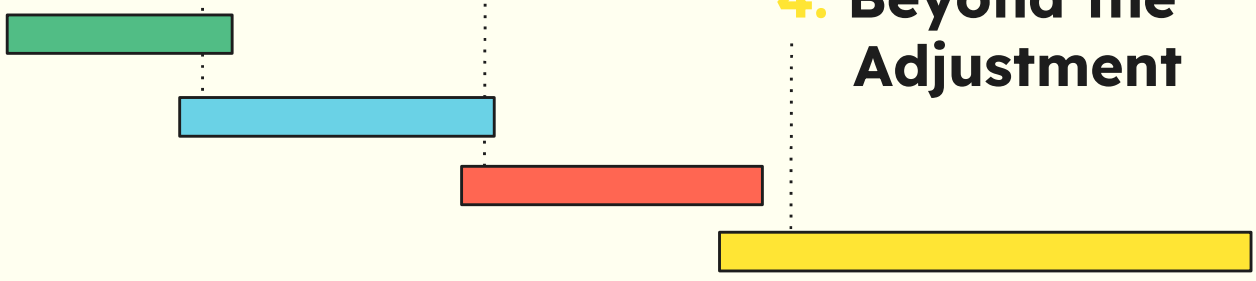
Let's Chat:

Chiropractic Insurance – From Basics to Beyond

MICHIGAN ASSOCIATION OF CHIROPRACTORS

1

1. Foundations of Insurance
2. The Life Cycle of a Claim
3. Mastering Managed Care
4. Beyond the Adjustment



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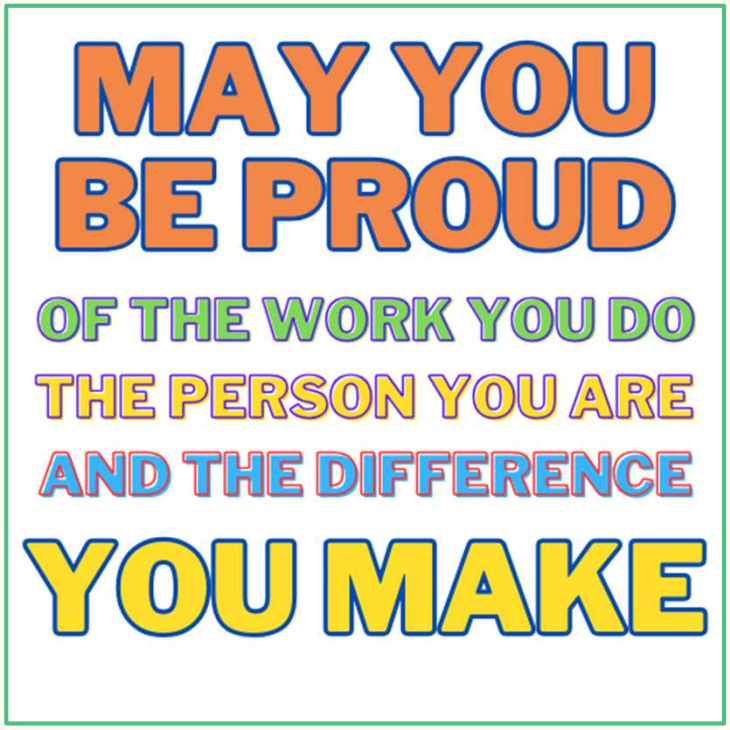


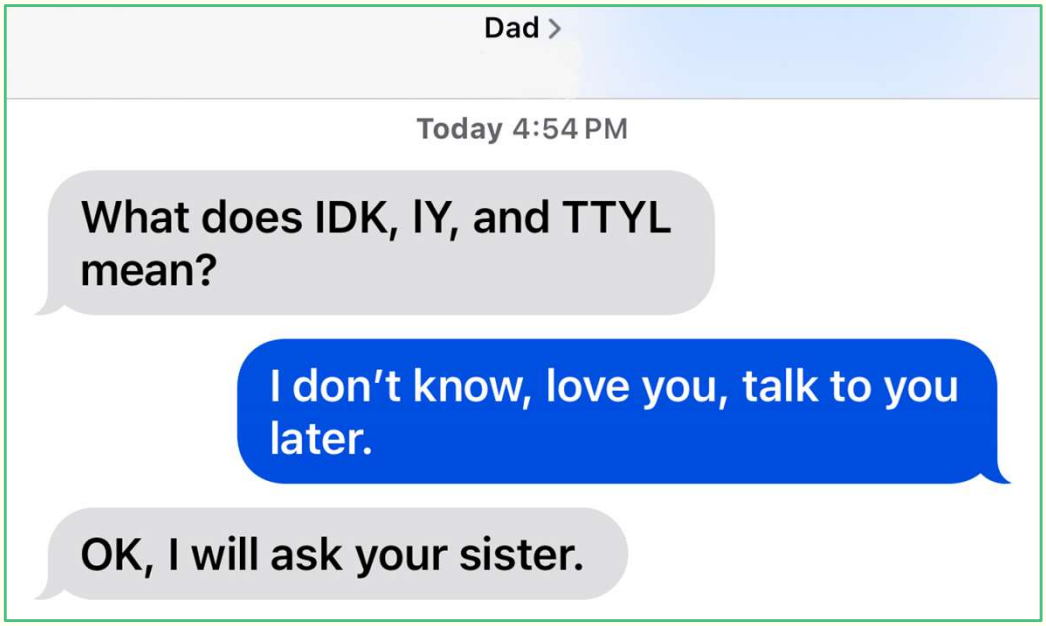
3

Foundations of Insurance

Goal: Build or refresh understanding of essential terms, structures, and processes.

- ❑ **Insurance Terminology**
- ❑ **Coding Systems Overview**
- ❑ **Insurance Plans Overview**
- ❑ **Plan Documents**

4



5

Key Insurance Terms & Concepts

Premium
The amount the patient (or employer) pays monthly for their insurance plan.

💡 ***Premiums*** *don't affect what the provider gets paid — just what the patient pays to have the plan.*

Deductible
The amount a patient must pay **out-of-pocket** before the insurance begins to pay for services.

💡 ***Deductibles*** *resets annually and applies to most covered services.*

Coinsurance
The patient's share of costs **after** the deductible is met, usually shown as a percentage (e.g., 20%).

💡 *Unlike a flat copay,* ***coinsurance*** *varies depending on the cost of the service.*

Copay
A fixed dollar amount the patient pays at the time of service (e.g., $20 office visit copay).

💡 ***Copays*** *usually apply to each visit and are separate from deductibles.*

6

Out-of-Pocket Maximum

The **most** a patient will pay in a plan year for covered services. Once reached, insurance pays 100%.

⇨ 💡 *May include deductibles, coinsurance, and copays.*

Explanation of Benefits (EOB)

A statement sent to the patient (and sometimes provider) showing what was billed, what was paid, and what the patient owes.

⇨ 💡 *This is not a bill—but it helps explain any balance.*

Medically Necessary

A service must be considered appropriate and necessary for diagnosis or treatment to be covered.

⇨ 💡 *Each payer has its own definition and documentation requirements.*

7

8

Coding Systems

ICD-10 Codes
- International Classification of Diseases
- Used to describe **diagnoses**.

💡 *Must support medical necessity and align with CPT codes.*

CPT Codes
- Current Procedural Terminology
- Used to describe **what service was performed**.

💡 *Think: spinal manipulation, exams, therapies, etc.*

HCPCS Codes
- Codes used for **supplies and services not listed in CPT**
- Examples: orthotics, supplies

💡 *Often used with Medicare and other government payers.*

9

ICD-10-CM

International Classification of Diseases, *10th* Revision, Clinical Modification

What they do: Identify **WHY** the patient is receiving care
Format: Alphanumeric; 3–7 characters

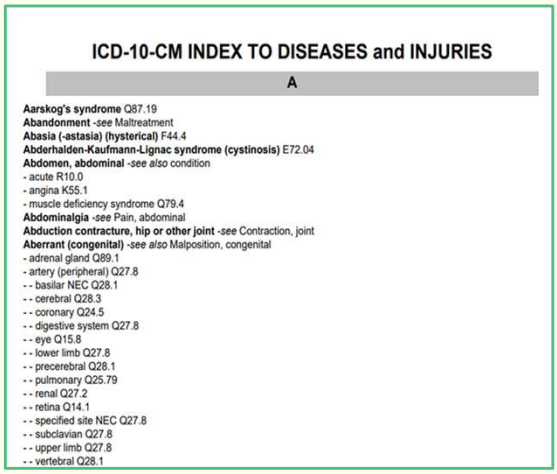
Structure Example:
- **M54.5** = Low back pain
- **S13.4XXA** = Sprain of ligaments of cervical spine, initial encounter

Format Breakdown:
- **1st character** = Letter (e.g., M = musculoskeletal)
- **2nd–3rd** = Numbers for general diagnosis category
- **4th–7th** = Provide greater specificity (e.g., location, laterality, encounter type)

