10 Code)	Service Code (CPT, HCPCS, DRG)	Quantity	Expected Cost
Primary service description here (P)				
Examination		99203	1	$XXX
P - Primary Service (initial reason for visit) C – Co-provider services R - Reoccurring Services or item (valid for up to 12 months from date on this form)		Total Expected Charges	$	
		Date of Good Faith Estimate:		

6. List the diagnosis code (if known)
7. List the appropriate CPT or HCPCS along with the name of the service or item.
8. List the expected quantity of each item or service
9. List the expected charges associated with each item or service.

142

142

NSA Good Faith Estimate



Estimated Services and Items		Date of Appointment		
Description (clear language)	Diagnosis Code (ICD-10 Code)	Service Code (CPT, HCPCS, DRG)	Quantity	Expected Cost
Primary service description here (P)				
Manipulation		98941	12	$XXX
Foot Orthotics		L3020	1	$XXX
Electric Stim		97014	5	$XX
Re-Evaluation		99213	1	$XXX
P - Primary Service (initial reason for visit) C – Co-provider services R - Reoccurring Services or item (valid for up to 12 months from date on this form)		Total Expected Charges	$	
		Date of Good Faith Estimate:		

This could also be used in a Personal Injury Case to outline expected needed care in a CARE PLAN for permanent residuals over the next year, or in a maintenance program.

143

143

NSA Good Faith Estimate

Estimated Services and Items		Date of Appointment		
Description (clear language)	Diagnosis Code (ICD-10 Code)	Service Code (CPT, HCPCS, DRG)	Quantity	Expected Cost
Primary service description here (P)				
Spinal Manipulation (R)		98941	1	$XX
Electric Stim (R)		G0283	5	$XX
Re-Evaluation		99213	1	$XXX
P - Primary Service (initial reason for visit) C – Co-provider services R - Reoccurring Services or item (valid for up to 12 months from date on this form)		Total Expected Charges	$	
		Date of Good Faith Estimate:		

Example of Medicare Advantage Good Faith Estimate

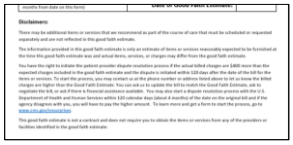
144

144

NSA Good Faith Estimate

10.The GFE Disclaimers:

a) There may be addition unforeseen items or services.
b) This is only an estimate
c) You have the right to initiate a dispute resolution process if the actual billed charges are over $400 more than the estimated charges. This must be done within 120 days after the date of the bill. Includes information how to do this.
d) Disclaimer stating that this is NOT a contract.



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145

Patients Have Rights

The Patient has the right to file a Complaint

- If the patient receives a bill that is at least $400 more than the total expected charges for that provider or facility on the good faith estimate, there is a new federal patient-provider dispute resolution (PPDR) process available under the No Surprises Act.
- The patient may request a payment review and decision from an independent company certified by the federal Department of Health and Human Services. These companies are referred to as Selected Dispute Resolution (SDR) entities.
- The SDR entity will decide what amount the patient must pay if the bill is at least $400 more for any provider or facility.

146

146

NSA Good Faith Estimate

- The GFE is valid for *up* to12 months from the date on the form.
- The GFE is good for recurring services or items
- The GFE is part of the MEDICAL RECORD.
- Keep a copy in the patient's chart via statutes set forth in your state law.

147

147

Required Compliance Documents

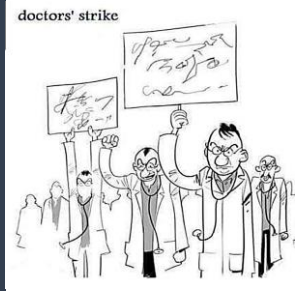
Update Your Financial Policies in Your Compliance Manuals

Manual Resources at www.AskMario.com

148

148

Notes Must Be Legible



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149

Michigan Public Health Code Section 333.16213

A licensee shall keep and maintain a record for each patient for whom the licensee has provided medical services, including a full and complete record of tests and examinations performed, observations made, and treatments provided.

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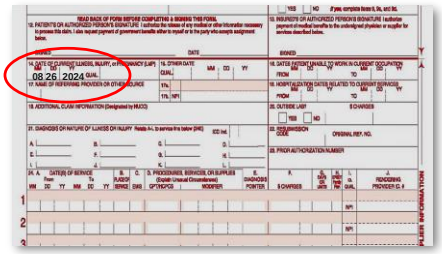

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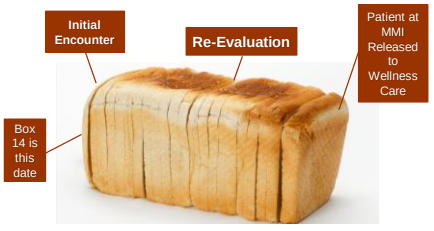


EPISODE OF CARE

152

152

WHAT? IS THE

PURPOSE

OF CHIROPRACTIC CARE?

153

153

Title XVII of the Social Security Act, Section 1862 [a][1][a]

"Medicare may only pay for items or services that are "reasonable and necessary" for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member."

www.ssa.gov/OP_Home/ssact/title18/1862.htm

154

154

BCBS Chiropractic Services Policy

goals and outcome measures for a new problem or a problem re-assessment. **(Plan)**

- A written plan of treatment relating to the type, amount, frequency, and duration of care is required for all patients. The plan of care must be updated as the patient's condition changes. A treatment plan is not valid for longer than 90 calendar days from the first treatment day under the certified treatment plan. The goal of the treatment plan should be to achieve functional improvements in the patient's condition. Specific treatment goals must be documented with anticipated time frames and objective measures to evaluate treatment effectiveness. Each complaint should be listed with selected treatment, duration, frequency, treatment goals, and objective measures to evaluate progress. The treatment plan should include the rationale for all services provided. A plan of care should be individualized for each patient. Documentation must support that each manipulation or treatment reported relates to a relevant symptomatic spinal and/or extraspinal region. Symptoms must bear a direct relationship to the level of subluxation cited. Documentation of "pain" is not sufficient; the location of pain or condition must be described. **(Plan of Care)**
- Signature requirements- Each medical record must be signed and dated by the clinician

155

155

156

Medical Necessity

OATS

1. The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services must have a direct therapeutic relationship to the patient's condi (Medicare does not pay for pain).

Treatment Goals

2. You must have a reasonable expectation of recovery or improvement of function.

P.A.R.T.

3. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam. A diagnosis of pain is not sufficient for medical necessity

157

157

Medicare Medical Necessity

- **Acute subluxation** - treatment for a new injury, identified by x-ray or physical exam. The treatment is expected to improve, arrest, or retard the patient's condition.
- **Chronic subluxation** - A patient's condition is considered chronic when it is not expected to completely resolve (as is the case with an acute condition), **but where the continued therapy can be expected to result in some functional improvement. Once the functional status has remained stable for a given condition, further manipulative treatment is considered maintenance therapy and is not covered**.

