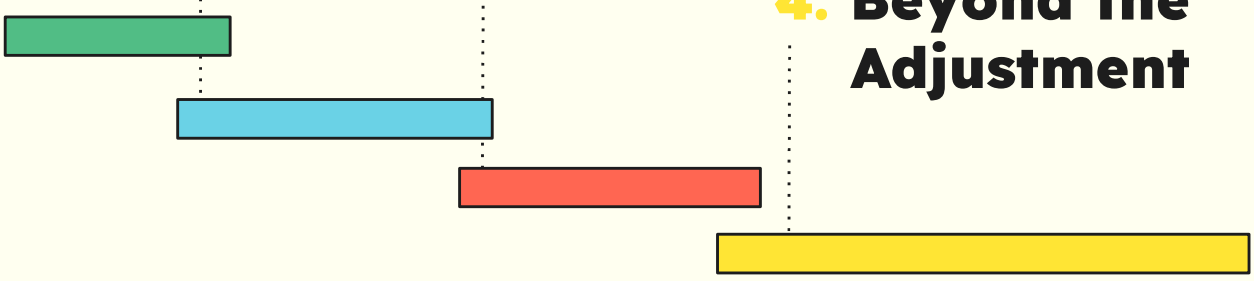
Let's Chat:

Chiropractic Insurance – From Basics to Beyond

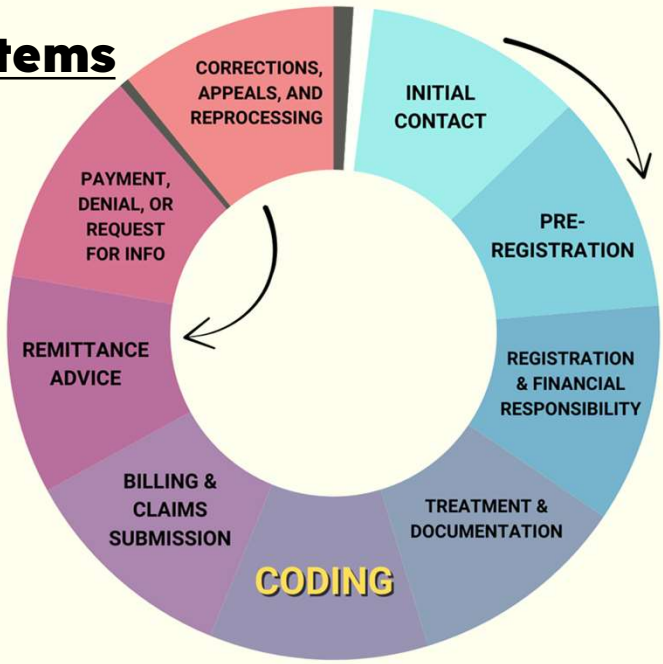
1

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



2

Coding Systems



3

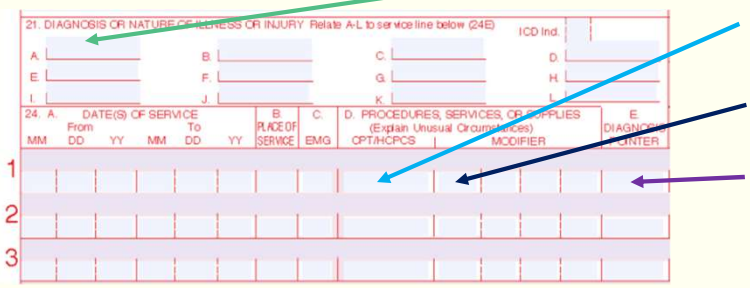
Beyond the Adjustment

Topics:

- ❑ Diagnosis coding (ICD-10)
- ❑ Diagnosis pointers
- ❑ NCCI edits
- ❑ Procedural coding (CPT)
- ❑ Modifier use

4

Coding MUST Work Together

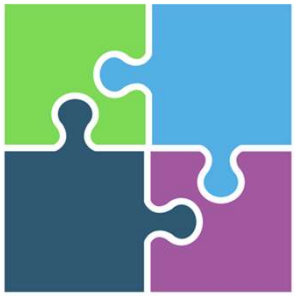


Diagnosis Coding Box 21

Procedural Coding Box 24D

Modifiers Box 24D

Diagnosis Pointers Box 24E



Each part has rules. When they're aligned and accurate, they tell a complete story - one that supports medical necessity, passes audits, and gets reimbursed.

5

ICD-10-CM: International Classification of Diseases, *10th* Revision, Clinical Modification

What they do: Identify **WHY** the patient is receiving care

- The 10th Revision was implemented in 2015.
- This revision was a *complete overhaul* from ICD-9.
- ICD codes are updated annually on October 1st.
- This includes new, revised, and deleted codes.
- Approximately 70,000 diagnosis codes (This is a significant increase from the approximately 14,000 codes in the previous version, ICD-9-CM)

*ICD-10-PCS (Procedure Classification System) is the code set for reporting procedures performed in a facility or inpatient setting. These codes are the same length; however, they have an entirely different structure than ICD-10-CM codes.

6

ICD-10 - Manual Layout; 2 Sections

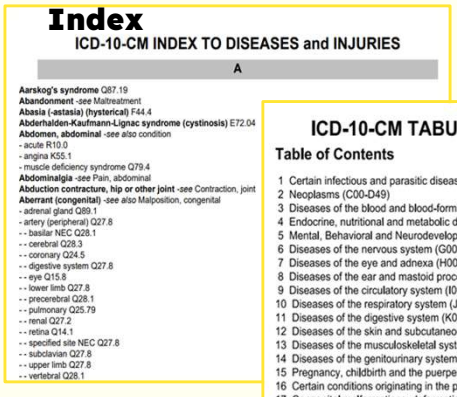
Alphabetic Index:

Search this section for the key/main term to locate an ICD-10-CM code.

The Tabular Index:

The Tabular List presents codes by chapter and in number order. Since all ICD-10-CM codes start with a letter, all code categories are in alphabetical order according to the first characters.

Alphabetical Index

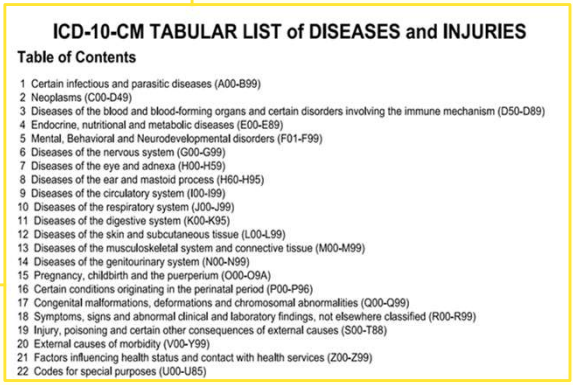


ICD-10-CM INDEX TO DISEASES and INJURIES

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

1 Certain infectious and parasitic diseases (A00-B99)
2 Neoplasms (C00-D49)
3 Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)
4 Endocrine, nutritional and metabolic diseases (E00-E89)
5 Mental, Behavioral and Neurodevelopmental disorders (F01-F99)
6 Diseases of the nervous system (G00-G99)
7 Diseases of the eye and adnexa (H00-H59)
8 Diseases of the ear and mastoid process (H60-H95)
9 Diseases of the circulatory system (I00-I99)
10 Diseases of the respiratory system (J00-J99)
11 Diseases of the digestive system (K00-K95)
12 Diseases of the skin and subcutaneous tissue (L00-L99)
13 Diseases of the musculoskeletal system and connective tissue (M00-M99)
14 Diseases of the genitourinary system (N00-N99)
15 Pregnancy, childbirth and the puerperium (O00-O9A)
16 Certain conditions originating in the perinatal period (P00-P96)
17 Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
18 Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)
19 Injury, poisoning and certain other consequences of external causes (S00-T88)
20 External causes of morbidity (V00-Y99)
21 Factors influencing health status and contact with health services (Z00-Z99)
22 Codes for special purposes (U00-U85)

7

ICD-10 - *Excludes1* Notation

Flashback to "Foundations of Insurance"

"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).*

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ICD-10 - *How to Locate Excludes1 Notation*

To see if an *Excludes1* note is listed, **walk UP the coding hierarchy**:

Start at the specific ★ ***Code → Subcategory → Category → Chapter***.