10

ICD-10 - Manual Layout; 2 Sections

Alphabetical Index

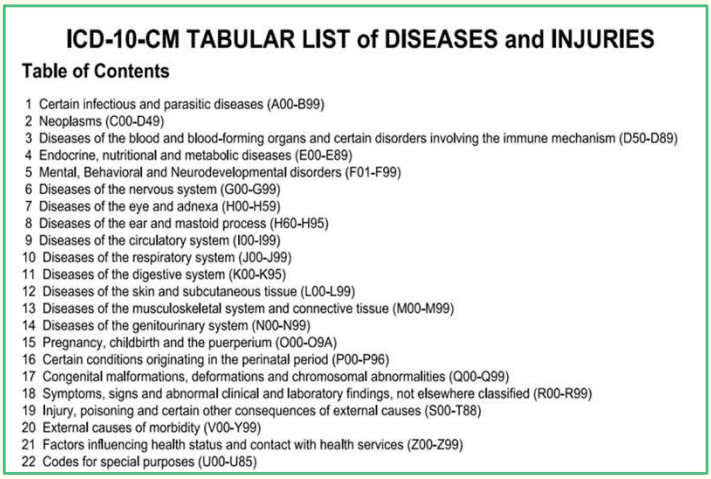


ICD-10-CM INDEX TO DISEASES and INJURIES

A

Aarskog's syndrome Q87.19
Abandonment -*see* Maltreatment
Abasia (-astasia) (hysterical) F44.4
Abderhalden-Kaufmann-Lignac syndrome (cystinosis) E72.04
Abdomen, abdominal -*see also* condition
- acute R10.0
- angina K55.1
- muscle deficiency syndrome Q79.4
Abdominalgia -*see* Pain, abdominal
Abduction contracture, hip or other joint -*see* Contraction, joint
Aberrant (congenital) -*see also* Malposition, congenital
- adrenal gland Q89.1
- artery (peripheral) Q27.8
- - basilar NEC Q28.1
- - cerebral Q28.3
- - coronary Q24.5
- - digestive system Q27.8
- - eye Q15.8
- - lower limb Q27.8
- - precerebral Q28.1
- - pulmonary Q25.79
- - renal Q27.2
- - retina Q14.1
- - specified site NEC Q27.8
- - subclavian Q27.8
- - upper limb Q27.8
- - vertebral Q28.1

Tabular Index



ICD-10-CM TABULAR LIST of DISEASES and INJURIES

Table of Contents

11

ICD-10 - Official Guidelines for Coding and Reporting

Level of Detail in Coding

"Diagnosis codes are to be used and reported at their highest number of characters available and to the **highest level of specificity** documented in the medical record.

ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth characters and/or sixth characters, which provide greater detail.

A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable."

12

ICD-10 - *Excludes1* Notation

"An excludes notes indicates that codes excluded from each other are independent of each other.

Excludes1
A type 1 Excludes note is a pure excludes note. It means "NOT CODED HERE!"

An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note.

An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition."

👉 *In chiropractic, it often shows up when a general pain code (like low back pain) is billed with a more specific diagnosis (like disc displacement or radiculopathy).*

13

ICD-10 - *Where Excludes1 Can Appear:*

📘 **Chapter level:** Applies broadly across condition types (e.g., entire musculoskeletal section)

🔠 **Category level:** First 3 characters (e.g., M54)

📁 **Subcategory level:** 4–5 characters (e.g., M54.5)

📄 **Specific code level:** Full code (e.g., M54.50)

🔍 **How to find them:**
When using a specific diagnosis code, walk **up the coding hierarchy** — from the code → subcategory → category → chapter — to see if an *Excludes1* note is listed.

📌 *Tip: Your EMR may not always show Excludes1 notes, so double-check using a trusted coding manual or tool.*

14

CPT - Current Procedural Terminology

What they do: Describe **WHAT** service or procedure was performed

Format: Always 5 digits, numeric only

Structure Example:

- **98940** = Chiropractic manipulation (1–2 regions)
- **99203** = New patient E/M visit, moderate complexity

💡 **Each CPT code corresponds to a billable service — they represent the *"what you did."***

15

Instructions from the CPT:

"Select the name of a procedure that *accurately* identifies the service performed.

Do not select a CPT code that *merely approximates* the service provided."

** Selecting a CPT code that only approximates the service provided can be considered fraudulent.*

16

HCPCS - Healthcare Common Procedure Coding System

What they do: Include services not found in the CPT system, often for equipment and supplies

Format: 1 letter + 4 numbers

Structure Example:

- S9090 = Vertebral axial decompression, per session
- L1851 = Knee orthosis, off the shelf

💡 *Often considered "experimental and/or investigational. Not commonly payable for services offered in a chiropractic office, with some payor exceptions.*

17

Insurance Plan Overview

HMO	PPO
Health Maintenance Organization	Preferred Provider Organization
Key Features	
• Requires patients to use **in-network providers** • Referral from PCP often required to see specialists • No out-of-network benefits (except emergencies)	• Patients can see **in-network *or* out-of-network providers** • No referral needed for specialists • Higher patient responsibility for out-of-network care
Relevance to Chiropractic	
• Must be in-network to be reimbursed by the plan • Pre-authorization may be required	• Greater flexibility in who patients can see • Often fewer restrictions than HMOs

18

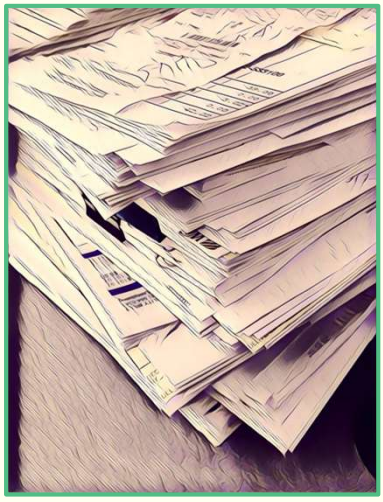
The Parts of Medicare

Part A	Part B	Part C	Part D	Medigap
Hospital Insurance	**Medical Insurance**	**Medicare Advantage (MA Plans)**	**Prescription Drug Covergae**	**Medicare Supplement**
• Covers inpatient hospital care, skilled nursing, hospice • ***Not relevant to chiropractors directly***	• Covers outpatient care • This is the part that applies to chiropractors • **For chiropractic, covers spinal manipulation when medically necessary** • *Does not cover exams, x-rays, or maintenance care*	• **Managed by private insurers** • **Required to cover at least the same services as Part A and Part B** • Rules vary by plan, may cover additional services (always verify individually) • May require prior auth or set networks	• Covers medications • ***Not directly relevant to chiropractic, but helpful to know for patient context***	• Extra coverage purchased from private insurance companies • Helps to pay out-of-pocket costs of Original Medicare • There are 10 different types of Medigap plans offered in most states, which are named by letters: A-D, F, G, and K-N.
Original Medicare, Traditional Medicare, or Fee-for-Service (FFS)		***Medicare Advantage***	***May be added to Original Medicare***	***May be added to Original Medicare***

19

Patient/Beneficiary Plan Document

- **Insurance Card(s)**
- **Summary of Benefits (SOB)**
- **Evidence of Coverage (EOC) / Certificate of Coverage**

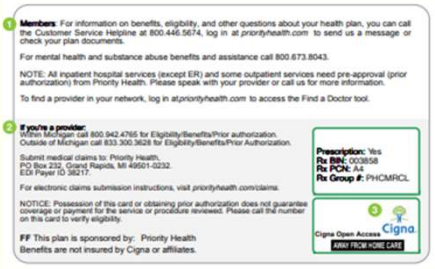


20

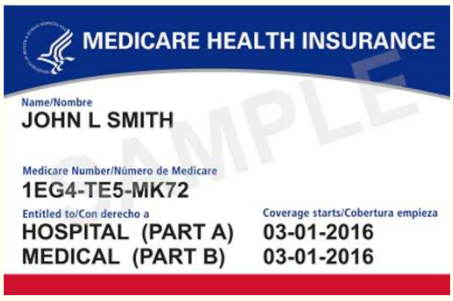
Insurance Card – Front & Back

- **Member Name & ID Number**
- **Plan Type** (HMO, PPO, Medicare Advantage, etc.)
- **Group Number**
- **Effective Date**
- **Plan Network Name** (e.g., Blue Care Network, Aetna Open Access, etc.)
- **Copays/Coinsurance listed** (sometimes includes PCP/specialist/copay amounts)
- **Customer Service or Provider Services Number**
- **Payer ID (for electronic claims)** – often on the back
- **Mailing Address for Claims** – sometimes still needed

👉 **Tip for offices:** Always scan both sides and verify that the patient's current plan matches what's on file.



21



The card shows:

Medicare Part A (HOSPITAL), Part B (MEDICAL), or both.

The date your coverage begins.

Medicare Beneficiaries receive the following instructions:

If you have Original Medicare:

- Carry your Medicare card with you when you're away from home.
- Show your Medicare card to your doctor, hospital, or other health care provider when you get services.
- If you have a Medicare drug plan or supplemental coverage, carry that plan card with you too.

If you join a Medicare Advantage Plan or other Medicare health plan:

- You'll use your plan's card to get services, not your Medicare card.
- Keep your Medicare card in a safe place in case you switch plans or go back to Original Medicare later.

22

Summary of Benefits (SOB)

This is usually a simplified chart or brochure.

What it includes:

- In-network and out-of-network **deductibles & out-of-pocket maximums**
- **Copays/Coinsurance** for various services
- Possibly any **visit limits** (e.g., "20 visits/year for chiropractic or PT")
- Possibly any authorization requirements for specialty services
- Notes about **preventive vs. diagnostic** care

👉 **Best Use:** Good for a quick reference, **but not a legally binding document** — always double-check with the EOC or provider manual when needed.