158

158

Medical Necessity

Acute exacerbation is a temporary but marked deterioration of the patient's condition that is causing significant interference with **activities of daily living** due to an acute flare-up of the previously treated condition. The patient's clinical record must specify the date of occurrence, nature of the onset, or other pertinent factors that would support the medical necessity of treatment. As with an acute injury, treatment should result in improvement or arrest of the deterioration within a reasonable period of time.

159

159

Medical Necessity

Maintenance Therapy

- **Once MMI has been reached, Medicare will NOT pay for maintenance or supportive care.**
  - 1. Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or 2. maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

160

160

Whiplash
Acceleration/Deceleration Trauma
Hyperextension/Hyperflexion Injury

161

161

The Personal Injury Consultation

- Obtain a police report, whenever possible, to verify the injury
- Mechanism of injury?
- Direction of force?
- Preparedness for impact

162

162

The Personal Injury Consultation

- What position in the auto were you?
  - Driver? Passenger?
- Document care obtained after the accident
- Home care?
- Progression of pain since the accident
- L, M, N, O,P,Q,R,S,T for each complaint region

163

163

Headrest Position

164

164

Headrest Position

165

165

Is There a Causal Connection?

Causal Connection - a relationship between two events. One event causes the other.

- The physician must document is there is a causal connection of the symptoms to the mechanism of trauma.
- Establish a baseline of symptoms prior to the injury and work to achieve “pre-accident status.”

166

166

The Personal Injury Consultation

****Duties under Duress**

- This area acknowledges the painful or difficult activities of daily living not otherwise reported. This is described as pain while performing an activity.

167

167

The *FUNCTIONAL* Consultation

168

168

The Universal Initial Report

- Status of the patient
  - New : Never seen before or not in the last three years
  - Established: Patient seen by you or other doctors in your group of the same specialty, within the last three years
- Chief Complaint (cc)
- PFSH – Past, Family, Social History
- Review of Systems (ROS)
- HPI: L, M, N, O, P, Q, R, S, T
- Dx
- Treatment Plan
- Signature

169

169

Medicare Initial Encounter Report

Symptoms causing patient to seek treatment
Family History
Past Health history
Mechanism of Trauma
Quality and character of symptoms/problem
Onset, duration, intensity, frequency, location and radiation
Provoking and Palliative Factors
Prior interventions, treatments, medications, secondary complaints

170

170

Medicare Initial Encounter Report

- **Q**uality and character of symptoms/problem
- **R**adiation of symptoms
- **S**everity
- **T**ime

171

171

Medicare Initial Encounter Report

Treatment Plan

- Recommended Level of Care
  - Duration and frequency of visits
- Specific Treatment Goals
  - What are you trying to accomplish?
- ***Objective*** measures to evaluate treatment effectiveness
  - How do you know when the treatment has been accomplished?

Date of Initial Treatment (Box 14)

172

172

What is the Purpose of *Specific* Treatment Goals?

173

173

Evidence Based
Outcomes Assessment Tools (OATs)

(*Functional Impairment Rating)*

174

174

Why Outcomes Assessment?

- An ***objective*** measure of the patient's **ADL** status
- Provides ***objective*** documentation regarding the patient's condition.
- Helps the doctor, patient and insurer to make *informed* decisions
- A deterrent to malpractice
- Backed up by refereed journals (JMPT, Spine)

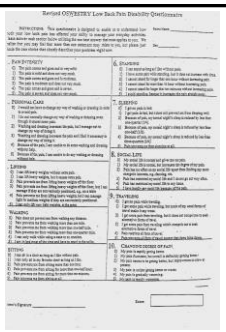
175

175

Revised Oswestry

Functional Disability Score

0-5% = None
6-20% = Mild
20-40% = Moderate
40-60% = Severe
60-80% = Crippled
80%+ Bed Bound


Revised OSWESTRY Low Back Pain Disability Questionnaire

176

176

Neck Pain Disability Index Score

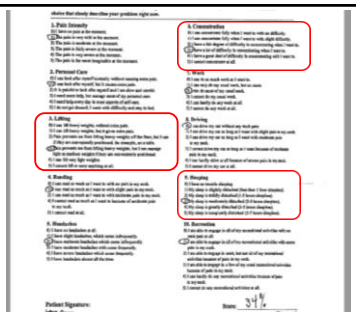
0-8 = None
10-28% = Mild
30-48% = Moderate
50-68% = Severe
>70% = Crippled


NECK PAIN DISABILITY INDEX QUESTIONNAIRE

177

177

Neck Pain Disability Index



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178

OATS → Tx Goals

179

179

Outcome Assessment Tests (OATs)

To be significant, the outcome assessment test must have a minimum reduction of a 30% in score between the initial exam and the re-exam to be clinically significant.

180

180

General Treatment Goals

As time progresses, the short term goals progress until finally they catch up with the long term goals.

181

181

Short – Term Goals (First 2-3 weeks)

1. **Decrease pain, spasms, edema and increase range of motion**
2. Resolution of any radicular pain in the lower extremity
3. Patient will be able to sleep in bed without pain for 6-8 hours.
4. Patient will be able to tie shoes without pain in 2 weeks
5. Independent with basic self-care ADL such as bathing without increased low back pain

182

182

Long – Term Goals (4-6 weeks)

1. Low back pain at worst less than or equal to 4/10 with all activities
2. Patient will ambulate 15 minutes at 2.0 miles per hour without increased low back pain
3. Bilateral hip flexion, multifidus and gluteal strength from 4+ to 5/5
4. Patient will be able to stand for 20 minutes or longer without pain in 4 weeks
5. Patient will demonstrate an improvement on their OATS score of >30% in 4 weeks
6. **To prepare the patient for a home-based exercise program**

183

183

UNIVERSAL SOAP NOTE TEMPLATE

Subjective
- Give chief complaint(s) as described by the patient that day.
- Give pain levels for each region being treated.
- Describe any functional improvement. This goes to reaching the treatment goals.

Objective
- Give all palpatory findings
- Repeat orthopedic and neurologic tests if applicable

Assessment
- The assessment shows the medical necessity for care. It is comparable to Medical Decision Making. You want to indicate how the patient is improved and why they still need care. *Example: The patient is improved with decreased arm pain and decreased edema, but still has subluxation and spasms at C7.*

Plan
- Document the segments adjusted, the technique used, and the patient's reaction to treatment. *Example: CMT C1, T3, T7, L5, and Right SI Diversified, Patient tolerated treatment without incident.* This is very important for risk management.

Signature: Either hand sign or electronic signature. Should have name of provider and credentials. Preferred to have time and date stamp.

184

184

P.A.R.T.

To demonstrate a subluxation based on physical examination, two of the four criteria mentioned under the above physical examination list are required, one of which must be asymmetry/misalignment or range of motion abnormality.

PART

185

185

P.A.R.T.

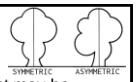
(2 of the 4 Required)

1. Pain/Tenderness - location, quality, intensity

Pain and tenderness findings may be identified through one or more of the following: observation, percussion, palpation, provocation, etc. Furthermore, pain intensity may be assessed using one or more of the following: visual analog scales, algometers, pain questionnaires, etc.