Chapter level: Applies broadly across condition types

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)

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

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ICD-10 - *How to Locate Excludes1 Notation*

1. Start at the Specific Code You Plan to Bill

Before submitting a claim, begin by reviewing the **ICD-10 code** you plan to use. Check if there is an **Excludes1 notation** listed directly beneath it.

📌 **Example:**

M54.2 Cervicalgia

Excludes1: cervicalgia due to intervertebral cervical disc disorder (M50.-)

- This means **M54.2 cannot be billed with any code in the M50 category** because cervicalgia (neck pain) is inherently included in cervical disc degeneration.

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2. Expand to the Subcategory Level

If no Excludes1 notation is present at the **individual code level**, look at the **subcategory level** (i.e., the three-character code).

📌 **Example:**

M54 Dorsalgia

Excludes1: psychogenic dorsalgia (F45.41)

- This means that **none of the codes in the M54 subcategory can be billed with F45.41**.
- If a patient's dorsalgia is entirely psychogenic (meaning there is no physical spinal pathology), then F45.41 alone would be the appropriate code.

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3. Check the Broader Category Level

Next, move up to the **category level** to see if any **Excludes1 notations apply to an entire condition group.**

📌 **Example:**

Other dorsopathies (M50-M54)

Excludes1: current injury - see injury of spine by body region
discitis NOS (M46.4-)

- This means that if the patient's condition is **due to trauma**, you **must** use an "S" injury code (e.g., S13.4XXA for a traumatic cervical disc injury) instead of an M50-M54 code.
- Additionally, this code category cannot be billed with Discitis NOS.
  - NOS stands for "Not Otherwise Specified."
  - It is used when there is insufficient detail in the medical documentation to assign a more specific code. NOS codes serve as default or unspecified options when a provider does not specify a more detailed diagnosis.

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4. Review the ICD-10 Chapter Level (If Necessary)

Finally, if the code or category does not have an **Excludes1 notation**, check the **beginning of the ICD-10 chapter** to see if a broad rule applies.

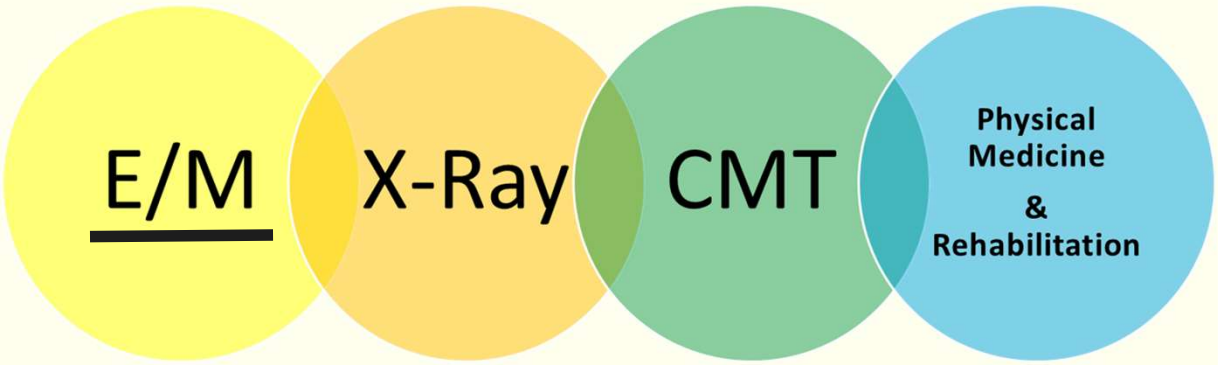
Chapter 13

Diseases of the musculoskeletal system and connective tissue (M00-M99)

Note: Use an external cause code following the code for the musculoskeletal condition, if applicable, to identify the cause of the musculoskeletal condition

13

Common Chiropractic CPT Code Sets



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Evaluation and Management Service

Chapter 1…

The "Who, What, When, Where, and How…."

E/M

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When is it appropriate to perform and bill for it?

- New patient first visit
- Established patients with:
  - New Conditions
  - New Injuries
  - Aggravation or exacerbation of existing injuries
- Periodic re-evaluation to assess whether a change in treatment is needed.

E/M

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When is it appropriate to perform and bill for it?

Because PRE, INTRA, and POST work is built into the definition of procedure codes…

An E/M code should only be billed when:

A "significant, separately identifiable Evaluation and Management (E/M) service above and beyond that associated with another procedure or service is performed and documented" according to the American Medical Association's guidelines.

E/M

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There are different levels of E/M service, ranging from a simple office visit to a comprehensive evaluation and management of a complex medical condition.
The level of service is determined by the physician based on the documentation of the Evaluation and Management service.

Evaluation & Management Services			
Office and Other Outpatient (99202-99215)			
New Patient (99202-99205)	~~99201~~	*Deleted in 2021*	
	99202	Level 1	Straightforward
	99203	Level 2	Low
	99204	Level 3	Moderate
	99205	Level 4	High
Established Patient (99211-99215)	*99211*	*Ancillary Staff*	
	99212	Level 1	Straightforward
	99213	Level 2	Low
	99214	Level 3	Moderate
	99215	Level 4	High

E/M

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New vs. Established Patients

To distinguish new and established patients for reporting evaluation and management services:

NEW PATIENT:

- ***Has not*** **received any professional services** from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, **within the past three years** (36 months).

ESTABLISHED PATIENT:

- ***Has*** **received professional services** from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, **within the past three years** (36 months).

E/M

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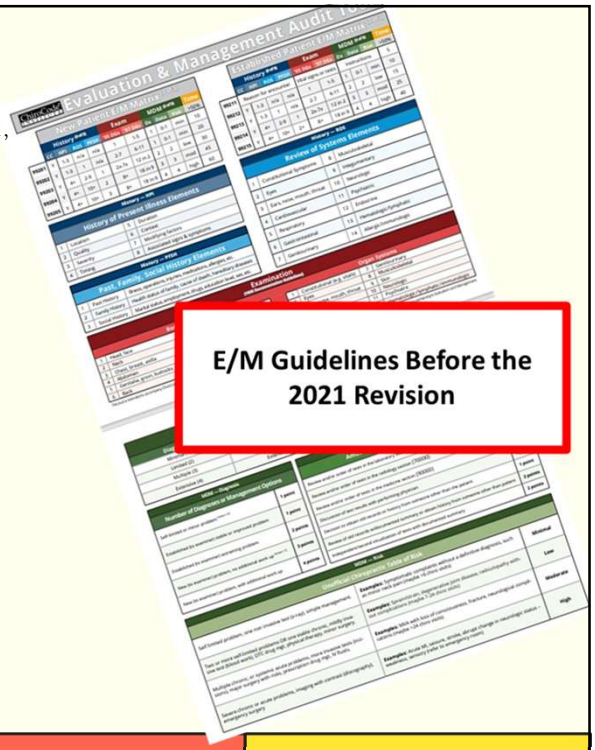
The AMA revised and updated the E/M Guidelines which went into effect on January 1, 2021.