23

Evidence of Coverage (EOC) or Certificate of Coverage

*This is the **full, official contract** between the patient and the insurance plan.*

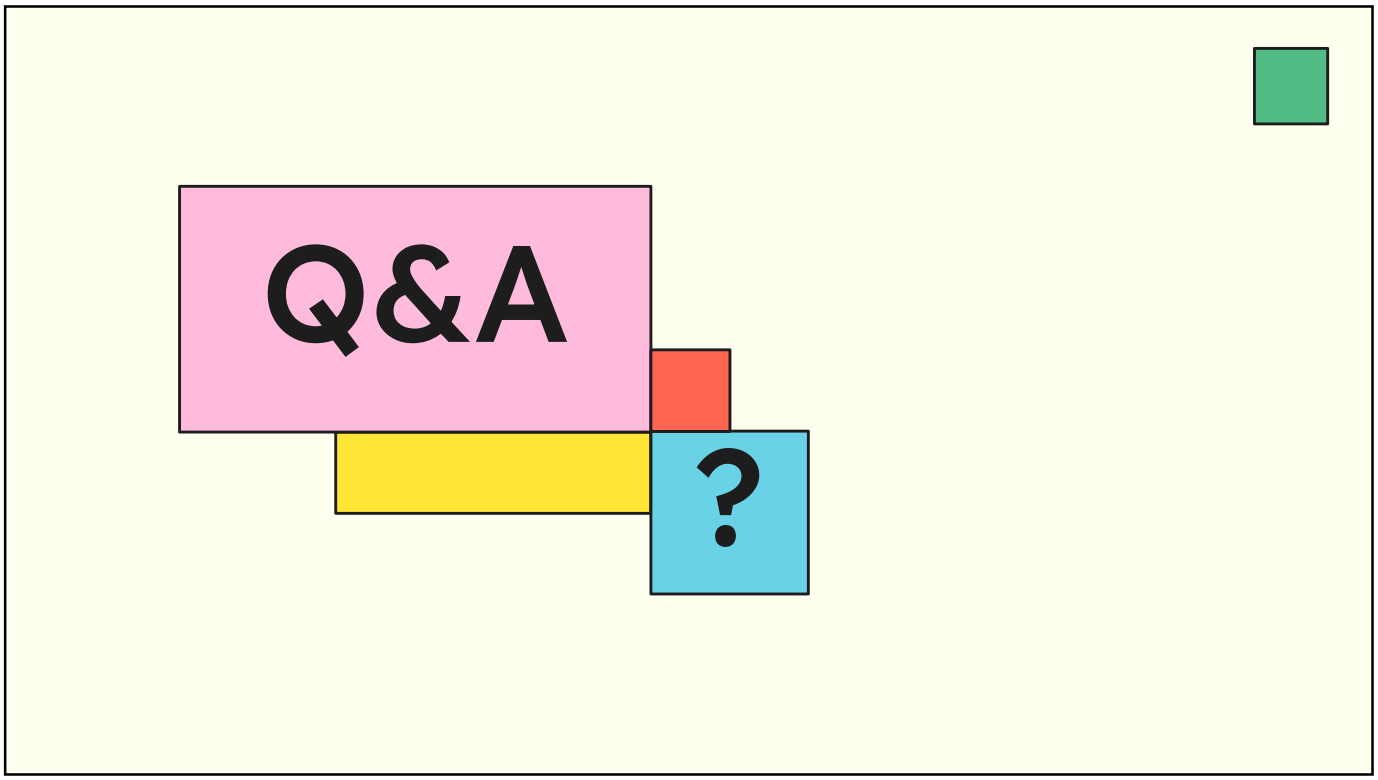
What it includes:

- Detailed **exclusions and limitations**
- Definitions *(e.g., what's "medically necessary")*
- Instructions on **how to appeal a denial**
- Complete rules around prior authorizations
- Chiropractic-specific policy rules *(often buried deep)*

👉 **Best Use: Most reliable source** for determining if a service is actually covered and under what circumstances.

👉 **Tip: When searching an electronic PDF**, use the *Ctrl and F keys* for a search window. Type common coverage terms *(i.e. chiropractic, maintenance, massage)*

24



25

1. Foundations of Insurance

2. The Life Cycle of a Claim

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4. Beyond the Adjustment

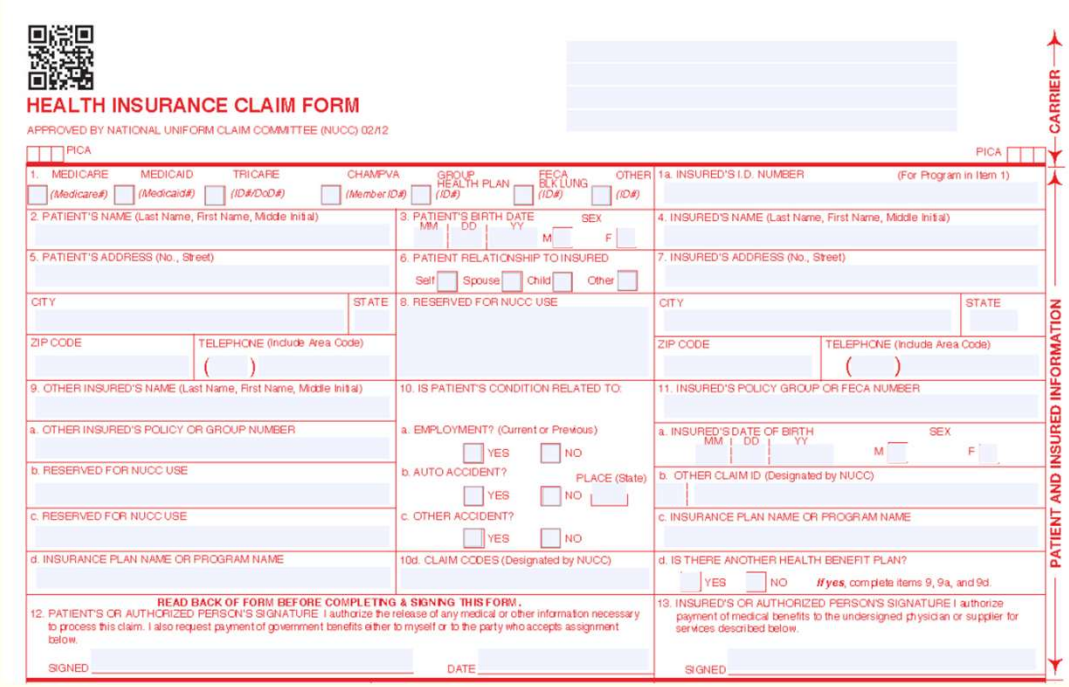
26

The Life Cycle of a Claim

Goal: Understand what happens from the moment a claim is created until it's paid - *and what to do if it's not.*

- ❑ **The Claim Life Cycle**
- ❑ **Common Causes of Denials**
- ❑ **Understanding and Using Denial Codes**
- ❑ **Correcting & Resubmitting Claims**
- ❑ **Appeals Process**
- ❑ **Rethinking the Schedule…**

27



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

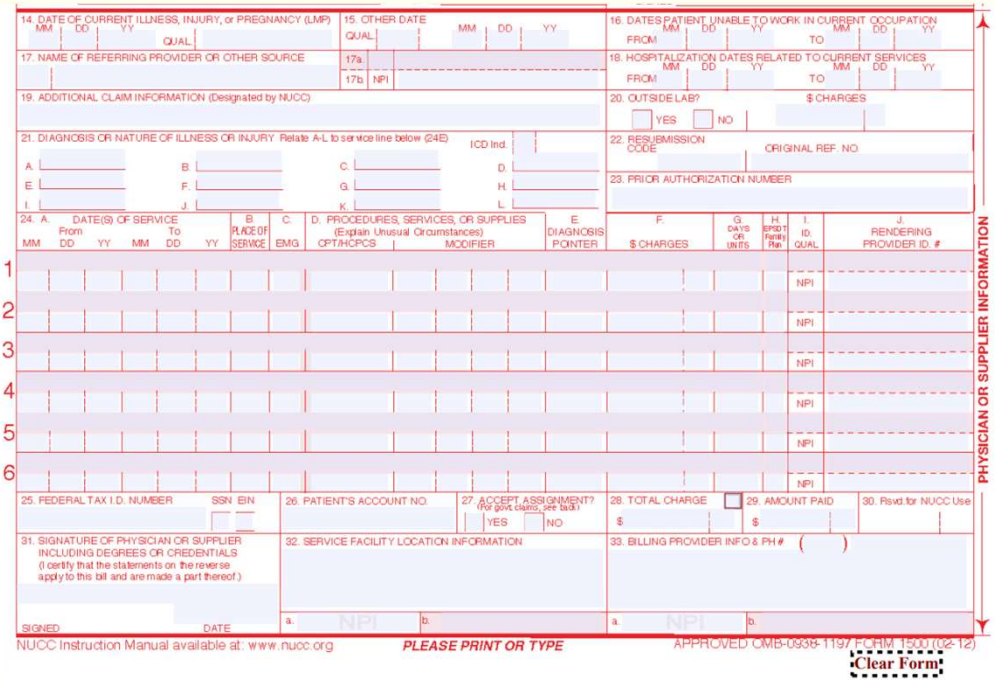
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

CARRIER

PATIENT AND INSURED INFORMATION

28



29

1) Paper Claims

Paper claims must be submitted using Form CMS-1500 in a valid version.

Offices are responsible for purchasing their own CMS-1500 claim forms which can be obtained from printers or printed in-house if they follow specifications developed by the National Uniform Claim Committee (NUCC). *(A standard printer or photocopier typically cannot duplicate the requirements.)*

NUCC 1500 Health Insurance Claim Form Reference Instruction Manual

2) Electronic Claims

Electronic claims are 1500 claims in an electronic (837) format.