186

P.A.R.T.



2. **Asymmetry/misalignment - sectional or segmental level**
   Asymmetry/misalignment - Asymmetry/misalignment may be identified on a sectional or segmental level through one or more of the following: observation (posture and gait analysis), static palpation for misalignment of vertebral segments, diagnostic imaging, etc.

3. **Range of Motion Abnormality**
   Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); and Range of motion abnormality - Range of motion abnormalities may be identified through one or more of the following: motion, palpation, observation, stress diagnostic imaging, range of motion measurements, etc.

187

P.A.R.T.

4. **Tissue, tone changes in skin, fascia, muscle, ligament**
   Tissue, tone changes using descriptions pertaining to the characteristics of **contiguous, or associated soft tissues (with the spine)**, including skin, fascia, muscle, and ligament. Tissue/Tone texture may be identified through one or more of the following procedures: observation, palpation, use of instruments, tests for length and strength etc.

188

Re-Examination

- A formal re-examination should be done "to determine progress and need for further care" on EVERY PATIENT IN ACTIVE CARE **(RISK MANAGEMENT)**
- Should be done every 10-15 visits or every **30**-45 days. *RECOMMENDED EVERY 30 DAYS*

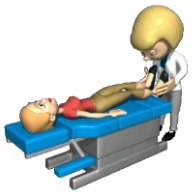
189

189

The Re-Examination

A re-examination should include

- A brief consultation about current condition
- Repeat of significant orthopedic and neurologic tests
- Visual Analog Scale or Borg Scale
- Outcome measures test repeated



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After the re-examination, update the record with an interim note or report:

- –Any change in diagnosis
- –Treatment frequency/schedule
- –Treatment goals
- –Restrictions
- –Referrals or further tests
- –Exercise/rehabilitation

191

191

E/M Guidelines
2024

192

192

Selecting the Appropriate Level of E/M

Medical Decision Making (MDM)

- Number and complexity of problems addressed
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

OR

Time

- Total time (face-to-face and non-face-to-face)

193

193

Medical Decision Making (MDM)

194

194

Use Technology to Reduce Time in the Office

- *Clerical staff* updates their insurance information
- Consider using telephone or video to pre-screen patients
- Schedule the patient for their *virtual* consultation appointment
- *Clinical staff* records the patient's chief complaint(s),history, new injuries, flare-ups, surgeries, medications, loss of function.
- Clinical staff alerts the Clerical staff to obtain past records
- Any work the clinical staff does, the doctor reviews the information **on the day of the examination appointment. That information gained goes into the Medical Decision Making (MDM) element.**

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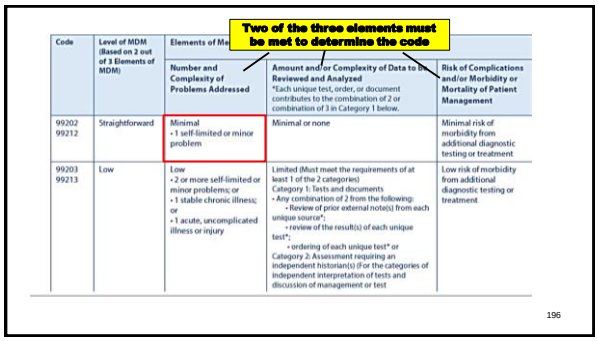

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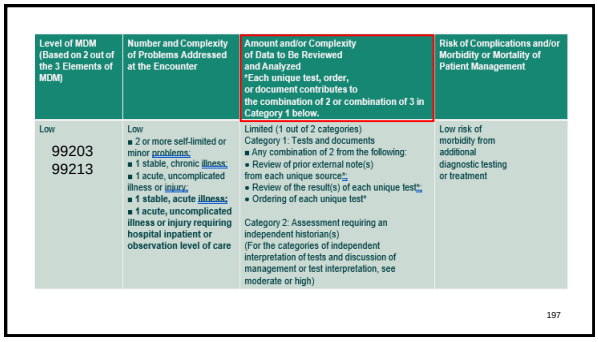

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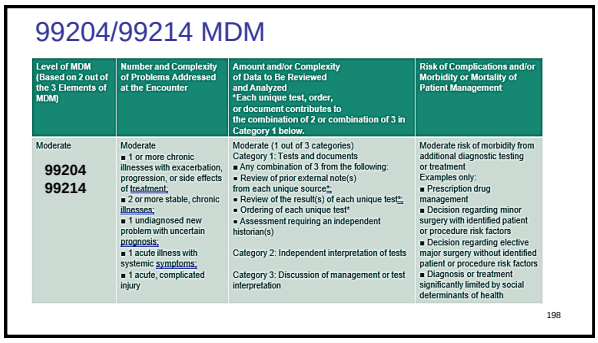

198

NEW 2024 Time Calculations

ONLY FOR OUTPATIENT SERVICES

CODE	TIME in Minutes
99201	Code Deleted
99202	Must meet or exceed 15
99203	Meet or exceed 30
99204	Meet or exceed 45
99205	Meet or exceed 60
99211	Time Removed
99212	Meet or exceed 10
99213	Meet or exceed 20
99214	Meet or exceed 30
99215	Meet or exceed 40

PRE-SERVICE + SERVICE + POST-SERVICE = *TOTAL* TIME

199

199

Number and Complexity of Problems

- Lumbar Pain
- Right sacroiliac pain
- Hyperpronation syndrome – Q-angle – Kinetic chain Disruption
- Lumbar DDD

2 or more self-limited problems
1 chronic illness
Number and Complexity = Low = 99203/99213

200

200

General Questions

- **Subjective** — History
- **Objective** — Exam
- **Assessment** — MDM

201

201

The SOAP Note Assessment (A)

- Provider records their professional opinions and judgments as to the patient's diagnosis, their progress and/or their functional limitations.
- You interpret the data presented in the objective portion of the note.
- You may also point out inconsistencies, justify your goals, discuss emotional status or indicate progress in therapy.

202

202

Answer the Questions

How is the patient improved?

What have you accomplished so far?

Why does the patient still need care?

What do you want to accomplished now?

203

203

MDM

S + O = A ⟶ P

204

204

A: The patient has improved with decreased pain, spasms, and edema. They have no further sleep disturbance due to pain. The patient still has intolerance to ADLs and instability due to deconditioning.

205

205

A: The patient has improved with decreased sleep disturbance and was able to stand for 30 minutes without pain. They still have weakness of the right piriformis and gluteals causing instability of the right SI region with walking and sitting.