The ***previous*** Evaluation and Management (E/M) guidelines utilized a ***complex point system*** to determine the appropriate code for billing purposes.

This system evaluated multiple aspects of the three key components:

1. History
2. Examination
3. Medical Decision-Making



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Current Evaluation and Management Guidelines

Revised and Effective January 1, 2021

With the revised guidelines, the physician's work in capturing the patient's pertinent history and performing a relevant physical exam is still a component of the evaluation and management of the patient. However, these elements are not used to determine the appropriate code level.

1. **History:** Providers should perform and document a *"medically appropriate history."*
2. **Examination:** Providers should perform and document a *"medically appropriate examination."*

With the **Revised 2021 Guidelines from the AMA**, the Medical Decision Making components determine the appropriate code level.

1. **Medical Decision-Making**... see next slide.

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Medical Decision-Making (MDM):

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option.

The level of MDM is defined by three elements:

1. The number and complexity of the **problem(s) addressed** during the encounter.
2. The amount and/or complexity of **data to be reviewed** and analyzed.
   - These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter.
   - This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported separately.
3. The **risk of complications and/or morbidity or mortality** of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), and treatment(s).

Level of MDM is based on 2 out of 3 Elements of MDM.

E/M

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Matrix for E/M Coding (AMA)

"A *significant, separately identifiable* Evaluation and Management (E/M) service *above and beyond* that associated with another procedure or service…"

E/M Guidelines for Office and Outpatient Codes

📌 *Tip: Using the Matrix, perform an internal audit on a random selection of your E/M billed services.*

E/M

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Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:
Note: this content will not be included in the CPT 2020 code set release

AMA AMERICAN MEDICAL ASSOCIATION

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed (*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.)	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  ▪ Review of prior external note(s) from each unique source*;
			  ▪ review of the result(s) of each unique test*;
			  ▪ ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 1 acute illness with systemic symptoms;
		or
		• 1 acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  ▪ Review of prior external note(s) from each unique source*;
			  ▪ Review of the result(s) of each unique test*;
			  ▪ Ordering of each unique test*;
			  ▪ Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or proce
				• Decis
				patien
				• Diagn
				of hea

99205
99215
	High	**High**
		• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• 1 acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  ▪ Review of prior external note(s) from each unique source*;
			  ▪ Review of the result(s) of each unique test*;
			  ▪ Ordering of each unique test*;
			  ▪ Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
				High risk o
				Examples
				• Drug t
				• Decis
				procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

The level of MDM is based on 2 out of 3 Elements of MDM.

E/M

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Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed
99211	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury

E/M

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Complexity of Problems Addressed

Page 4-6: E/M Guidelines for Office and Outpatient Codes

Self-limited or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

Stable, chronic illness: A condition or illness that is lasting, and always present even though the stage and severity may vary. Chronic conditions usually last anywhere from a year or until the death of the patient. The illness is stable with treatment goals being met but without treatment, the risk of death would be significant. Examples: noninsulin-dependent diabetes or controlled hypertension.

Acute, uncomplicated illness or injury…

Chronic illness with exacerbation, progression, or side effects of treatment…

Undiagnosed new problem with uncertain prognosis…

Acute illness with systemic symptoms:

Acute, complicated injury:

Chronic illness with severe exacerbation, progression, or side effects of treatment:

Acute or chronic illness or injury that poses a threat to life or bodily function:

E/M

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Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*
99211	N/A	N/A
99202 99212	Straightforward	Minimal or none

99203
99213
	Low	**Limited**
		(Must meet the requirements of at least 1 of the 2 categories)
		Category 1: Tests and documents
		• **Any combination of 2 from the following:**
		  • Review of prior external note(s) from each unique source*;
		  • review of the result(s) of each unique test*;
		  • ordering of each unique test*
		or
		Category 2: Assessment requiring an independent historian(s)
		(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)

E/M

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Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A
99202 99212	Straightforward	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low risk of morbidity from additional diagnostic testing or treatment

E/M

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E/M

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Resources for E/M Documentation and Self-Audits:

- **Documentation Job Aid for Chiropractic Doctors - Medicare**
- **Reference specific payor Provider Manuals for additional documentation requirements.**
- **SOAP Notes**

E/M

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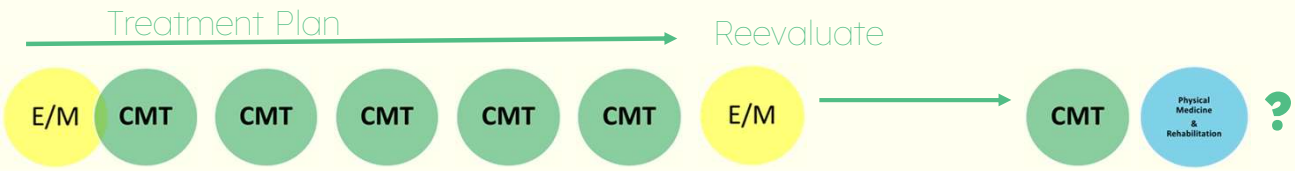
Resources for E/M Documentation and Self-Audits:

Part 2 … PLOT TWIST!

- **Reinjury, reexam…**



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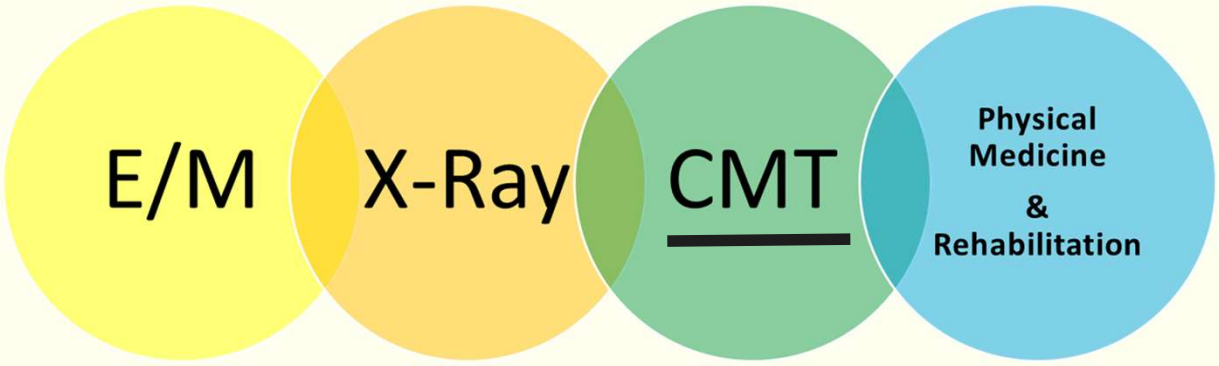
Common Chiropractic CPT Code Sets



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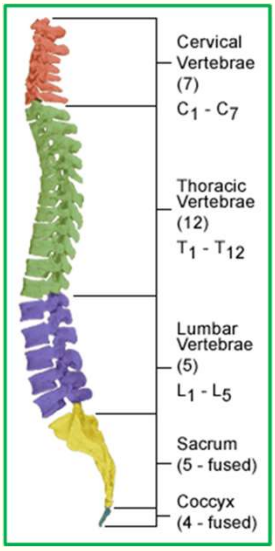
Chiropractic Manipulative Treatment



Chiropractic Manipulative Treatment (CMT) is a form of manual treatment to influence joint and neurophysiological function. This treatment may be accomplished using a variety of techniques.