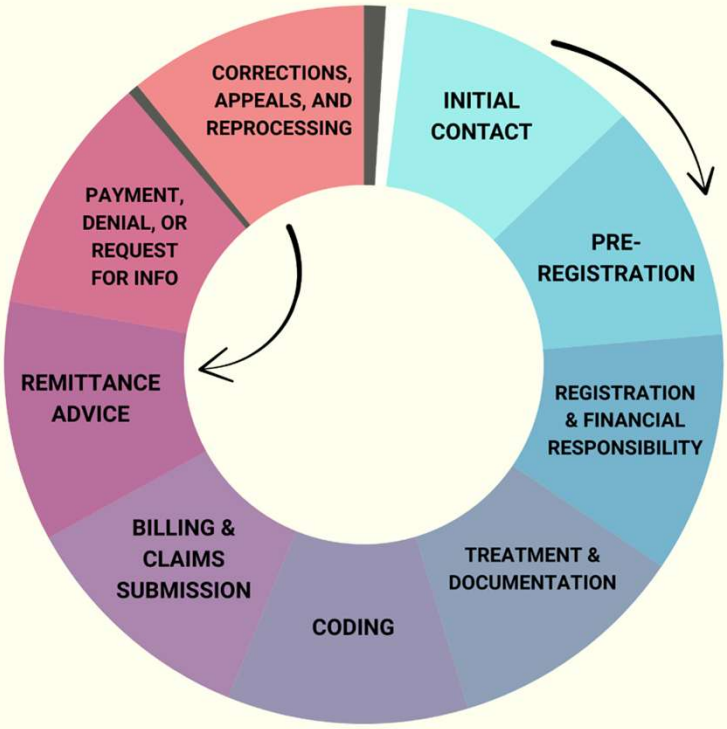
Medicare Claims Processing Manual Chapter 26 - Completing and Processing Form CMS-1500 Data Set

💡 **Look for other payers' instructions in specific provider or policy manuals!**

👉 **Tip: If you're new to billing, start by reviewing the Medicare QR code!**

30

The Claims Life Cycle



31

Step 1 – First Point of Contact

- Gather basic info: name, DOB, insurance
- Initial red flags: out-of-network, special plan types
- Start pre-screening for eligibility

💡 Train your team to listen for clues — the conversation is more than just scheduling.

Step 2 - Pre-Registration

- Eligibility & Benefits Verification
  - Confirm active coverage, deductible, copay
  - Chiropractic visit limits
  - Coverage for E/M, X-Ray, Therapies
- Good Faith Estimate
  - Required for self-pay/out-of-network
  - Use templates or software
  - Helps build trust

32

Step 3 – Registration & Financial Responsibility

- Enter plan info accurately
- Review plan docs if necessary
- Signed forms: HIPAA, Consent, financial responsibility, ABN, etc.
- Collect copays up front when possible

Pause. Check. Proceed.

✅ **Take Time to Double-Check:**

- All required forms are signed
- Insurance info is entered accurately
- Benefits and limits are confirmed
- Patient financial responsibility is clearly explained

💡 **Why It Matters:**

- Prevents billing errors and future denials
- Sets clear expectations with the patient
- Ensures you're ready to document medical necessity properly

33

Step 4 - Treatment & Documentation
What You Do & What You Write Must Match

Start with Your Findings

- E/M visits set the tone: what did you find, what's the plan?
- Use clear documentation to support the medical necessity of treatment
- Document objective findings: pain, restriction, neuro tests, etc.

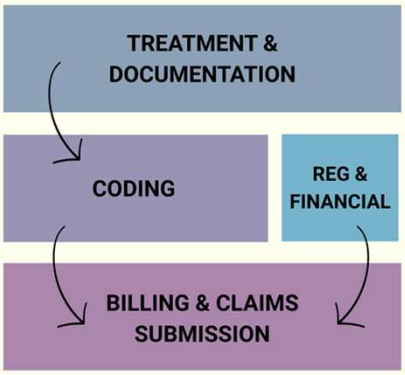
Know Your Payors - Each payer may have specific documentation rules

SOAP notes should tell a story:

S: Subjective - What the patient tells you
O: Objective - What you found
A: Assessment - What it means
P: Plan - What you're doing

💡 **Notes must connect to the diagnosis codes and CPT codes you bill!**

34



Steps 4 & 5 – Documentation → Coding
<u>If You Didn't Document It, You Can't Code It</u>

Treatment Tells the Story

- Clear, specific documentation is the foundation for accurate coding
- Every diagnosis and procedure should be traceable back to the visit note

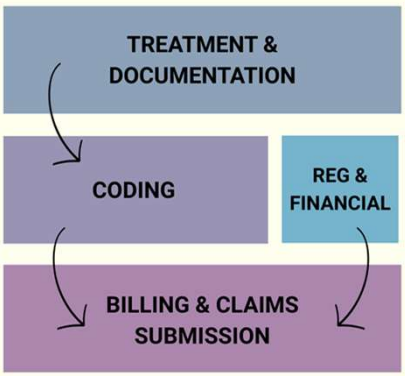
Coding Isn't One-Size-Fits-All

- Avoid "cookie-cutter" coding — base it on that day's unique visit
- Don't over- or under-code: let the documentation guide your choices
- Your E/M, CMT, and Therapy codes must reflect the services rendered

💡 **Why This Matters**

- Improves claim accuracy
- Reduces denials
- Supports medical necessity and audit readiness

35



Step 6 – Billing & Claims Submission
<u>It All Comes Together on the Claim Form</u>

Billing Starts Long Before Submission

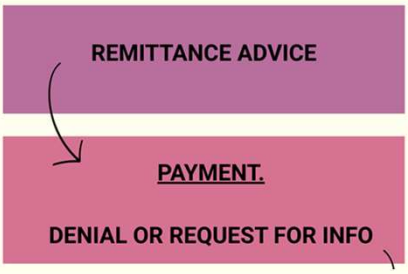
- Claims rely on the coding from Step 5 ***<u>and</u>*** the patient data from Step 3
- Accurate diagnosis and procedure codes must connect to verified benefits and insurance info

Every Detail Matters
Claim form must include:

- Patient & insurance details
- Provider & clinic info
- Procedure & diagnosis codes
- Modifiers and diagnosis pointers
- Dates of service and charges

💡 **Why It Matters**
Clean claims = faster payment
Mistakes = delays, denials, or rejections
Strong billing = strong revenue cycle

36



Step 8 – Remittance Advice
Did We Get Paid or Not?

The Remittance Advice (RA) or EOB (Explanation of Benefits) is the payer's response to your claim.

It explains how the claim was processed and what was paid (or not).

What to Look For:

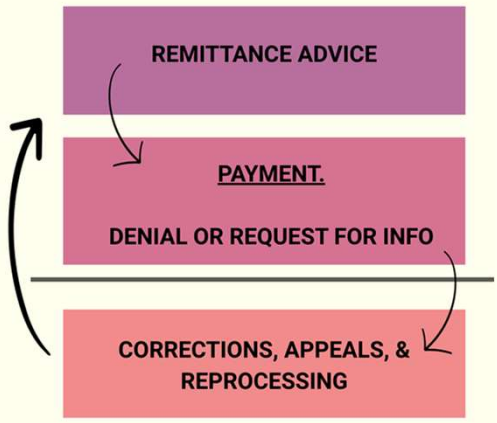
- Amount paid to provider
- Patient responsibility (copay, deductible, coinsurance)
- Denied or adjusted charges with **REASON CODES**
- Allowed amounts vs. billed charges

💡 **Why It's Important:**

- Confirms what got paid
- Flags what needs follow-up, correction, or appeal
- Tells your staff what to post and what to follow up on

37

Steps 9 & 10 – What's Next?



Payment, Denial, or Request for Info

After reviewing the RA/EOB, you'll know:

- Paid: Post the payment and reconcile
- Denied: Understand why (check the reason codes!)
- Pending info: Payer needs more documentation before deciding

Corrections, Appeals & Reprocessing

If denied or underpaid:

- Submit ***corrected claims*** for billing errors
- File an ***appeal*** with supporting documentation if you disagree decision
- Follow up! Track open items until they're resolved

Keep in Mind:

- Timely filing and appeal deadlines vary by payer
- The goal: Get the right payment for the right care

38

Full Circle: What This All Means for Your Office

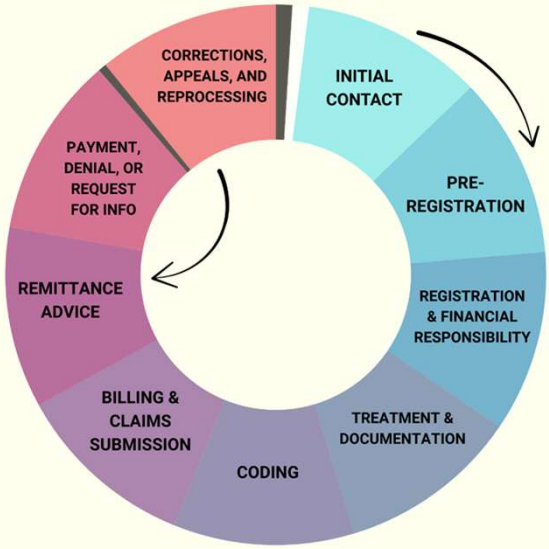
Every step matters.
Small errors at the start can lead to big problems later. Build strong front-end systems to reduce back-end headaches.

Document with intention.
Your treatment, codes, and billing all depend on accurate, complete documentation. Tell the full story clearly and consistently.

Communicate proactively.
Stay in sync with patients and payers—verify, confirm, explain, and follow up.

Don't just submit—follow through.
Check remittance advice, review denials, and follow up with corrections or appeals. It's not "one and done."

Your goal: Clean claims, timely payment.
Mastering the life cycle = fewer denials, better cash flow, and more time for patient care.



39

Rejections vs. Denials

To fix the problem, first understand where and why it happened.

What's the Difference? *Denial vs. Rejection*

Rejection:
- Happens before the claim is processed.
- Usually due to errors in claim format, missing fields, invalid patient/payer info, etc.

Denial:
- Claim was processed but not paid (or only partially).
- Usually has a reason code (CARC/RARC) and can be corrected or appealed.

40

Denials vs. Rejections & Who's Liable

Claim Rejections usually occur **before the claim is accepted into the payer's system** (e.g., formatting issues, missing data). These are not official denials and must be corrected and resubmitted.
→ **Provider's responsibility to fix and resend.**

Claim Denials are processed claims that are **determined not payable**, either due to plan limitations, medical necessity, or errors.
→ **Liability depends on the reason:**

- **Provider Liability:** for coding/billing errors, missed filing deadlines, or improper documentation.
- **Patient Liability:** when services aren't covered by their plan (e.g., maintenance care, out-of-network, or excluded services), the claim was billed correctly, and patient was informed in advance.