206

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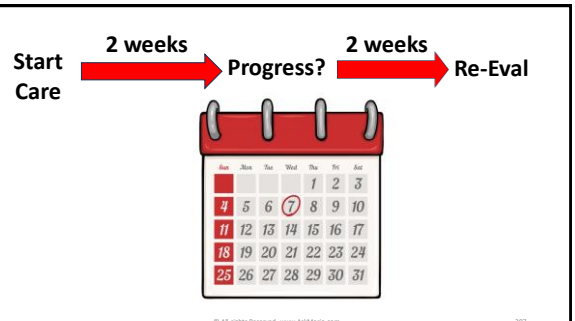

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PATIENT TREATMENT CONSIDERATIONS

208

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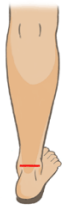
209

Chiropractic Provides Mechanical Solutions for a Mechanical Problem

210

210

VISUAL INSPECTION



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211

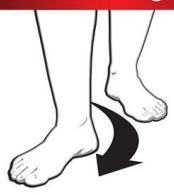
The 5 Red Flags of Pronation

1. Foot flare during gait
2. Internal knee rotation
3. Bowed achilles tendon
4. Flat feet
5. Uneven shoe wear

212

212

1 Foot Flare During Gait



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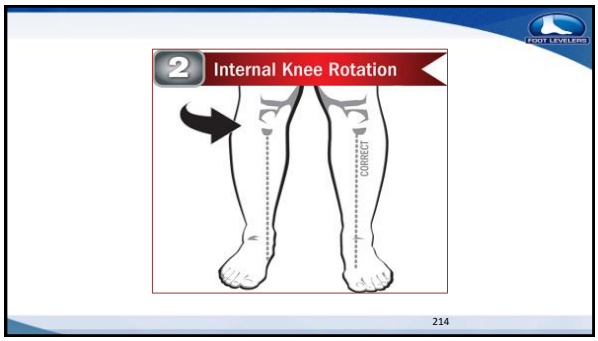

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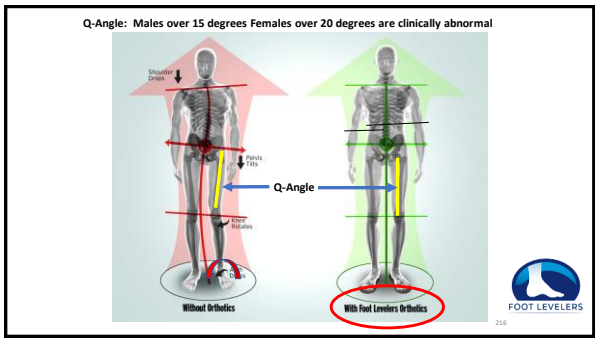

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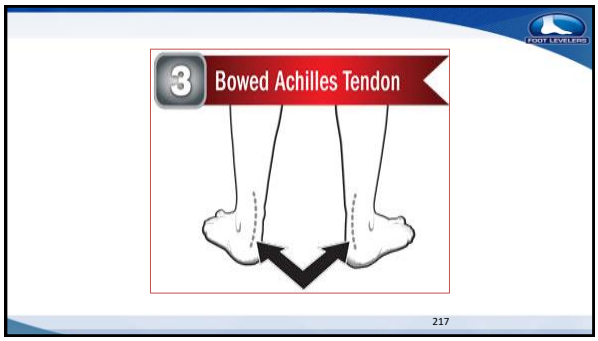

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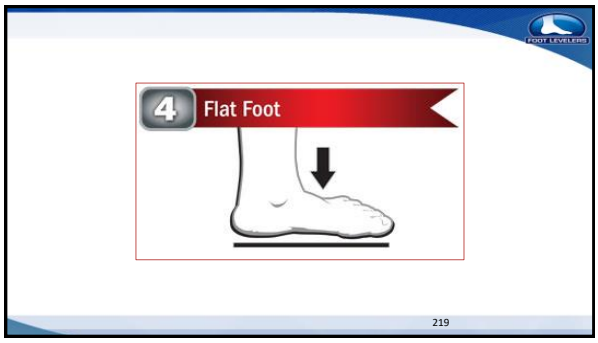

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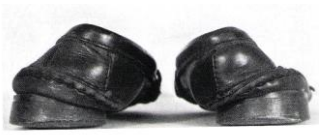
220

Check the Shoes



Pronation?

221

Check the Shoes

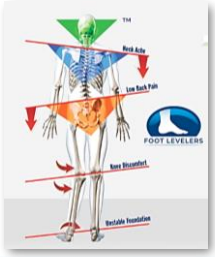
Metatarsalgia?

222

223

223

Why Foot Levelers?



224

224

DEM BONES

Dem bones, dem bones, dem dry bones,
Now shake dem skeleton bones!

The toe bone's connected to the foot bone,
The foot bone's connected to the hip bone.
WHAT?

225

225

- Loss of the Transverse Arch Effects on Posture
- Steppage gait and the perception of the CNS.
- Rotation and the arches.
- Foot Movement and the Greater Trochanters

226

226

Kinetic Chain

Upper kinetic chain consists of:
- fingers,
- wrists,
- elbows,
- shoulders,
- shoulder blades
- spinal column.

Lower kinetic chain consists of:
- toes,
- feet,
- ankles,
- knees,
- hips,
- Pelvis,
- spinal column.

227

227

You Live with a Kinetic Chain

228

228

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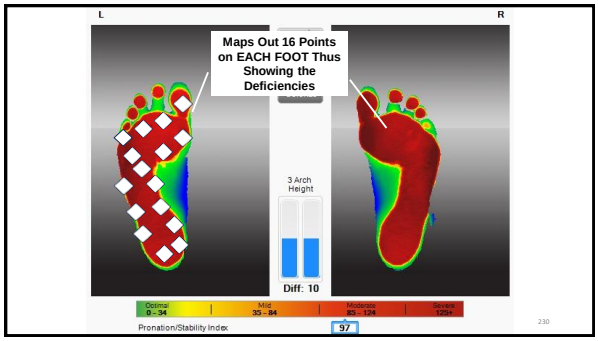

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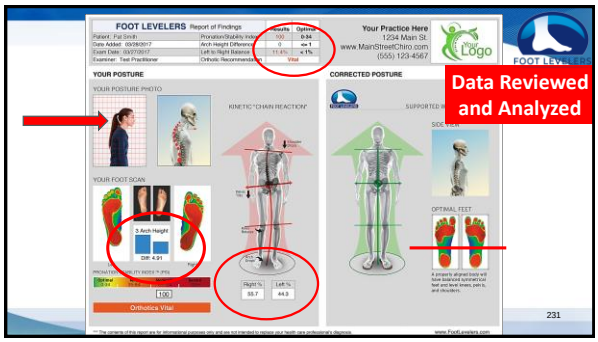

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232

What is the difference

Over-the-Counter

1. Only supports one arch and often incorrectly, causing more harm than good
2. Offers generic solutions for several foot conditions
3. Durability is questionable, so you may spend more money over time replacing them
4. Adds cushioning to treat the symptom rather than the underlying problem
5. Does not provide custom support for your gait

Custom-Made, Functional

1. Support all 3 arches of your feet to help balance your body
2. Promote optimum posture and enhance your treatments
3. Guaranteed or your money back
4. Individually designed based on 3D imaging or impressions of your feet
5. Patented Gait Cycle System® offers support through each phase of your gait