98940	- Chiropractic Manipulative Treatment (CMT); **spinal, 1-2 regions**
98941	- Chiropractic Manipulative Treatment (CMT); **spinal, 3-4 regions**
98942	- Chiropractic Manipulative Treatment (CMT); **spinal, 5 regions**
98943	- Chiropractic Manipulative Treatment (CMT); **extraspinal, 1 or more regions**

CMT

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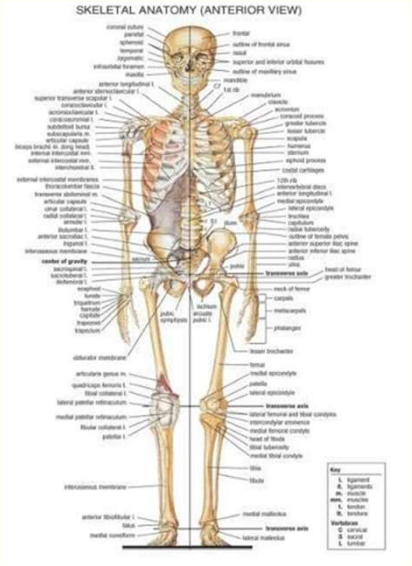

Spinal Regions (98940 – 98942)

- Cervical region *(atlanto-occipital joint)*
- Thoracic region *(costovertebral/costotransverse joints)*
- Lumbar region
- Pelvic region *(sacro-iliac joint)*
- Sacral region

Extraspinal Regions (98943)

- Head region *(including temporomandibular joint, excluding atlanto-occipital)*
- Lower extremities
- Upper extremities
- Rib cage *(excluding costovertebral and costotransverse joints)*
- Abdomen

CMT

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ICD Codes related to Region

Extra-spinal	M99.00	Segmental and somatic dysfunction of **head region**
Spinal	M99.01	Segmental and somatic dysfunction of **cervical region**
	M99.02	Segmental and somatic dysfunction of **thoracic region**
	M99.03	Segmental and somatic dysfunction of **lumbar region**
	M99.04	Segmental and somatic dysfunction of **sacral region**
	M99.05	Segmental and somatic dysfunction of **pelvic region**
Extra-spinal	M99.06	Segmental and somatic dysfunction of **lower extremity**
	M99.07	Segmental and somatic dysfunction of **upper extremity**
	M99.08	Segmental and somatic dysfunction of **rib cage**
	M99.09	Segmental and somatic dysfunction of **abdomen and other regions**

CMT

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The Definition of the CMT Codes includes 3 Parts:

1. **Pre-assessment,**
2. **Manipulation, and**
3. **Post-assessment**

These combine, or *bundle* together, to form each CMT code. These parts are inherent and cannot be routinely unbundled.

If chiropractors perform a ***distinct procedure*** that is not inherent in the manipulation, then, according to the **National Correct Coding Initiative (NCCI) edits**, a modifier must be added to communicate that an exception has been made.

CMT

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PRE Service work may include a review of:	INTRA Service work includes:	POST Service work includes:
The patient's records	Discussion about the service with the patient	An evaluation and discussion with the patient about the effect of treatment
Their diagnostic tests	A pertinent evaluation and assessment of the patient	Arrangement of additional services or referral to another provider
Communication with other providers	The procedure performed	Discussion of the case with other providers
The actual preparations for care		

CMT

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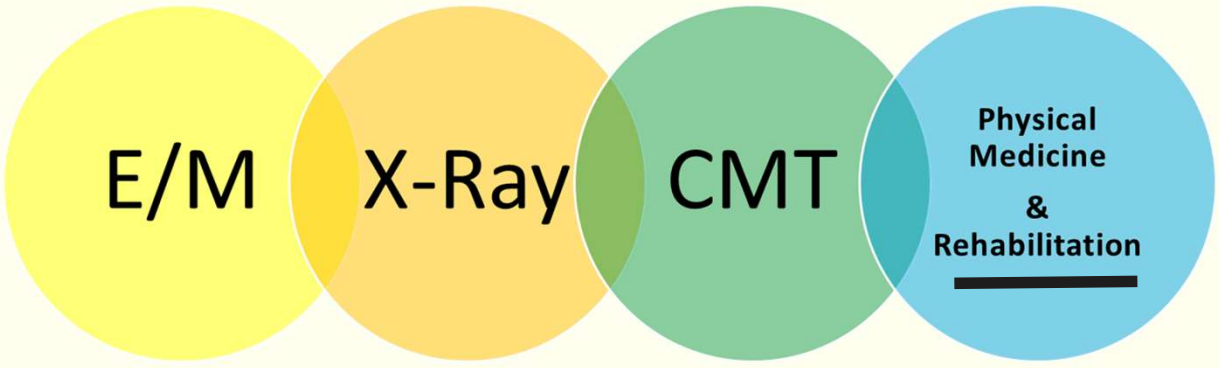
Common Chiropractic CPT Code Sets



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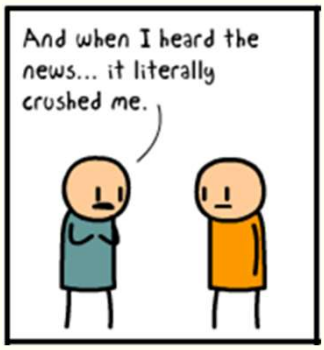
Instructions from the CPT:



"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**.*

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Strategies for reporting services when there is *not a CPT code* that "accurately identifies" the service performed

✅ **HCPCS Level II:**
Search for a HCPCS Level II code (if one exists) that accurately describes the service and is accepted by the payer.

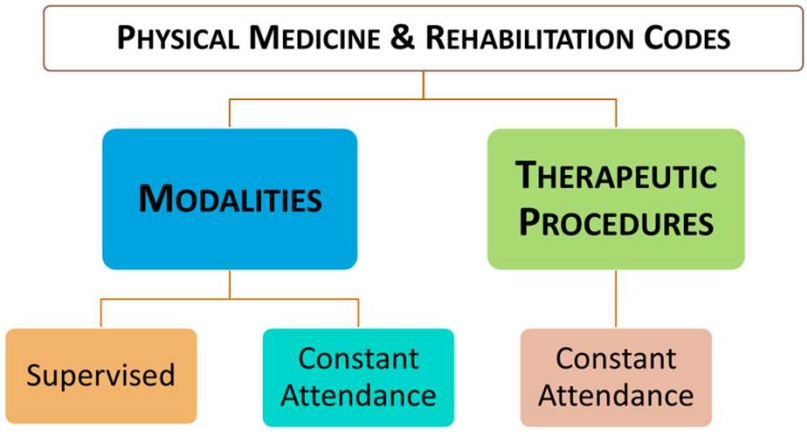
✅ **Modifiers:**
Application of a CPT or HCPCS modifier that, when applied to the code that most closely represents what was performed, accurately identifies the service.

✅ **Unlisted Code:**
Report an unlisted code specific to the category of codes the service belongs to. Unlisted codes always end in '99'. Be sure to send a copy of the medical report and enter a brief description of the service in Item Number 19 or shaded area of Item Number 24 on the 1500 Claim Form.

40

Physical Medicine and Rehabilitation Evaluations CPT® Code range 97010- 97799

The Current Procedural Terminology (CPT) code range for Physical Medicine and Rehabilitation 97010-97799 is a medical code set maintained by the American Medical Association.