✅ Tip: Always document financial responsibility discussions and use ABNs or other waivers as appropriate.

41

When Do Denials Happen?

🟠 **Front-End Denials (Before Claim Submission)**

These happen before the claim even gets processed, often due to eligibility or setup errors.

Examples:
- Patient has no active coverage
- No referral or authorization
- Insurance card info was entered incorrectly

→ **These are preventable with good pre-registration processes.**

42

When Do Denials Happen?

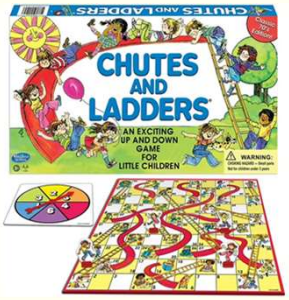
- **Pre-Payment Denials (After Submission, Before Payment)**

The claim is submitted but denied during processing.

Examples:

- Missing/invalid codes or modifiers
- Diagnosis doesn't support procedure
- Timely filing limit exceeded

→ **These require correction and resubmission.**



43

When Do Denials Happen?

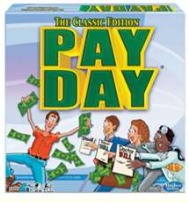
- **Post-Payment Denials (Audits or Recoupments)**

Payer paid initially, but later denies after reviewing documentation.

Examples:

- Lacking medical necessity
- Documentation doesn't support billed services
- Errors found during audit

→ **May require appeal or refund of overpayment.**



44

What Are CARC and RARC Codes?

CARC = Claim Adjustment Reason Code

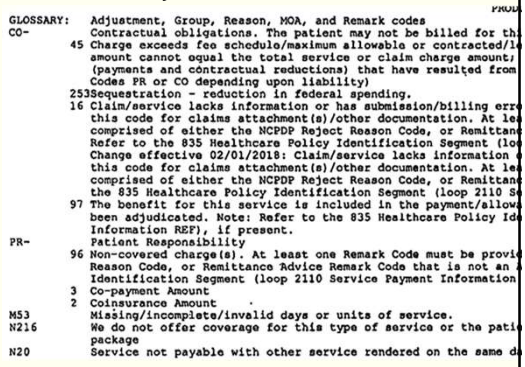
- Explains **why a claim (or service line) was paid differently than billed.**
- These are the **main denial or adjustment codes** you see on EOBs/ERAs.
- Example:
  - **CO-16** = *Claim/service lacks information which is needed for adjudication.*

RARC = Remittance Advice Remark Code

- Gives **additional detail** about the adjustment/denial.
- Helps clarify or expand on the CARC code.
- Example:
  - **MA27** = *Missing/incomplete/invalid modifier(s).*

Think of it like this:

- **CARC** tells you the **what.**
- **RARC** tells you the **why…..**


GLOSSARY: Adjustment, Group, Reason, MOA, and Remark codes
CO- Contractual obligations. The patient may not be billed for th
45 Charge exceeds fee schedule/maximum allowable or contracted/l
amount cannot equal the total service or claim charge amount;
(payments and contractual reductions) that have resulted from
Codes PR or CO depending upon liability)
253 Sequestration - reduction in federal spending.
16 Claim/service lacks information or has submission/billing err
this code for claims attachment(s)/other documentation. At le
comprised of either the NCPDP Reject Reason Code, or Remittan
Refer to the 835 Healthcare Policy Identification Segment (lo
Change effective 02/01/2018: Claim/service lacks information
this code for claims attachment(s)/other documentation. At le
comprised of either the NCPDP Reject Reason Code, or Remittan
the 835 Healthcare Policy Identification Segment (loop 2110 S
97 The benefit for this service is included in the payment/allow
been adjudicated. Note: Refer to the 835 Healthcare Policy Id
Information REF), if present.
PR- Patient Responsibility
96 Non-covered charge(s). At least one Remark Code must be provi
Reason Code, or Remittance Advice Remark Code that is not an
Identification Segment (loop 2110 Service Payment Information
3 Co-payment Amount
2 Coinsurance Amount
M53 Missing/incomplete/invalid days or units of service.
N216 We do not offer coverage for this type of service or the pati
package
N20 Service not payable with other service rendered on the same d

45

Understanding Denial Code Prefixes

When reviewing an **Explanation of Benefits (EOB)** or **Electronic Remittance Advice (ERA)**, you'll see adjustment reason codes that start with a prefix. These prefixes help you understand **who is responsible** and **why** the payment was adjusted.

✅ CO – Contractual Obligation

- **Not billable to the patient.**
- Amount adjusted due to the contract between the provider and the payer.
- Common with fee schedule reductions or bundled services.

✅ PR – Patient Responsibility

- **May be billable to the patient.**
- Includes **deductibles, copays, and coinsurance.**
- Be sure this matches what the patient was told during verification.

✅ OA – Other Adjustment

- **Not typically billable to the patient.**
- Used for **informational or administrative reasons** like duplicate claims or bundling issues.

✅ PI – Payer Initiated Reductions

- **Not usually billable to patient.**
- Often related to **medical necessity** or **policy guidelines** (e.g., services not covered).

✅ CR – Correction and Reversal

- Used for **reversals of prior claim payments**, often seen when a claim was processed incorrectly and is being reprocessed.

46

Common Causes of Denials

Eligibility Issues
- Coverage was inactive on DOS, the wrong payer was billed, the COB wasn't updated, or a required referral or prior authorization wasn't obtained.

Missing or Incorrect Codes/Modifiers
- Required CPT or ICD-10 codes are missing, invalid, or inaccurate.
- Modifiers may be missing or used incorrectly.

Diagnosis/Procedure Mismatch
- The diagnosis doesn't support the procedure billed, the two aren't linked correctly in Box 24E of the CMS-1500 form, or an *Excludes1* notation exists

Filing Outside Timely Limits

Services Not Covered or Not Medically Necessary
- The procedure isn't a benefit under the patient's plan, or the payer determined it wasn't necessary based on submitted codes or documentation.

Lack of Documentation
- The payer requested records to support the claim and either didn't receive them, received insufficient information, or determined the documentation didn't meet their standards.

47

Availity essentials | Provider Help Center

Correct a claim

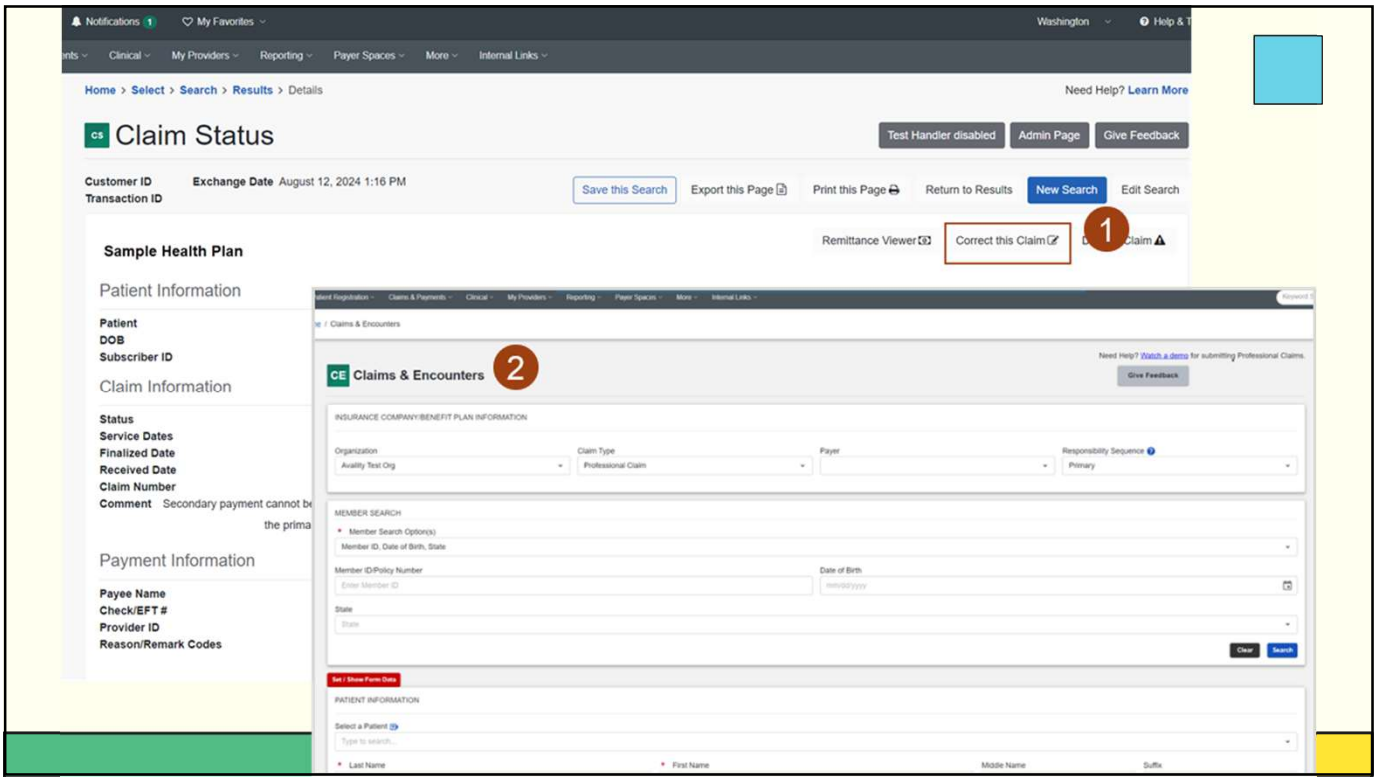
The following options are available in Availity Essentials for correcting a claim that has already been accepted for processing by a payer.