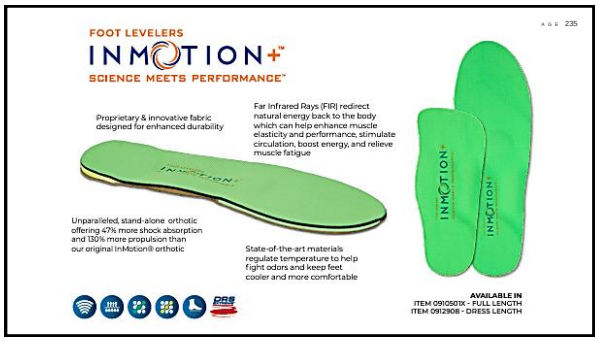
233

FOOT LEVELERS

COMPARISON BETWEEN CUSTOM ORTHOTICS AND PREFABRICATED INSERTS	FOOT LEVELERS	GENERIC or PREFABRICATED
Maximum Comfort	✓	✗
Premium Materials/Support	✓	✗
Individually Designed for You	✓	✗
Crafted by Hand	✓	✗
3-Arch Advantage®	✓	✗
Pelvic Stabilization	✓	✗
Whole-Body Pain Relief	✓	✗
1 Year, 100% Satisfaction Guarantee	✓	✗
Backed by Research	✓	✗
Made in America	✓	✗

PAGE 234

234



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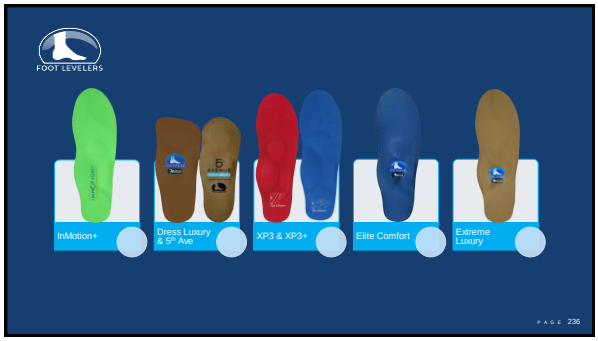


236

- **L3020** -- Foot insert, molded to patient model, longitudinal/metatarsal support, each Guideline: Prescription Custom Fabricated Foot insert, each, removable. **This type of device is fabricated from a three-dimensional model of the patient's own foot (e.g. cast, foam impression, or virtual true 3-D digital image).** Includes additions such as postings, padded top covers, soft tissue supplements, balance padding and lesion or structure accommodations.
- **L3030** -- Foot insert, removable, formed to patient foot, each Guideline: Prescription Custom Fabricated Foot insert, each, removable. This type of device is **formed directly to the patient's foot through the use of an external heat source**. The heat source should sufficiently and permanently alter the shape of the device, activating a resin, or other method by which the shape of the device is sufficiently and permanently altered in order to provide continuous contact with the unique characteristics of the plantar aspect of the patient's foot. It may also have an intrinsic or extrinsic post designed to control foot motion.

FOOT LEVELERS

237

Scan *Every* Patient

Make this your protocol

- Various studies show **overpronation creates biomechanical dysfunction**
- It's an educational opportunity to show patients **the feet play an instrumental part in the care you provide**

FOOT LEVELERS

238

238

TAKE THEIR ***COMPLETE*** VITALS

FOOT LEVELERS

239

239

Degenerative Disc Disease

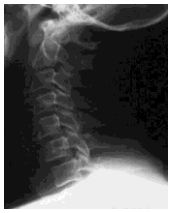
DDD over the entire spine was 90% in men and women aged >50 years

240

240

Clinical Indications For Plain Films

- Differential Diagnosis from the history and physical examination.
- Indications:
  - Degenerative conditions
  - Inflammatory conditions
  - Fracture
  - Neoplasms
  - Infection



241

241

Clinical Indications for MRI

- Non-responsive, deteriorating or lingering symptoms after 4 weeks
- Myelopathy
- Best for soft tissues, brain, spinal cord, joint effusion.

242

Clinical Indications for CT

- Cross-sectional views of the body
- Best for bone, organs, and blood vessels
- Assessing injuries, identifying tumors, and evaluating the extent of disease.

243

Radiology Reports

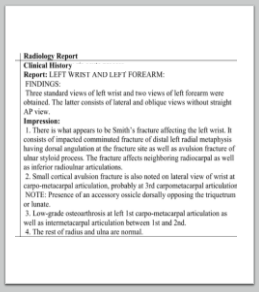
- The standard of care is that all radiographic studies are performed to reach a diagnostic conclusion.
- A written, usually typed, interpretation of the study is included as part of the patient's permanent record.
- Reports are signed and dated by the individual performing the interpretation.

244

244

Radiology Report

Views
Clinical Indications
Alignment
Bone
Cartilage
Soft Tissue
Signature



Radiology Report
Clinical History
Report: LEFT WRIST AND LEFT FOREARM:
FINDINGS:
Three standard views of left wrist and two views of left forearm were obtained. The latter consists of lateral and oblique views without straight AP view.
Impression:
1. There is what appears to be Smith's fracture affecting the left wrist. It consists of impacted comminuted fracture of distal left radial metaphysis having dorsal angulation at the fracture site as well as avulsion fracture of ulnar styloid process. The fracture affects neighboring radiocarpal as well as inferior radioulnar articulations.
2. Small cortical avulsion fracture is also noted on lateral view of wrist at carpo-metacarpal articulation, probably at 3rd carpometacarpal articulation NOTE: Presence of an accessory ossicle dorsally opposing the triquetrum or lunate.
3. Low-grade osteoarthrosis at left 1st carpo-metacarpal articulation as well as intermetacarpal articulation between 1st and 2nd.
4. The rest of radius and ulna are normal.

245

245

HEDIS® LBP IMAGING

- Imaging of for uncomplicated lower back pain is not indicated for the first 28 days of care unless a specific exclusion exists.
- Documentation of the following can exclude the member from the 28-day waiting period:
- Cancer, malignant neoplasm, HIV or major organ transplant any time prior to or within 28 days after the imaging study.
- Recent trauma within 90 days prior to or within 28 days after the imagining study.
- Spinal infection, neurologic impairment or IV drug abuse within one year prior to or within 28 days after the imaging study.
- Neurologic impairment within one year prior to or within 28 days after the imaging study.