41

MODALITIES **THERAPEUTIC PROCEDURES**

Is the service a **modality** or a **procedure**?

Consider what is causing the functional change:

A ***physical agent*** → **Modality**
- Light, sound, thermal, electrical, mechanical, force, etc.

The ***clinical skill*** of the physician → **Therapeutic Procedure**
- Evidence that clinical direction is necessary to achieve a particular therapeutic result.

42

MODALITIES

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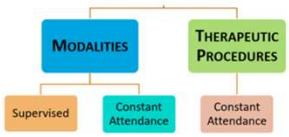
43



SUPERVISED

- Does not require direct and constant contact with the patient.
- Untimed and unattended.

CONSTANT ATTENDANCE

- Involves "visual, verbal, and/or manual contact with the patient" during delivery of the service
- Provider cannot leave the patient while they are participating in or performing the service.
- There must be a clinical need to stay with the patient.

AMA CPT Assistant

44

MODALITIES

SUPERVISED

- Hot or cold packs
- **Mechanical traction**
- **Electrical stimulation (unattended)**
- Vasopneumatic devices
- Paraffin bath
- Whirlpool
- Diathermy
- Infrared
- Ultraviolet

CONSTANT ATTENDANCE

- **Electrical stimulation (manual)**
- Iontophoresis
- Contrast baths
- **Ultrasound**
- Hubbard tank

- Unlisted modality

45

MODALITIES

- A **physical agent** that is **APPLIED** to produce changes
- Usually not the only treatment
- Due to the *passive* nature of modalities, generally used to enable patient to take part in more active aspects as therapy progresses
- Medical necessity limits the number of modalities that can be provided on a single date of service
- Multiple heating modalities should not be used on the same day

46

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- Multiple heating modalities should not be used on the same day

47

THERAPEUTIC PROCEDURES

CONSTANT ATTENDANCE

- **Therapeutic exercises**
- **Neuromuscular reeducation**
- Aquatic therapy
- Gait training
- **Massage**
- **Unlisted therapeutic procedure**
- **Manual therapy**
- Therapeutic procedures, group
- Therapeutic activities
- Sensory integrative techniques
- Self-care/home management training
- Community/work reintegration
- Wheelchair management
- Work hardening/conditioning

48

THERAPEUTIC PROCEDURES

CONSTANT ATTENDANCE

- **Require direct 1-on-1 contact**
- **Billed based on Time**
  - One unit = "Each 15 minutes"
  - Except for 97150 (Therapeutic procedures, group)

- Application of "**Clinical Skill**" is necessary
- Purpose of these codes is an "**attempt to improve function**"
- ***Not*** limited to any particular specialty group

49

Medical Necessity

- Therapy in **asymptomatic persons** or in persons without an identifiable clinical condition is considered *not medically necessary*.
- Therapy in persons whose condition is **neither regressing nor improving** is considered *not medically necessary*.
- Once **therapeutic benefit has been achieved**, or a home exercise program could be used for further gains, continuing supervised therapy is not considered medically necessary.

50

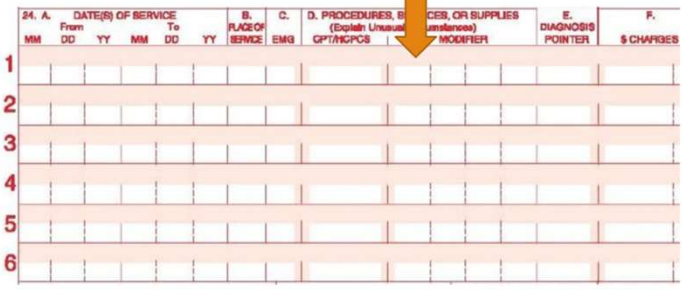
Coding *with* Modifiers

FOR CHIROPRACTIC

51

Modifier Basics:

- Modifiers go in **box 24 D** of the CMS-1500 billing form.
- Always two characters
- May be alpha or numeric



98940 - AT

Procedure Code *Modifier*

Use modifiers to **communicate certain information** about a service performed or a product dispensed.

More than one modifier may be appropriate depending on the circumstances concerning the service.

While rare in chiropractic, **up to four modifiers** may be used to fully explain the circumstances concerning the service/ services rendered.

52

Modifiers May Describe:

- That multiple procedures were performed
- Why the procedure was necessary
- Where on the body procedure was performed
- Other information that may be required with the insurance payer

Documentation is ALWAYS needed to support modifier usage.

53

Why Do You Need to Know the Correct Use of Modifiers?

- Reduces Denials
- Maximizes your Reimbursements
- Reduces Audits
- Shows You Know!

54

Common Modifiers Used in Chiropractic Coding

AT	GA	25	59 *X modifiers* (XE, XS, XP, XU)
GY	GP	25, TC	Q5, Q6

55

What determines the use of a modifier?

- **Centers for Medicare & Medicaid Services**
- **National Correct Coding Initiative (NCCI)**
  - Developed to promote proper coding of services
  - Prevent inappropriate payments when incorrect code combinations are reported on claims
- **Individual payer guidelines**

56

Basic Steps to Reduce Audits

1. Use the most current versions of the CPT, HCPCS, and ICD-10-CM code sets. Many healthcare providers still bill codes that haven't been in use for years.
2. Ensure the proper usage of modifiers on your claims where appropriate. Many coding situations require that modifiers be used.
3. Utilize the **National Correct Coding Initiative (NCCI) edits** in your defense if your billing standards are supported by these edits. Correct coding and billing typically match the NCCI standards. Thus, In the event of an appeal, these NCCI guidelines can demonstrate that the correct billing protocol was followed.
4. Stay current on payer policies and coverage by signing up for their newsletters or email notifications. Changes in policies are often announced in these publications. Many payer websites also allow you to search for billing and coding policies.
5. Review OIG reports and change your billing policies as appropriate to avoid known coding problems.
6. Review documentation requirements and update as necessary to ensure that your records meet high standards. Consider performing a self-audit.

57

What is the NCCI? Procedure to Procedure (PTP) Edits?

Name	Type	Compressed size	Password pr...	Size	Ratio	Date modified
ccipra-v240r0-f4	Text Document	1,852 KB	No	36,269 KB	95%	11/21/2017 8:26 AM
ccipra-v240r0-f4	Microsoft Excel Worksheet	12,573 KB	No	13,647 KB	8%	11/20/2017 1:05 PM

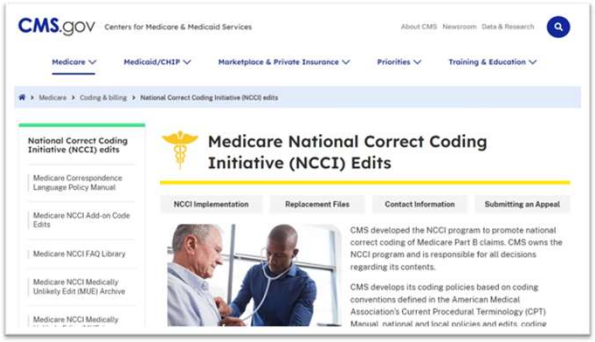
58

	A	B	C	D	E	F	G	H	I	J	K
1	CPT only copyright 2017 American Medical Association. All rights reserved.										
2	Colum1/Column2 Edits										
3	Column 1	Column 2	*=in existence	Effective	Deletion	Modifier	PTP Edit Rationale				
4			prior to 1996	Date	Date	0=not allowed					
5					*=no data	1=allowed					
6						9=not applicable					
452198	98941	96375		20090101	20121231	1	Standards of medical / surgical practice				
452199	98941	96376		20090701	20121231	1	Standards of medical / surgical practice				
452200	98941	97112		20010701	*	1	Standards of medical / surgical practice				
452201	98941	97122		19971001	19990331	1	Standards of medical / surgical practice				
452202	98941	97124		19971001	*	1	Standards of medical / surgical practice				
452203	98941	97140		19990401	*	1	Standards of medical / surgical practice				
452204	98941	98927		19970401	*	0	Mutually exclusive procedures				
452205	98941	98928		19970401	*	0	Mutually exclusive procedures				

59

Medicare National Correct Coding Initiative (NCCI) Edits

1. NCCI Policy Manual
2. Procedure to Procedure (PTP) Edits
3. Modifier 59 Article



60

The CMT codes (98940-98942) have three parts: the pre-assessment (history), the manipulation, and the post-assessment…

These combine, or bundle together, to form each CMT code. These parts are inherent and cannot be routinely unbundled.