Correct a claim using Claim Status and Claims & Encounters

1. In the Claim Status application, submit an inquiry for the claim you want to correct and select the claim in the search results.
2. On the Claim Status results page, select **Correct this Claim**. If the **Correct this Claim** button does not display, the claim cannot be corrected using this option.
3. The claim information opens in the Claims & Encounters application. Make any necessary changes on this page.

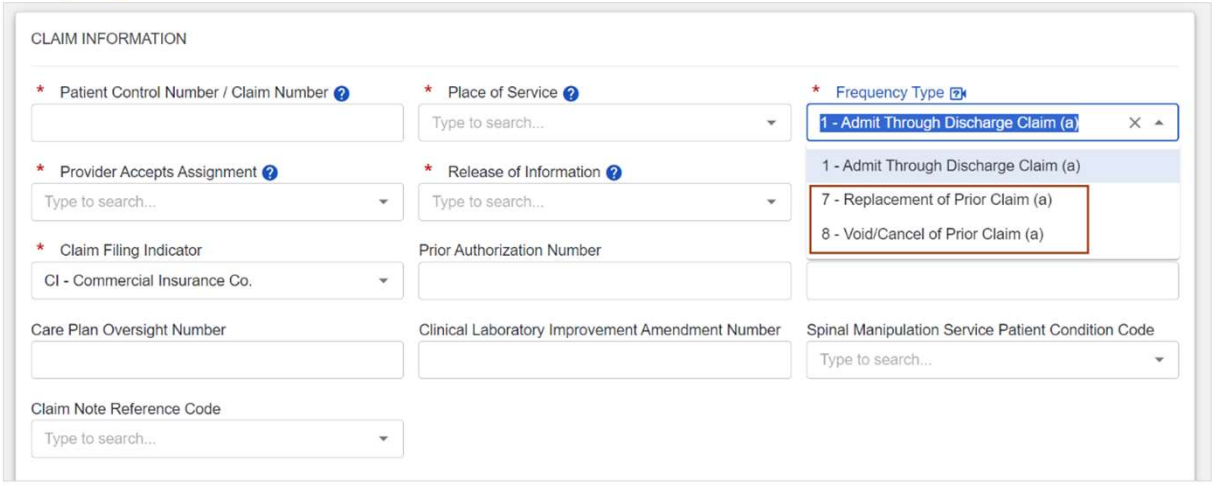
📌 ***Tip:*** *For each payer that you bill, create a resource listing their process, timeframe, requirements, etc. for correcting or appealing claims.*

48



49

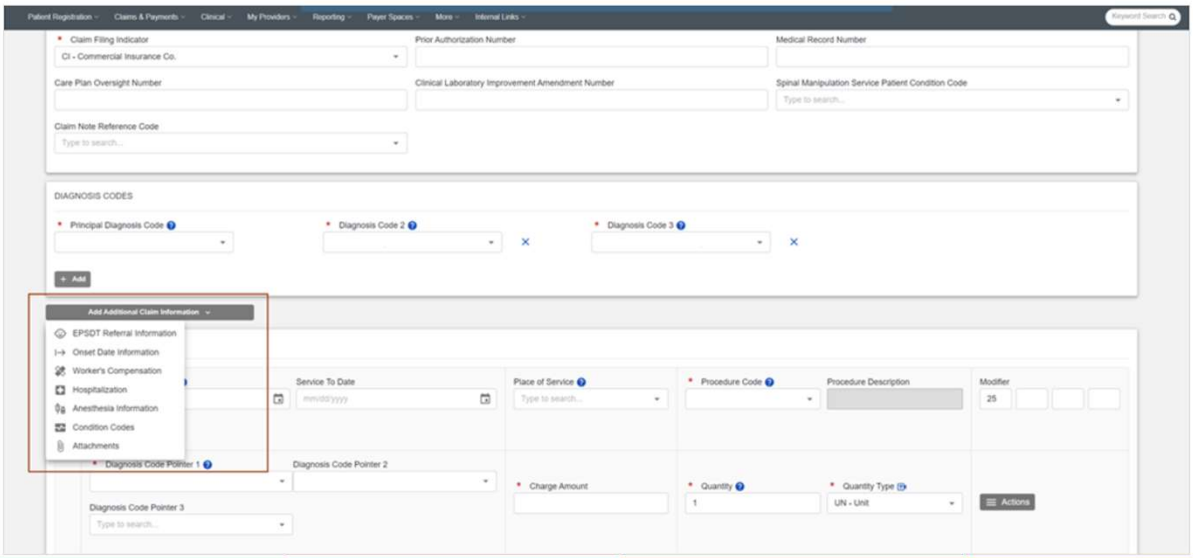
Note: In the **Frequency Type** field in the Claim Information section, select **7 - Replacement of Prior Claim** or **8 - Void/Cancel of Prior Claim** for a claim correction:



50

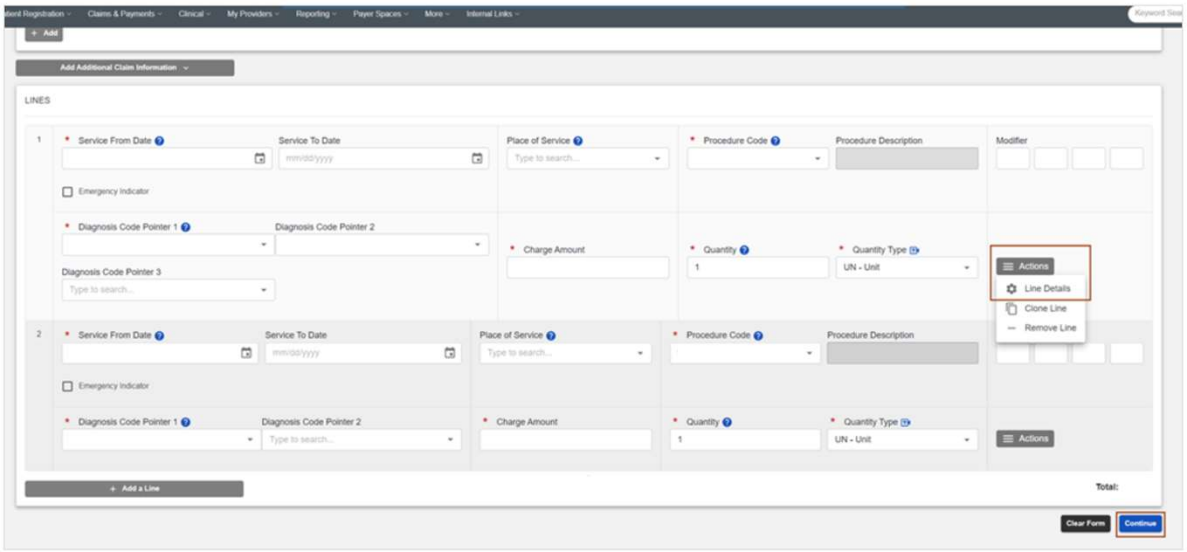
4. To add a claim note or reference code, select the applicable option in the **Claim Note Reference Code** field and then enter information in the field that displays.

5. You can add additional information by selecting the **Add Additional Claim Information** button and then selecting the type of information – such as EPSDT referral information, onset date information, etc. – you want to add.



51

6. To add additional information to service lines, select the **Actions** menu on the right side of the service line and then select **Line Details**. Enter information on the line details page and select **Save** at the bottom of the page to save the added information and navigate back to the claim form.



7. When you're ready to submit the corrected claim, select the **Continue** button at the bottom of the form to navigate to the claim summary page. Review the claim summary information and then select the **Submit** button at the bottom of the page to submit the corrected claim.

52

From WPS - GHA Medicare:

How to Correct a Rejected Claim

Published on Mar 30, 2016, Last Updated Dec 23, 2024

Jurisdictions: J5B J8B

Medicare rejects a claim when it is missing key data needed to make an official determination on (adjudicate) the claim. These rejected claims are also called unprocessable claims. Although these claims finalize in the claims processing system and appear on a remittance advice, Medicare does not consider them to be processed claims. You cannot request a redetermination on these claims because they have not received an initial determination. They also do not qualify for a Clerical Error Reopening (CER). You can only correct a rejected or unprocessable claim by submitting a new claim with the correct information.

53

Identifying an Unprocessable Claim

You can identify an unprocessable claim by the reason and remark codes that appear on the remittance advice. Unprocessable claims include Remittance Advice Remark Code (RARC) MA130, which states, "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information."

Unprocessable claims also include a Claim Adjustment Reason Code (CARC) indicating that the claim is missing information or that the information is incomplete or invalid. Since providers are responsible for submitting complete and correct claims, unprocessable claims reject as a Contractual Obligation (CO), meaning the provider cannot bill the patient for the rejected service. The following are some of the most common group/CARC code combinations assigned to unprocessable claims:

- CO-16: Claim/service lacks information which is needed for adjudication.
- CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
- CO-181: Procedure code was invalid on the date of service.