246

246

BCBS Guidelines on Imaging for LBP

Exclusions: There are several categories or reasons that will remove the case from the LBP HEDIS measure if the imaging is done within the first 28 days of the diagnosis, because a medical need Those include:

- Cancer
- Neurologic impairment
- Spinal infection
- Recent Trauma

247

247

Exclusion List for Imaging of the LBP

Exclude any member who has had a diagnosis for which imaging is clinically appropriate. Any of the following will meet the criteria:

- **Cancer:** any time in the member's history through 28 days after the episode start date.
- **Recent trauma:** any time during the 90 days prior to the episode start date through 28 days after.
- **IV Drug abuse:** any time during the 12 months prior to the episode start date through 28 days after.
- **Neurologic Impairment:** any time during the 12 months prior to the episode start date through 28 days after.
- **HIV:** any time in the member's history through 28 days after the episode start date.
- **Spinal infection:** any time during the 12 months prior to the episode start date through 28 days after.
- **Major organ transplant:** any time in the member's history through 28 days after the episode start date.
- **Prolonged use of corticosteroids:** 90 consecutive days of corticosteroid treatment any time during the 12 months prior to and including the episode start date. Examples of corticosteroid treatment medications are Hydrocortisone, Cortisone, Prednisone, Prednisolone, Methylprednisolone, Triamcinolone, Dexamethasone, and Betamethasone.

Exclude members in hospice from the eligible population for this measure.

248

248

Exclusions from LBP HEDIS

Cancer – there are 1,484 diagnosis codes for cancer active now or a personal history of cancer any tune during the patient's lifetime. Some common diagnosis codes are:

- Z85.9 Personal history of malignant neoplasms, unspecified (any cancer)
- Z86.03 Personal history of neoplasm of uncertain behavior (any cancer)
- Z85.3 Personal history of malignant neoplasm of the breast
- Z85.40 Personal history of malignant neoplasm of unspecified female genital organ (cervix, uterus, ovary, etc.)
- Z85.45 Personal history of malignant neoplasm of unspecified male genital organ (prostate, testicular, etc.)
- Z85.820 Personal history of malignant melanoma of the skin

249

249

Exclusions from LBP HEDIS

Neurologic impairment – there are five diagnosis codes for impairment any time during the 12 months prior to the diagnosis. Two common codes are:

- R26.2 Difficulty in walking, not elsewhere classified
- R26.89 Other abnormalities of gait and mobility

  Includes: Gait disorder, painful gait
  Gait disorder, weakness
- R29.2 Abnormal reflex

250

250

Exclusions from LBP HEDIS

Spinal infection – there are 13 diagnosis codes for infection any time during the 12 months prior to the diagnosis. Two common codes are:

- M46.46 Discitis, unspecified, lumbar region
- M46.36 Infection of the intervertebral disc (pyogenic), lumbar region

251

251

Exclusions from LBP HEDIS

Recent trauma – there are 19, 255 diagnosis codes for trauma up to 90 days prior to the diagnosis. One generic trauma code is:

- G89.11 Acute pain due to trauma

252

252

253

253

Is Your Coding Doomed?

- Increased Specificity in ICD-10
- Increased Detail in Documentation
- Code to the Highest Level of Specificity

254

254

ICD-10-CM

Mario Rule #1: Code what you know

Codes that describe symptoms and signs are only acceptable if that is the highest level of diagnostic certainty documented by the doctor. Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established.

255

255

Unspecified Codes

- Symptoms versus pathology
- "Unspecified Codes" are for use when the information in the medical record is **insufficient** to assign a more specific code.
- Report codes at the highest specificity documented.

UNSPECIFIED

256

ICD-10-CM

Signs and symptoms that are associated routinely with a disease (**condition)** process **should not** be assigned as additional codes, unless otherwise instructed by the classification.

257

257

ICD-10-CM

Code all documented conditions that coexist at the time of the visit that REQUIRE OR AFFECT patient care. Do not code conditions that no longer exist.

Co-morbidity or complicating factors

258

258

ICD-10-CM

- Do NOT code for unconfirmed diagnoses that are probable, suspected, to rule out, etc.
- **The acute condition should always be listed first.**

Mario Rule #3: Whatever is worst, goes first

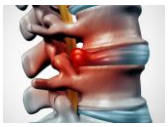
259

259

Sprain and Disc Codes Together

S33.5xxA Lumbar Sprain
M51.37 Lumbar Degenerative Disc Disease
NO S AND M

Sprain and Disc Conditions cannot be together for some carriers (BCBS, UHC)



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260

Combo-Code Examples

ICD-10
M54.30 Sciatica unspecified side
M54.31 Sciatica Right } M99.05
M54.32 Sciatica Left

M54.40 Sciatica with lumbago unspecified
M54.41 Sciatica with lumbago right } M99.03
M54.42 Sciatica with lumbago left

261

261

ICD-10 Changes

The code **M54.5 LUMBAGO/LOW BACK PAIN** was DELETED and is not a billable code

Lumbago/Lumbalgia (M54.5) was be replaced with the following:

- **M54.50 Low back pain, unspecified** (includes loin pain and lumbago NOS)
- **M54.51 Vertebrogenic low back pain**
- **M54.59 Other low back pain**

262

262

ICD-10 Changes

M54.50 Low back pain, unspecified (includes loin pain and lumbago NOS)

- Most closely replaces the Lumbalgia (M54.5)
- Still an UNSPECIFIED CODE
- **Use as a LAST RESORT**

Ask Yourself:

Lumbalgia (low back pain) due to _____

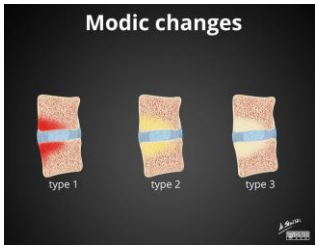
263

263

ICD-10 Changes

M54.51 Vertebrogenic low back pain

- Due to **MODIC** Changes in the low back vertebral endplate pain
- **Needs to be verified with MRI**



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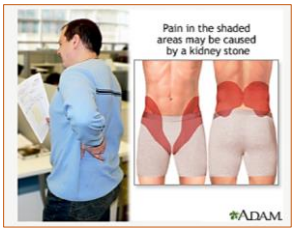
ICD-10 Changes

M54.59 Other low back pain

- Describes pain in the area surrounding the low back
- Usually refers to systemic or organ conditions causing LBP



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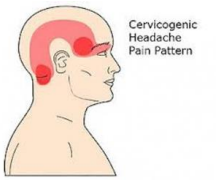
ICD-10 Clinical Examples

Cervicogenic Cephalgia

G44.86

Code also the associated cervical spinal condition, if known



Code Order Example:

M50.32 – cervical DDD — CAUSE

G44.86 – cervicogenic cephalgia — EFFECT

266

266

Disorder vs. Displacement

M50.12	Delete	Cervical disc disorder with radiculopathy, mid-cervical region
M50.120	Add	Mid-cervical disc disorder, unspecified
M50.121	Add	Cervical disc disorder at C4-C5 level with radiculopathy
M50.122	Add	Cervical disc disorder at C5-C6 level with radiculopathy
M50.123	Add	Cervical disc disorder at C6-C7 level with radiculopathy