If chiropractors perform a distinct procedure that is not inherent in the manipulation, then, according to the **National Correct Coding Initiative (NCCI) edits**, a modifier must be added to communicate that an exception has been made.

61

25

Evaluation & Management (E/M)

New Patient

- 99202
- 99203
- 99204
- 99205

Established Patient

- 99211
- 99212
- 99213
- 99214
- 99215

25 Modifier:

Significant, Separately Identifiable Evaluation and Management (E/M) Service

- By adding the 25 modifier the provider is telling the payer that the Evaluation and Management service performed is a *significantly greater assessment* than that included with the CMT service.
- ★ **ONLY** appended the 25 modifier to Evaluation & Management (E/M) CPT codes
- **DOCUMENTATION!** – see E/M section
- Refer to the new 2021 Evaluation & Management Guidelines (effective January 1, 2021) when billing an E/M code.

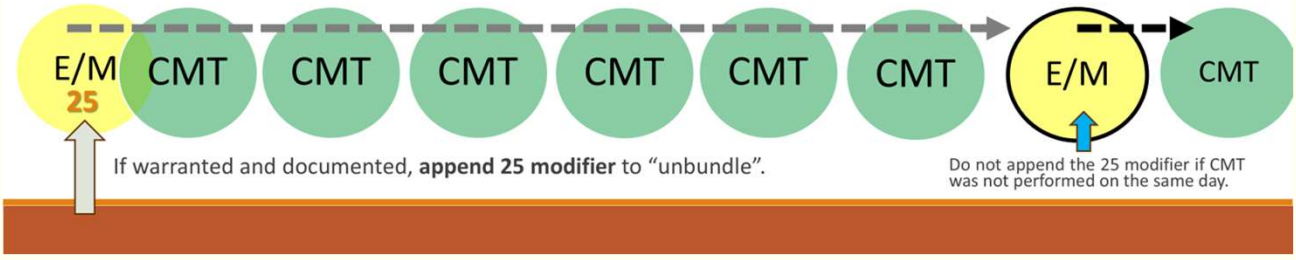
62

25 Modifier

- In chiropractic, this modifier should only be used when CMT and the E/M service are done on the same day and the circumstances support its use.
- If an E/M service is performed without a CMT, the 25 modifier is *not* appended.

When is an E/M code appropriate?

- New patient visit (has not received professional services in your office within the last three years)
- Established patient with a new condition or new injury
- Established patient with an aggravation/exacerbation/re-injury
- A periodic re-evaluation to assess if a change in treatment is warranted



If warranted and documented, **append 25 modifier** to "unbundle".

Do not append the 25 modifier if CMT was not performed on the same day.

63

59

59: Distinct Procedural Service

What we'll cover in this section:

- ❑ **What:** Definition
- ❑ **Why:** National Correct Coding Initiative (NCCI)
- ❑ **How:** Coding Examples
- ❑ **And:** X Modifiers

64

The CPT Manual defines modifier 59 as follows:

Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a **procedure or service was distinct or independent** from other non-E/M services performed on the same day.

Modifier 59 is used to identify procedures/services, *other than E/M services*, that are not normally reported together, but are appropriate under the circumstances.

Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

65

National Correct Coding Initiative

The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes should not be reported together either in all situations or in most situations.

For PTP edits that have a Correct Coding Modifier Indicator (CCMI) of **"0," the codes should never be reported together** by the same provider for the same beneficiary on the same date of service. If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied.

For PTP edits that have a CCMI of "1," the codes **may be reported together only in defined circumstances** which are identified on the claim by the use of specific NCCI-associated modifiers.

66

NCCI Coding Edits

Column 1	Column 2	Indicator	PTP Edit Rationale
98941	98940	0	More extensive procedure
98941	99202	1	CPT Manual or CMS manual coding instructions
98940	97112	1	Standards of medical/surgical practice
98940	97124	1	Standards of medical/surgical practice
98940	97140	1	Standards of medical/surgical practice

This list is a small portion of the Medicare NCCI edits found here:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits
*See this list for additional questions regarding the 59 modifier usage or other edits.

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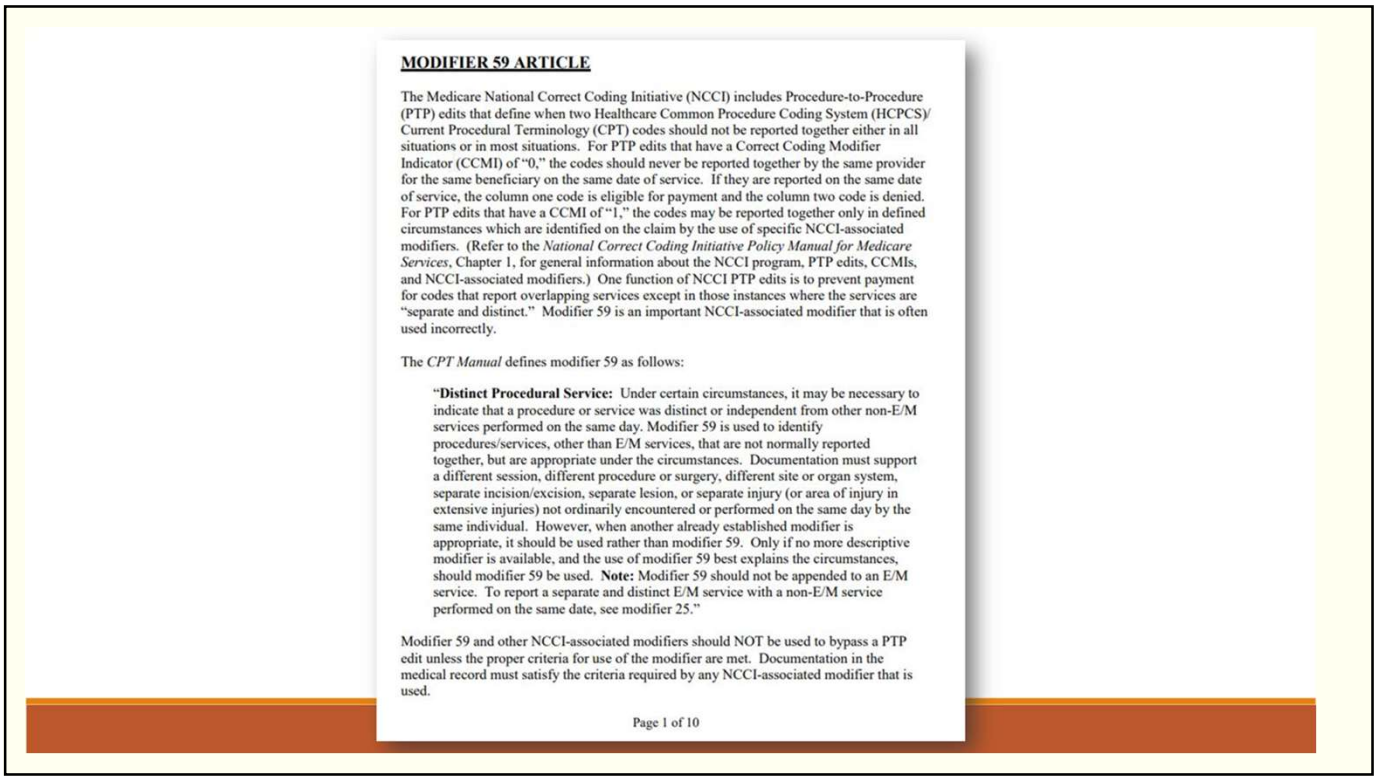
National Correct Coding Initiative Policy Manual for Medicare Services