See the link for some of the most common unprocessable RARC codes along with tips for correcting the claim.

https://www.wpsgha.com/guides-resources/view/318

54

CMS 1500 to Electronic 837 Crosswalk ("Loops")

Item No.	Narrative	ANSI 837 version 5010	Loop	Data Element Description	Status	Requirements for version 5010
1	Type of health insurance	2-0050-SBR09	2000B	Claim filing indicator code	R	Must=MB for Medicare Part B claims
1A†	Insured's I.D. number	2-0150-NM109	2010BA	Subscriber primary identifier	R	Enter the patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer. (For Medicare the patient is always the subscriber.) (NM101) = (IL) (NM108) = (MI)
2	Patient's name (Last Name, First Name, Middle Initial)	2-0150-NM103 2-0150-NM104 2-0150-NM105	2010BA	Subscriber last name Subscriber first name Subscriber middle name or initial	R R S	Enter the patient's name as shown on their Medicare card. (For Medicare, the patient is always the subscriber.)
3	Patient's birth date Patient's sex	2-0320-DMG02 2-0320-DMG03	2010BA	Subscriber birth date Subscriber gender code	R R	Enter the patient's birth date. Must be formatted as CCYYMMDD. Date Qualifier (DMG01)=D8 Enter the patient's sex. F=Female M=Male U=Unknown
4†	Insured name (Last name, First Name, Middle Initial)	2-3250-NM103 2-3250-NM104 2-3250-NM105	2330A	Other insured last name Other insured first name Other insured middle name	S S S	If there is insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. Required if any other payers are known to potentially be involved in paying this claim.

https://www.wpshealth.com/resources/files/npi_1500_crosswalk.pdf

55

If the Claim was Filed Correctly, but Denied…. What Can Be Appealed?

You can appeal **denials** (and sometimes rejections) that are:

- **Medically necessary but denied**
- **Incorrectly processed**
  - Payer used wrong fee schedule, paid wrong amount, or denied based on misinformation.
- **Lack of documentation** (when you can resubmit with records)
- **Bundling or downcoding errors** (e.g., 99203 downcoded to 99202 without justification)
- **Timely filing denials** *(sometimes, if you have proof of timely submission)*
- **Out-of-network** misrouting or COB errors

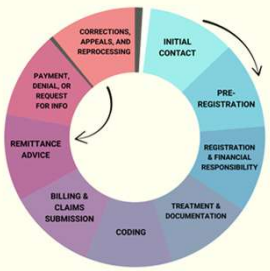
What Usually *Can't* Be Appealed?

- **Rejections** due to:
  - Invalid or missing data (fix and resubmit)
  - Incomplete claim formats
  - Patient eligibility errors (unless fixed by the patient)
- **Denials due to coding errors**
- **Contractual exclusions** (e.g., services that are never covered)
- **Past timely filing deadlines** without a valid exception

56

💡 "Appeal" Tips

- **The appeal/claim review/reconsideration process is part of the claim cycle**
  Don't skip it — appeals are your opportunity to fix errors or fight unfair denials.
- **Always read the denial code(s) carefully**
  Don't assume! Use the code descriptions to guide your next steps.
- **Know your payer policies**
  Bookmark payer manuals, medical policies, and submission instructions. Some payers have a preliminary process before the formal appeal.



- **Submit appeals timely**
  Mark your calendar! Each payer has its own appeal deadline — usually 60-180 days.
- **Appeals are not personal — they're process**
  A denial doesn't mean you did something wrong. It's part of the cycle, so stay proactive.

57

What to Include in an Appeal Letter:

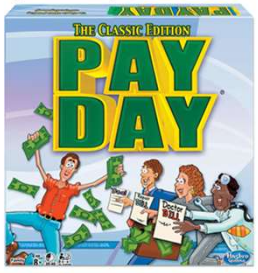
1. **Clear and concise appeal letter**
   - State why you're appealing
   - Include patient name, DOS, claim #, and denial reason
2. **Supporting documentation, if requested**
   - SOAP notes, treatment plans, X-rays
3. **Reference relevant payer policies**
   - **Quote the specific policy number** or section from the payer's manual that supports your billing
   - For example: "Per BCBSM Chiropractic Provider Manual"
4. **Reference national standards when applicable**
   - Such as **NCCI (National Correct Coding Initiative) edits** for bundling issues or modifier use
   - Also consider: **CMS guidelines**, **Medicare Benefit Policy Manual**, or **ICD-10/CPT official guidance**
5. **Any additional supporting evidence** (Proof of timely filing, Screenshots from payer portals, Notes/Reference #s from customer service calls)

58

59

✅ Key Takeaways from *"The Lifecycle of a Claim"*

- **Every claim tells a story** — from first patient contact to payment or appeal, each step plays a role.
- **Prevention is power** — clear documentation, eligibility checks, and accurate coding help stop denials before they happen.
- **Understand the *why* behind denials** — reading EOBs carefully and decoding CARCs/RARCs gives you the roadmap to correction.
- **Rejections ≠ Denials** — know the difference so you can respond appropriately.
- **Appeals are part of the process** — don't give up on claims too early. Use payer policies and national guidelines (like NCCI) to your advantage.
- **Track trends** — repeat denials often mean a workflow issue. Fix the system, not just the claim.
- **Patient liability is limited** — in most cases, especially when errors occur, you *cannot* pass denied charges on to the patient.



60

Let's Talk Patient Load: *Finding the Right Fit*

It's Not Just About Patient Volume
More patients doesn't always mean more profit—especially if:

- Claims are getting denied and not followed up on
- Documentation is rushed or incomplete
- Front desk staff is stretched too thin to verify benefits properly
- You're spending evenings catching up on notes or appeals

Backlog = Bottleneck

If you've got:

- Claims that haven't been submitted in 7+ days
- An increase in unexplained denials
- Reimbursement checks slower than usual

… It's time to ask: ***Are we over-scheduled for our current workflow capacity?***

61

Signs Your Schedule *May* Be Too Full

- Frequent reschedules and cancellations (patients feeling rushed, not valued, lack of or miscommunication)
- Documentation not done the same day
- Insurance verifications falling through the cracks
- You can't find time to review your own aging report

Better Balance = Better Business
Sometimes scaling back a bit leads to:

- Better reimbursement per visit (less write-offs, cleaner claims)
- Happier patients with better outcomes
- Staff with more time to handle billing properly
- More clarity and control!

62

Q&A

?

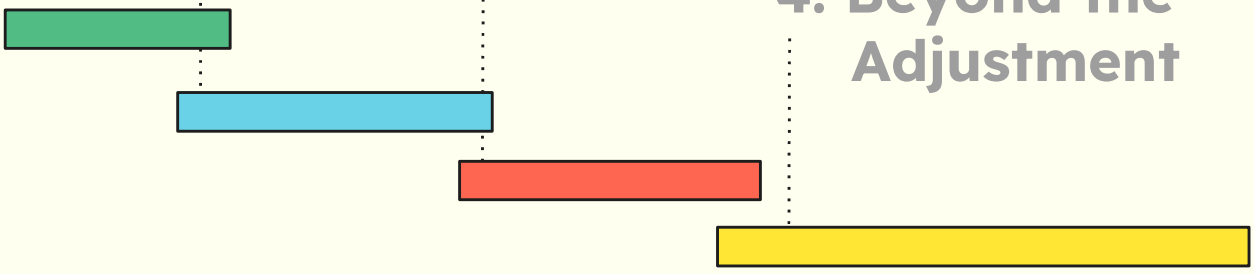
63

1. Foundations of Insurance

2. The Life Cycle of a Claim

3. Mastering Managed Care

4. Beyond the Adjustment



64

Mastering Managed Care

Goal: Understand your role and responsibilities as a participating provider, how to manage contracts, and where to find the info that governs your responsibilities.

- ❑ **Credentialing vs. Contracting**
- ❑ **In-Network Provider Responsibilities**
- ❑ **Reimbursement Strategies**
- ❑ **Termination of Participation**

65

Credentialing & Contracting with Payers

What is Credentialing?

- Verification of provider qualifications and professional background
- Required by insurance companies, hospitals, and networks
- Common platform: CAQH (Council for Affordable Quality Healthcare)

📌 ***Tip:*** Check out CAQH University for more training on this topic

66

Credentialing & Contracting with Payers

What is Contracting?

- Formal agreement between a provider and payer for services and rates
- Defines terms of reimbursement, responsibilities, and network inclusion
- ***Remember: The provider agreement is a legally binding contract.***

67

Credentialing vs. Contracting

Credentialing	Contracting
Confirms you're qualified	Defines how you get paid
Done before contracting	Includes fee schedules and rules
Involves CAQH, licenses, etc.	Legal agreement with payer

68

Becoming a Participating Provider

1. Complete credentialing application (often via CAQH)
2. Submit documentation (license, insurance, etc.)
3. Await primary source verification and committee approval
4. Negotiate and sign contract (if applicable)
5. Receive welcome letter/participation effective date
6. **Retain your contract and contact details**—many offices lose track of this important info

🔑 Just because you're in a network doesn't mean you're contracted with all of the payer's products *(like HMO, PPO, or EPO)* - confirm your participation scope!

69

Should You Join This Network?

Before **signing a provider contract, review:**

📝 **Documents to Request:**

- ❑ Full provider agreement (the contract)
- ❑ Provider Manual
- ❑ Utilization review policies
- ❑ All referenced materials (addenda, policies, etc.)
- ❑ Required forms and claims processes
- ❑ Complete fee schedule and methodology

70

Questions to Ask: *(when considering joining a network)*

- ❑ **Covered Lives:** Are there enough patients in your area to make participation worthwhile?
- ❑ **Marketing Plan:** Is the insurer growing in your region?
- ❑ **Fee Schedule:** Are the rates sustainable for your practice?
- ❑ **Utilization & Referral Policies:** Are they fair and realistic?
- ❑ **Patient Cost Share:** Are co-pays and deductibles reasonable?

🔁 ***Annual Review Tip:*** *Re-evaluate network participation yearly to make sure it aligns with your financial and clinical goals.*

71

In-Network Provider Responsibilities

- ✅ Know what your contract and provider manual require
  - ★ *Most payers require billing of all covered services and accepting the payer's allowable amounts as payment in full*
- ✅ Verify patient benefits before care
- ✅ Disclose non-covered services and out-of-pocket costs up front
- ✅ Use correct modifiers and forms (following payer policies)
- ✅ Follow documentation protocols and clinical guidelines
- ✅ Avoid improper balance billing
- ✅ Follow pre-auth/referral requirements
- ✅ Submit claims accurately and on time

72

Compliance & Audit Readiness

- ✅ Document clearly and defensibly - *if it's not documented, it didn't happen!*
- ✅ Understand how "medical necessity" is defined by each payer
- ✅ Perform regular internal audits of documentation
- ✅ Analyze your billing trends (e.g., percentage of each CPT code billed) to catch issues early
- ✅ Expect retrospective audits and recoupment risks

73

In-Network Provider Responsibilities

- 👉 Tip: Build a "payer cheat sheet" for your front desk and billing staff for quick reference!
- 📌 Review your provider manual and payer policy updates regularly — rules can and do change!