Disc Disorders include protrusions, bulges, and herniations

267

267

Disorder vs. Displacement

M50.12	Delete	Cervical disc disorder with radiculopathy, mid-cervical region
M50.120	Add	Mid-cervical disc disorder, unspecified
M50.121	Add	Cervical disc disorder at C4-C5 level with radiculopathy
M50.122	Add	Cervical disc disorder at C5-C6 level with radiculopathy
M50.123	Add	Cervical disc disorder at C6-C7 level with radiculopathy
M50.22	**Delete**	**Other cervical disc displacement, mid-cervical region**
M50.220	Add	Other cervical disc displacement, mid-cervical region, unspecified level
M50.221	Add	Other cervical disc displacement at C4-C5 level
M50.222	Add	Other cervical disc displacement at C5-C6 level
M50.223	Add	Other cervical disc displacement at C6-C7 level

Disc Displacement include protrusions, bulges, and herniations, but **does not include cord or nerve root compression**

268

268

ICD-10 Changes for 2025

M51.84	**Other intervertebral disc disorders, thoracic region**
M51.85	Other intervertebral disc disorders, thoracolumbar region
M51.86	Other intervertebral disc disorders, lumbar region
M51.87	Other intervertebral disc disorders, lumbosacral region
M51.9	Unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc disorder

Excerpt from: *ICD-10 Coding of the Top 100 Conditions for the Chiropractic Office by Mario Fucinari DC, CPCO*

269

269

ICD-10 Changes for 2025

M65.91	**Unspecified synovitis and tenosynovitis, shoulder**
M65.911	Unspecified synovitis and tenosynovitis, right shoulder
M65.912	Unspecified synovitis and tenosynovitis, left shoulder
M65.919	Unspecified synovitis and tenosynovitis, unspecified shoulder

Shoulder synovitis is an inflammatory condition of the inner layer of the capsule in the shoulder joint. **Tenosynovitis** is tendinitis accompanied by inflammation of the protective covering around the tendon (tendon sheath).

Excerpt from: *ICD-10 Coding of the Top 100 Conditions for the Chiropractic Office by Mario Fucinari DC, CPCO*

270

270

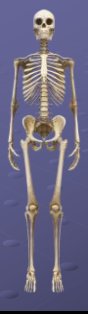
Sequencing of Codes

- Alphanumeric characters are reported on the insurance claim form because you are communicating to a computer.
- Be sure to use the correct codes to the highest degree of specificity.
- The diagnosis you provide directly relates to the level of care permitted by the third-party payers.

271

271

Choosing the Diagnosis

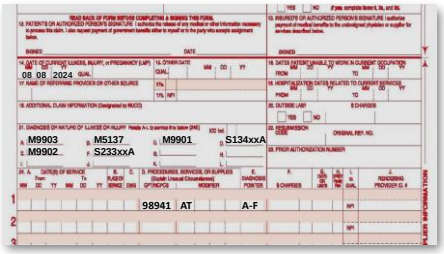


Name	Abbreviation	Code
Cervical	C1-C7	M99.01
Thoracic	T1-T12	M99.02
Lumbar	L1-L5	M99.03
Sacrum and Coccyx	S or SC	M99.04
Ilium/Illi	I or SI	M99.05

272

272

EXAMPLE MEDICARE CLAIM FORM



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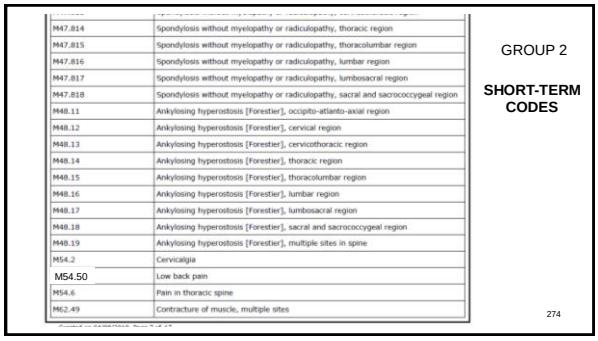
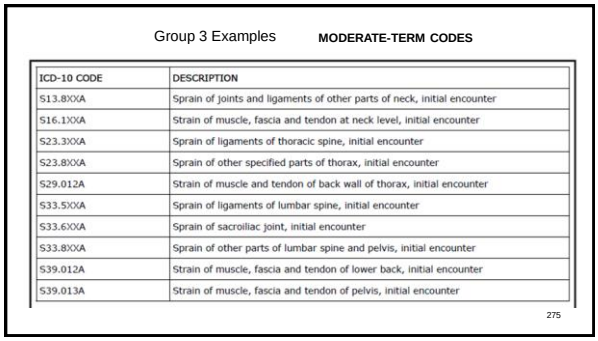


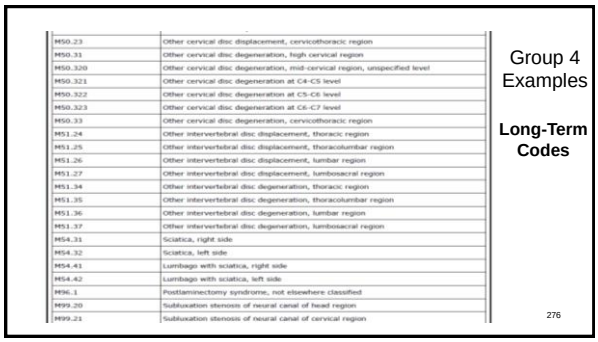
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M48.11	Ankylosing hyperostosis [Forestier], occipito-atlanto-axial region
M48.12	Ankylosing hyperostosis [Forestier], cervical region
M48.13	Ankylosing hyperostosis [Forestier], cervicothoracic region
M48.14	Ankylosing hyperostosis [Forestier], thoracic region
M48.15	Ankylosing hyperostosis [Forestier], thoracolumbar region
M48.16	Ankylosing hyperostosis [Forestier], lumbar region
M48.17	Ankylosing hyperostosis [Forestier], lumbosacral region
M48.18	Ankylosing hyperostosis [Forestier], sacral and sacrococcygeal region
M48.19	Ankylosing hyperostosis [Forestier], multiple sites in spine
M54.2	Cervicalgia
M54.50	Low back pain
M54.6	Pain in thoracic spine
M62.49	Contracture of muscle, multiple sites

274



ICD-10 CODE	DESCRIPTION
S13.8XXA	Sprain of joints and ligaments of other parts of neck, initial encounter
S16.1XXA	Strain of muscle, fascia and tendon at neck level, initial encounter
S23.3XXA	Sprain of ligaments of thoracic spine, initial encounter
S23.8XXA	Sprain of other specified parts of thorax, initial encounter
S29.012A	Strain of muscle and tendon of back wall of thorax, initial encounter
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
S33.6XXA	Sprain of sacroiliac joint, initial encounter
S33.8XXA	Sprain of other parts of lumbar spine and pelvis, initial encounter
S39.012A	Strain of muscle, fascia and tendon of lower back, initial encounter
S39.013A	Strain of muscle, fascia and tendon of pelvis, initial encounter