S. Chiropractic Manipulative Treatment

Medicare covers chiropractic manipulative treatment (CMT) of 5 spinal regions. Physical medicine and rehabilitation services described by CPT codes 97112, 97124 and 97140 are not separately reportable when performed in a spinal region undergoing CMT. If these physical medicine and rehabilitation services are performed in a different region than CMT and the provider is eligible to report physical medicine and rehabilitation codes under the Medicare program, the provider may report CMT and the above codes using modifier 59 or XS.

Column 1	Column 2	Indicator	PTP Edit Rationale
98940	97112	1	Standards of medical/surgical practice
98940	97124	1	Standards of medical/surgical practice
98940	97140	1	Standards of medical/surgical practice

68



MODIFIER 59 ARTICLE

The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes should not be reported together either in all situations or in most situations. For PTP edits that have a Correct Coding Modifier Indicator (CCMI) of "0," the codes should never be reported together by the same provider for the same beneficiary on the same date of service. If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied. For PTP edits that have a CCMI of "1," the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers. (Refer to the *National Correct Coding Initiative Policy Manual for Medicare Services*, Chapter 1, for general information about the NCCI program, PTP edits, CCMIs, and NCCI-associated modifiers.) One function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are "separate and distinct." Modifier 59 is an important NCCI-associated modifier that is often used incorrectly.

The *CPT Manual* defines modifier 59 as follows:

> "**Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used.

Page 1 of 10

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Modifier 59 Article

The **CPT Manual** defines modifier 59 as follows:

- "Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a **procedure or service was distinct or independent** from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances.
- **Documentation must support** a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.
- **Note: Modifier 59 should not be appended to an E/M service.** To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

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AT

AT = Active Treatment

The Active Treatment (AT) modifier was developed to clearly define the difference between active treatment and maintenance treatment.

- Original Medicare (Part B) pays only for active/corrective treatment to correct acute or chronic subluxation. *Medicare Part B does not pay for maintenance therapy.*
- If active/corrective treatment is being performed, chiropractic claims for 98940/98941/98942 should include the AT modifier.
- **The AT modifier is only used on 98940/98941/98942, *never* any other CPT codes.**
- Do not use the AT modifier for maintenance therapy chiropractic manipulative treatments.

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Active Treatment:

Includes "active/corrective treatment to correct ACUTE or CHRONIC subluxation."

Acute: Patient is being treated for a new injury, identified by x-ray or physical exam (P.A.R.T. exam). The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.

Chronic: Is not expected to significantly improve or be resolved without further treatment (as is the case with acute conditions), but where continued therapy can be expected to result in some functional improvement.

Use of the AT modifier requires supporting documentation in the patient's medical record.

Once clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy.

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AT Modifier & Other Payers

- Payers that follow Original Medicare (Part B) coding requirements for the AT modifier:
  - Medicare Advantage Plans (Part C)
  - Medicaid
  - Veterans
  - Workers Compensation
- Various third-party payers have adopted this coding rule.

PriorityHealth

Provider › Provider Manual › Billing & payment › Modifiers › AT

AT: Active treatment modifier

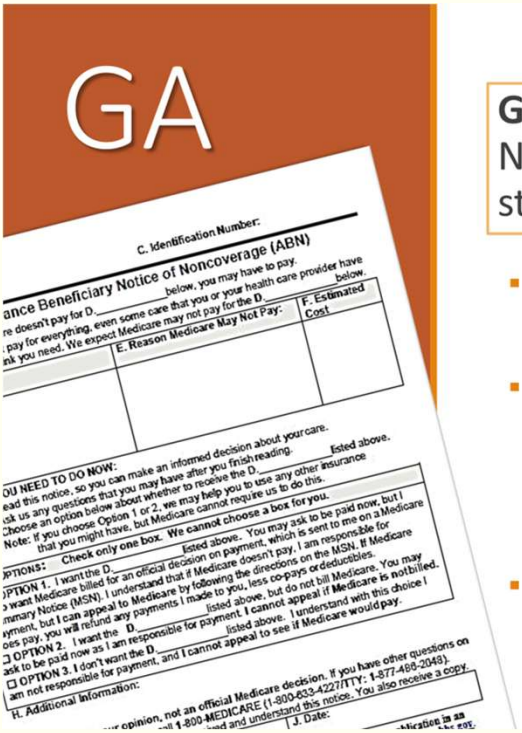
The Active Treatment (AT) modifier was developed to clearly define the difference between active treatment and maintenance treatment. The Centers for Medicare and Medicaid Services (CMS) has required the AT modifier on chiropractic codes since 2004. Now Priority Health is aligning with CMS for all other products.

AT modifier is required when:

AT should be appended to chiropractic CPT codes 98940, 98941 and, 98942 to identify chiropractic services that are covered according to our medical policy for commercial products. The AT modifier indicates that services are for acute conditions and allows for coverage of the chiropractic services.

73

GA



C. Identification Number:

ance Beneficiary Notice of Noncoverage (ABN)

re doesn't pay for D. _____ below, you may have to pay.
pay for everything, even some care that you or your health care provider have
nk you need. We expect Medicare may not pay for the D. _____ below.

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

OU NEED TO DO NOW:
ead this notice, so you can make an informed decision about your care.
sk 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.

PTIONS: Check only one box. We cannot choose a box for you.
PTION 1. I want the D. _____ listed above. You may ask to be paid now, but I want Medicare billed for an official decision on payment, which is sent to me on a Medicare mmary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for ayment, but I can appeal to Medicare by following the directions on the MSN. If Medicare oes 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:

ur opinion, not an official Medicare decision. If you have other questions on
ll 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).
ad and understand this notice. You also receive a copy.
J. Date:

GA = Advanced Beneficiary Notice of Noncoverage (ABN) waiver of liability statement on file

- Unlike the AT modifier's purpose to describe "active treatment", the GA modifier *does not* ***describe*** "maintenance care".
- The GA modifier is used to show that you:
  1. **<u>You have a *current* ABN signed by the beneficiary on file</u>** because…
  2. You expect Medicare to deny a service as **not reasonable and necessary.**
- If the patient chooses Option 1 on the ABN form, you must bill the service. The GA modifier is appended to the CMT code.

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Maintenance Therapy:

Includes "services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition."

When further clinical improvement cannot reasonably be expected from continuous ongoing care, and chiropractic treatment becomes supportive rather than corrective in nature, treatment is then considered maintenance therapy.