74

Suggested Fields for "Payer Reference Guide"

	A	B	C	D
1	**Field**	**Description**		
2	**Payer Name**	Full name of the payer (e.g., BCBSM PPO, Aetna HMO)		
3	**Plan Types Covered**	PPO, HMO, EPO, Medicare Advantage, etc.		
4	**Credentialing Contact Info**	Phone/email for credentialing or revalidation help		
5	**Contract Effective Date**	Date participation began		
6	**Termination Terms**	Notice period and method of termination (e.g., certified mail)		
7	**Fee Schedule Location**	Where the fee schedule is saved or accessed		
8	**Commonly Covered Services**	List of most used codes like 98940–98942, therapies, x-rays		
9	**Pre-Authorization Required?**	Yes/No + details on what needs pre-auth (e.g., therapies)		
10	**Referral Required?**	Yes/No + who can refer (PCP, specialist)		
11	**Modifier Rules**	E.g., AT for CMT, GP for therapy, etc.		
12	**Forms to Use**	ABNs, proprietary payer forms, etc.		
13	**Timely Filing Limit**	E.g., 90 days, 180 days		
14	**Claims Submission Info**	Clearinghouse used or paper submission address		
15	**Appeals Contact**	Phone, fax, or portal for submitting appeals		
16	**Online Portals**	Eligibility, benefits, claim tracking portals		
17	**Reimbursement Notes**	Tips, quirks, or unique things to know		
18				

75

Reimbursement Strategies

Setting Fees & Building Your Chargemaster

- Your **chargemaster** is your office's official fee schedule - set it with intention!
- Base your fees on time, complexity, value, and market rates
- Avoid copying payer rates - set ***your*** rates where you've determined
- Keep your chargemaster updated annually and apply fees consistently

MICHIGAN LEGISLATURE MCL - Section 500.3157

(15) As used in this section:

(a) "Charge description master" means a uniform schedule of charges represented by the person as its gross billed charge for a given service or item, regardless of payer type.

76

Key Element of a Chargemaster

Sometimes referenced as "charge description master" or "CDM"

1) **Office and Provider Information**
2) **Chargemaster Applicable Year and Date of Last Revision**
3) **CPT or HCPCS Code**
   - List all procedure codes and services delivered in your office
4) **CPT Definition of the Procedures**
   - Include the official and accurate description of procedure
5) **Billed Charges**
   - The full, undiscounted price before insurance adjustments or discounts.
6) **If Time Units Apply to the Code**
   - Important for modalities and timed procedures

77

MAC Article by Carl Alden

📌 Factors to Consider when setting your Fee Schedule:

- **Office Costs**
- **Competition**
- **Insurance**
- **Collections**


MAC

About Member Center Events & Licensure

The Factors to Consider When Setting Your Fee Schedule

By: Carl Alden, MAC Consultant

The Michigan Association of Chiropractors (MAC) is often asked, "How much should I be charging?" or a similar question. This is understandable, as the pricing of products or services greatly affects a business's ability to either survive and prosper or struggle to stay afloat. In the health care market, this question becomes even more complicated than in most businesses. Competition from other healthcare providers, insurance companies, existing laws, and the tendency for people to ignore health spending until a crisis all play a role in how you set your rates and the business environment in which you need to work.

Unfortunately, the MAC is subject to laws just like any individual or organization. One of these laws has to do with banning price fixing (anti-trust). Even suggesting where you should set your fee schedule could lead to the MAC being prosecuted for price fixing. That's why when I've been asked that question in the past, my standard answer has always been, "I don't know and even if I did, I couldn't tell you."

Fortunately, that's not the end of the story. The MAC can provide you with some information to help you set the fees for your office. Every office (the DC owner) has the right and responsibility to set the fees for their office. Here are some factors to consider when setting your fees:

Office Costs

If your office doesn't cover your costs, you will not be able to stay in business and help anyone.

78

Discounting & Dual Fee Schedules

- Dual fee schedules (charging different fees for insured vs. cash patients) are a **compliance risk** unless properly structured
- Use **legal** mechanisms like:
  - Time-of-service prompt-pay discounts (following the OIG guidelines)
  - Hardship discounts (with policy)
  - Membership or concierge models, such as a Retainer Agreement (with legal review)
- Under the Federal and State **No Surprises Act (NSA)**, the **Good Faith Estimate (GFE)** form is required for uninsured, out-of-network, and self-pay patients (essentially anything that isn't being billed to insurance)

★ ***Review discount policies with legal counsel if unsure.***

79

Understanding Termination of Participation

Voluntary Termination

- Review contract for termination terms (notice period, method)
- Notify patients as required
- Update practice materials and payer databases

Involuntary Termination

- Can result from audit findings or contract breaches
- May require a corrective action plan
- Can impact your credentialing elsewhere

80

✅ Key Takeaways from *"Mastering Managed Care"*

- **Credentialing ≠ Contracting –** Know the difference and track both!
- **Read *(and keep!)* your contracts –** Don't guess or assume what you have agreed to.
- **Stay on top of network rules –** Manuals and policies are always evolving.
- **Set smart, consistent fees –** Your chargemaster is your foundation.
- **Use discounts carefully –** Follow legal and ethical guidelines.
- **Thinking of terminating? –** Know the process and plan ahead.

81

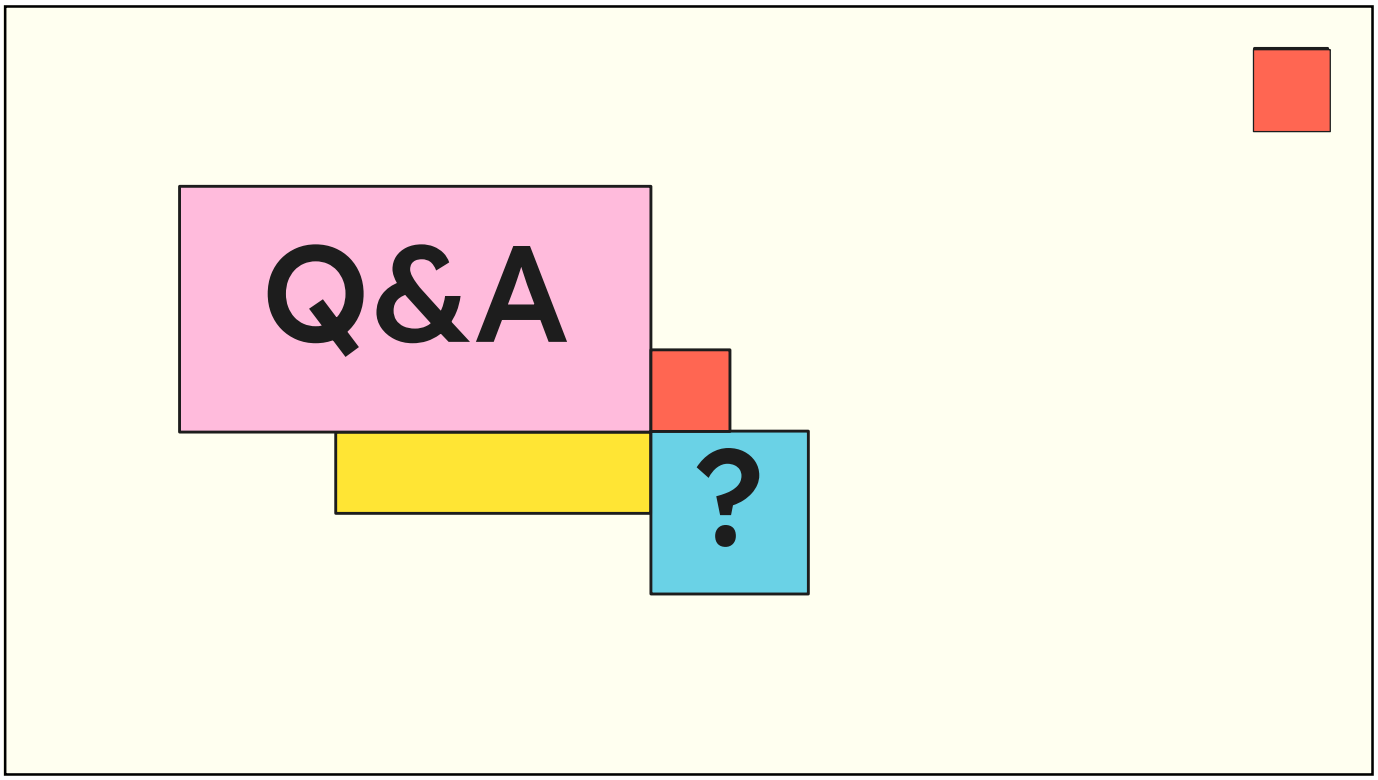
"Managed Care…?" *Empowering Your Patients to Speak Up*

When patients advocate for better chiropractic coverage, insurers notice. Educate them on key issues that affect their care:

- High co-pays
- Prior authorization delays
- Per-diem payment limits

Created as part of the Chiropractic Future Strategic Plan, use the handout with QR codes to share three easy-to-read flyers in your office.

82



83

1. Foundations of Insurance

2. The Life Cycle of a Claim

3. Mastering Managed Care

4. **Beyond the Adjustment**

84

Beyond the Adjustment

To Be Continued…

85