275



M50.23	Other cervical disc displacement, cervicothoracic region
M50.31	Other cervical disc degeneration, high cervical region
M50.320	Other cervical disc degeneration, mid-cervical region, unspecified level
M50.321	Other cervical disc degeneration at C4-C5 level
M50.322	Other cervical disc degeneration at C5-C6 level
M50.323	Other cervical disc degeneration at C6-C7 level
M50.33	Other cervical disc degeneration, cervicothoracic region
M51.24	Other intervertebral disc displacement, thoracic region
M51.25	Other intervertebral disc displacement, thoracolumbar region
M51.26	Other intervertebral disc displacement, lumbar region
M51.27	Other intervertebral disc displacement, lumbosacral region
M51.34	Other intervertebral disc degeneration, thoracic region
M51.35	Other intervertebral disc degeneration, thoracolumbar region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M96.1	Postlaminectomy syndrome, not elsewhere classified
M99.20	Subluxation stenosis of neural canal of head region
M99.21	Subluxation stenosis of neural canal of cervical region

276

ICD-10 Sequencing of Codes

Sequencing of the codes:

- Neurological diagnosis
- Structural descriptor diagnosis
- Functional diagnosis
- Soft tissue
- Extremity
- Complicating factors

277

277

ICD-10 Sequencing of Codes

Sequencing of the codes:

- Neurological diagnosis
  - Postlaminectomy syndrome (M96.1)
  - Disc Displacement
  - Neuritis
- Structural descriptor diagnosis
- Functional diagnosis
- Soft tissue
- Extremity
- Complicating factors

278

278

ICD-10 Sequencing of Codes

Sequencing of the codes:

- Neurological diagnosis
- Structural descriptor diagnosis
  - Degenerative Disc Disease
  - Spinal Stenosis
  - Scoliosis
- Functional diagnosis
- Soft tissue
- Extremity
- Complicating factors

279

279

ICD-10 Sequencing of Codes

Sequencing of the codes:

- **Neurological diagnosis**
- **Structural descriptor diagnosis**
  - **Degenerative Disc Disease**
  - **Spinal Stenosis**
  - **Scoliosis**
  - **Segmental and Somatic Dysfunction**
- **Functional diagnosis**
- **Soft tissue**
- **Extremity**
- **Complicating factors**

280

280

ICD-10 Sequencing of Codes

Sequencing of the codes:

- **Neurological diagnosis**
- **Structural descriptor diagnosis**
- **Functional diagnosis**
  - **Disuse Atrophy/Deconditioning**
- **Soft tissue**
- **Extremity**
- **Complicating factors**

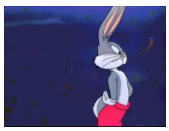
281

281

Deconditioning Syndrome

"Diminished ability or perceived ability to perform tasks involved in a person's usual activities of daily living."

Rehabilitation of the Spine by Craig Liebenson. © 2007, Pg. 7



282

282

Deconditioning Syndrome

M62.59 Muscle wasting and atrophy, not elsewhere classified, **multiple sites**

M62.511 Muscle wasting and atrophy, not elsewhere classified, **right shoulder**

M62512 Muscle wasting and atrophy, not elsewhere classified, **left shoulder**

283

283

ICD-10 Sequencing of Codes

Sequencing of the codes:

- **Neurological diagnosis**
- **Structural descriptor diagnosis**
- **Functional diagnosis**
- **Soft tissue**
  - **Myositis**
  - **Fibromyalgia**
- **Extremity**
- **Complicating factors**
- **External Cause Codes (VA, PI, WC)**

284

284

ICD-10 Sequencing of Codes

Sequencing of the codes:

- **Neurological diagnosis**
- **Structural descriptor diagnosis**
- **Functional diagnosis**
- **Soft tissue**
  - **Myositis**
  - **Fibromyalgia**
- **Extremity**
- **Complicating factors**
- **External Cause Codes (VA, PI, WC)**
- **Social Determinants of Health (SDOH)**

285

285

What About NON-COMPLIANT Patients!

- Z91.19 Patient's noncompliance with other medical treatment and regimen
- Z91.190 Patient's noncompliance with other medical treatment and regimen due to financial hardship
- Z91.198 Patient's noncompliance with other medical treatment and regimen for other reason
- Z91.199 Patient's noncompliance with other medical treatment and regimen due to unspecified reason

286

286

Social Determinants of Health Codes

- Social Determinants of Health Codes will shift the severity designation for the codes describing **inadequate housing and housing instability**. Whereas these codes are currently designated as "non-complication or comorbidity," that would change, and they'd be considered a complication or comorbidity.
- This may affect reimbursement in Medicaid. If you use these Z codes as tertiary diagnoses, you could get paid more if these become considered complications or comorbidities.

287

287

Disc Rehabilitation Therapy

- The history for rehabilitation documentation should identify what activity intolerances are present.
- The rehabilitation care must identify the **"patient-centered"** goals of care.
- **Restoring those ***functions*** becomes the main goal or end point of care.

288

288

Rehabilitation Therapy

Every rehabilitation program must start with an assessment of abnormal function (strength, endurance, coordination, balance and flexibility)

The quantifiable functional deficit is the baseline from which to determine progress

Ask the patient, "What can you NOT do?"

289

289

Rehabilitation Therapy

- The physician or therapist is required to have direct one-on-one patient contact.
- DOCUMENT WHO ATTENDED
- The patient must perform the rehab exercises while the doctor instructs, oversees, and corrects the biomechanics.
- The codes for rehab services are based on 15-minute intervals.

290

290

Foot Levelers THERA-CISER®

291

291

Foot Levelers Tri-Flex®

292

292

Rehabilitation Therapy

Documentation Requirements:

1) What was done
2) Location/Region (lumbar, knee, shoulder, etc.)
3) Amount of time service performed
   - Units
   - Minutes
   - Clock time

293

293

The 5 Ws of Therapy

1) What was done?
2) Where (Location/Region)?
3) Why (Rationale)?
4) What are the settings/resistance?
5) Who oversaw/attended?

294

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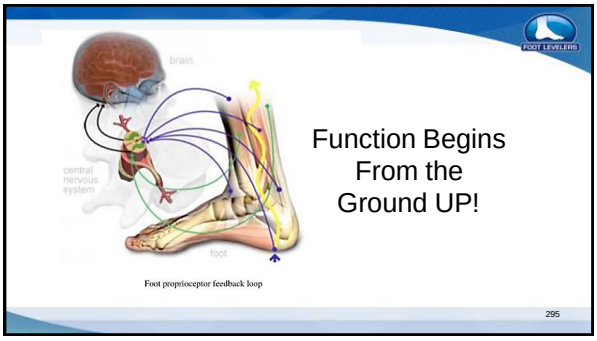


295

Comprehensive Treatment Protocols

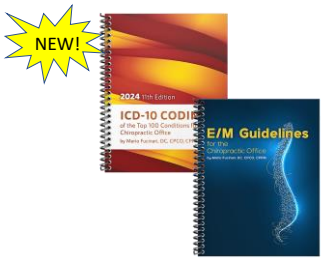
Manipulation
Rehabilitation
Orthotic Support of the Kinetic Chain
Nutritional Support

SYNERGY
1+1=3

296

296

297



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298

298

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- ICD10 Coding Book and Manuals at www.Askmario.com
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299

299