75

GA Modifier and "the ABN Form"

- **Form CMS-R-131 (Exp. 01/31/2026)**
- **The ABN form is only for use with Medicare Part B patients.**
- Medicare Advantage plans may have similar requirements through a *notice of noncoverage* rather than an ABN.
- Some Medicare Advantage and commercial plans may pay for maintenance care ("routine care"). Check individual patient policies.
- Modifier GA *should not* be submitted in conjunction with modifier AT.

76

GY

GY Modifier:

Notice of liability *not issued*, *not required* under payer policy

- Could be used on all services that are **statutorily excluded** or do not meet the definition of any Medicare benefit.
- Providers do not have to submit claims for noncovered services to Medicare Part B (e.g., massage, therapy, X-ray, etc.) unless the beneficiary requests claims are submitted, or if a denial is needed for secondary insurance claims processing.
- For any service you submit on a claim to Medicare that is *not 98940, 98941, or 98942*

77

GP

GP Modifier:

Services delivered under an outpatient physical therapy plan of care

Therapy Modifiers

- CMS Requirement: All claims containing a procedure code from the list of **"Applicable Outpatient Rehabilitation HCPCS Codes"** should contain a therapy modifier.
- The modifier will distinguish the discipline of the plan of care:
  - Modifier GN – Services delivered under an outpatient speech-language pathology plan of care
  - Modifier GO – Services delivered under an outpatient occupational therapy plan of care
  - **Modifier GP – Services delivered under an outpatient physical therapy plan of care**
    - ***GP is used for therapy provided in chiropractic office**

78

CMS Requirement… but Medicare doesn't pay chiropractors for Physical Medicine & Rehabilitation Services?!?

1. Chiropractors are not required to bill Medicare Part B for non-covered services *(see GY information),* but may need to in certain circumstances:
   - The patient asks the provider to bill the services to Medicare Part B.
   - The patient has Medicare as primary insurance and a secondary insurance that may pay for the therapy.
2. Additionally – this modifier is required for use by insurers that follow Medicare coding rules (i.e. Veterans).
3. Various private payers have adopted the coding requirements for the GP modifier (i.e. BCBSM, UHC).

79

What Codes Require the GP Modifier?

The following *"Always Therapy"* HCPCS codes require a GP modifier:

92507	92508	92526	92608	92609	96125	97012	97016	97018
97022	97024	97026	97028	97032	97033	97034	97035	97036
97039	97110	97112	97113	97116	97124	97139	97140	97150
97530	97533	97535	97537	97542	97750	97755	97760	97761
97762	97799	G0281	G0283	G0329				

* *Some codes commonly used in a chiropractic office are highlighted.*

80

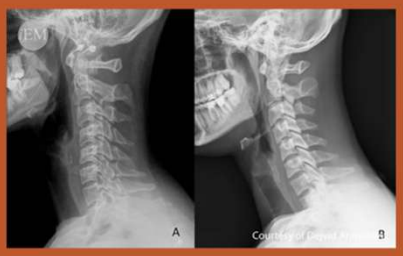
How do I bill therapies to Medicare?

Billing therapies to Medicare per patient's request	Billing therapies to Medicare (primary) to pass to patient's secondary insurance	Billing therapies to commercial insurer that requires GP modifier and patient's policy covers therapy
97140 – GPGY59 98940 – AT	97112 – GPGY59 98940 – AT	97110 – GP 97124 – GP59 98940
97012 – GPGY 98940 – AT	97110 – GPGY 98940 – AT	

*See coding rules for GY and 59 modifiers for rationale on including these modifiers on specific codes/claims.

81

26 *or* TC



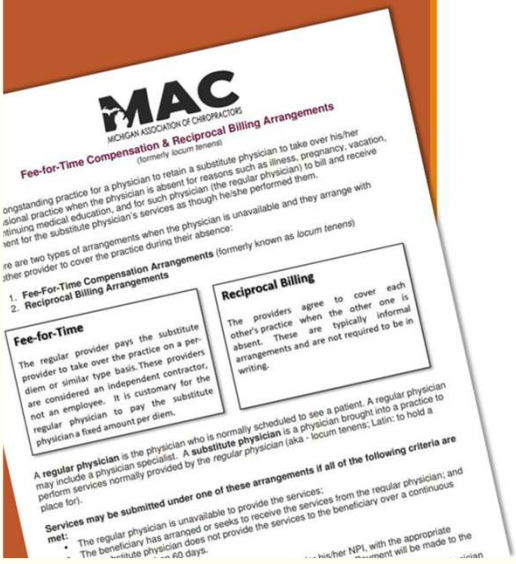
26 = Professional Component
TC = Technical Component

- X-ray codes are typically considered a "global code" that includes BOTH a **Technical** (taking the X-ray) AND a **Professional** (reading the X-ray) component.
- If the same provider is performing both the technical and professional components of a service, the global service should be reported without the modifier.
- Chiropractors use one of these modifiers on X-ray codes when only one or the other component is performed.

Technical Component	Professional Component
72100 – TC	72100 – 26

82

Q5 *or* Q6



MAC
MICHIGAN ASSOCIATION OF CHIROPRACTORS

Fee-for-Time Compensation & Reciprocal Billing Arrangements
(formerly locum tenens)

ongstanding practice for a physician to retain a substitute physician to take over his/her
ssional practice when the physician is absent for reasons such as illness, pregnancy, vacation,
ntinuing medical education, and for such physician (the regular physician) to bill and receive
ent for the substitute physician's services as though he/she performed them.

re are two types of arrangements when the physician is unavailable and they arrange with
other provider to cover the practice during their absence:

1. **Fee-For-Time Compensation Arrangements** (formerly known as locum tenens)
2. **Reciprocal Billing Arrangements**

Fee-for-Time

The regular provider pays the substitute provider to take over the practice on a per-diem or similar type basis. These providers are considered an independent contractor, not an employee. It is customary for the regular physician to pay the substitute physician a fixed amount per diem.

Reciprocal Billing

The providers agree to cover each other's practice when the other one is absent. These are typically informal arrangements and are not required to be in writing.

A **regular physician** is the physician who is normally scheduled to see a patient. A regular physician may include a physician specialist. A **substitute physician** is a physician brought into a practice to perform services normally provided by the regular physician (aka - locum tenens: Latin: to hold a place for).

Services may be submitted under one of these arrangements if all of the following criteria are met:

- The regular physician is unavailable to provide the services;
- The beneficiary has arranged or seeks to receive the services from the regular physician; and
- [illegible] physician does not provide the services to the beneficiary over a continuous [illegible] 60 days.

[illegible] his/her NPI, with the appropriate [illegible] will be made to the [illegible]

"Locum Tenens"

Q5 = Service furnished under a *Reciprocal Billing Arrangement* by a substitute physician

- The providers agree to cover each other's practice when the other one is absent. These are typically informal arrangements and are not required to be in writing.

Q6 = Service furnished under a *Fee-for-Time Compensation Arrangement* by a substitute physician

- The regular provider pays the substitute provider to take over the practice on a per-diem or similar type basis. These providers are considered an independent contractor, not an employee. It is customary for the regular physician to pay the substitute physician a fixed amount per diem.

★ When billing Reciprocal Billing or Fee-for-Time Arrangements, refer to these resources for details:
- CMS Medicare Claims Processing Manual, Chapter 1 Section 30.2.11
- MAC document: "Fee-for-Time Compensation & Reciprocal Billing Arrangements"

★ Contact individual private payers for their specific policies on these arrangements.

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