MICHIGAN ASSOCIATION OF CHIROPRACTORS

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MARK YOUR CALENDAR!

EXPRESS CONVENTION

November 22 - 23, 2025

Comfort Inn & Suites, Mt. Pleasant

15 CEs

SPRING CONVENTION

April 24 - 26, 2026

Grand Traverse Resort, Acme

16 CEs

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Earned Sick Time Act (ESTA) Takes Effect on October 1st for Small Businesses

- Earlier this year the Michigan Legislature passed into law legislation amending Michigan's Earned Sick Time Act (ESTA).
- Michigan law now requires all employers to provide earned sick time to their employees.
- The MAC Legal Affairs team urges all chiropractors with even one employee to review the new law and, if needed, amend their paid leave policies.

An employer is considered a "small business" if it employs 10 or fewer employees. This includes full-time, part-time, and temporary employees including those provided through a temporary service or staffing agency or similar entity.

Small businesses need to comply effective 10/1/2025.

Large businesses were required to begin when the act went into effect, 2/21/2025.

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Earned Sick Time Act (ESTA) Resources

MAC Members: The MAC has created a FAQ document that can help practices answer questions, available here.

Additional Resources

- Michigan Earned Sick Time Act (ESTA)
- Michigan Department of Labor and Economic Opportunity (LEO)
  - Webinar with LEO Deputy Director of Labor Sean Egan (Recording)(Slides)
  - LEO FAQs
  - LEO Earned Sick Time Act website

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State of Michigan New Requirements for X-Ray Operators
MIOSHA X-Ray Training Rules
• Applies if CAs or other non-licensed staff take x-rays in your office.
• Deadline: March 13, 2027 – CAs must complete a 40-hour radiology training program (clinical + didactic).
• The MAC will provide a cost-effective program before the deadline.
• Certification triggers CE cycle: Once a CA certifies, the 2-year CE requirement begins immediately.
  • Example: Certify 3/1/25 → CE due 3/1/27.
  • Waiting to certify delays CE cycle.
• Action:
  • ASAP: Prepare a "Written Statement of Assurance" for every CA/unlicensed individual currently taking x-rays in your office [Sample].
  • Next: Stay Tuned & Plan your office's certification timing.
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MICHIGAN CHIROPRACTORS CAN NOW BECOME CERTIFIED DOT EXAMINERS!
The MAC is partnering with PassMyPhysical.com to help YOU obtain the training you need to perform DOT examinations, expand your practice, and enhance public safety!
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Become a Certified DOT Examiner

The MAC is partnering with PassMyPhysical.com to help YOU obtain the training you need to perform DOT examinations, expand your practice, and enhance public safety!

PASSMYPHYSICAL.COM TRAINING:

- Meets FMCSA core curriculum requirements
- Provides six (6) hours of Michigan chiropractic continuing education through Northeast College of Health Sciences and PACE
- Makes it easy to pass on your first try, with a pass rate of more than 99%
- Provides a same-day certificate for your NRCME exam registration
- **Has a discounted rate for MAC members!**

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MICHIGAN CHIROPRACTIC
LICENSE RENEWAL REQUIREMENTS

The current Administrative Rules require that doctors obtain 30 hours of continuing education over the two-year licensure period for license renewal, **10 of which must be completed in person**.

<u>These 30 hours must include</u>:

- 2 hours in Physical Measures
- 1 hour in Ethics
- 1 hour in Sexual Boundaries
- 1 hour in Pain and Symptom Management
- 2 hours of Implicit Bias Training

The MI Board of Chiropractic (BOC) and the Department of Licensing and Regulatory Affairs (LARA) regulates these rules.

**2 hours in Performance and Ordering of Tests is no longer a requirement.*

You must also have completed the **Human Trafficking training**. This is a one-time only requirement and not needed for every license renewal.

LARA: Michigan Chiropractic Licensing Guid

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The FY 2026 ICD-10-CM become effective on October 1, 2025.

The ICD-10-CM update includes:

- **487 new codes**,
- **38 revised codes**, and
- **28 deleted codes**.

Download and review the **2026 Addendum (ZIP)** under the **ICD-10 Files** section.

No Change	**T78.08 Anaphylactic reaction due to eggs**
Add	**T78.080 Anaphylactic reaction due to egg with tolerance to baked egg**
Add	**Excludes1:** Anaphylactic reaction due to egg with reactivity to baked egg (T78.081)
Add	**T78.081 Anaphylactic reaction due to egg with reactivity to baked egg**
Add	**Excludes1:** Anaphylactic reaction due to egg with tolerance to baked egg (T78.080)
Add	**T78.089 Anaphylactic reaction due to eggs, unspecified**

**Despite numerous additions and changes, the changes do not always affect chiropractic.*

No Change	**R52 Pain, unspecified**
No Change	**Excludes1:**
Revise from	pelvic and perineal pain (R10.2)
Revise to	pelvic and perineal pain (R10.2-)
No Change	**R53 Malaise and fatigue**
No Change	**R53.8 Other malaise and fatigue**
No Change	**Excludes1:**
Revise from	exhaustion and fatigue due to recurrent depressive episode (F33)
Revise to	exhaustion and fatigue due to recurrent depressive episode (F33-)

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DIAGNOSIS CODING RESOURCES

**The International Classification of Diseases (ICD) is updated annually on October 10. Stay informed about updates to ensure you use the most current codes and avoid outdated ones, which will cause claim denials.*

CMS ICD-10 Files: https://www.cms.gov/medicare/coding-billing/icd-10-codes

- Scroll down to ICD-10 Files, click on **2025 ICD10 CM & PCS Files**
- Select **2025 Code Tables, Tabular, and Index (ZIP)**
- This will automatically download to your *Downloads* folder
- Then open the PDF: "icd10cm_*tabular*_2025"
- On the left, top bar, click on the **3 lines** indicating the Table of Contents and Chapters.
- Click on Chapter 13, Diseases of the Musculoskeletal System
- Once in this chapter, **hit *Ctrl* and *F* on your keyboard for a search window** to appear.
- Type the code you are looking for and hit enter.

**Alternatively, if you are looking for the Alphabetical section of the manual, view the Index PDF.*

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CDC ICD-10 Tool: https://icd10cmtool.cdc.gov/?fy=FY2025

- Ensure you are using the most current version by changing the Fiscal Year to the latest
- Search condition, disease, or symptom terms in the "**Enter Search Term(s)**" field, or
- Search diagnosis codes in the "**Enter code in Tabular**" field.
- Note the Legend icons in the Tabular List.

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CMS: Billing and Coding Article *("Local Coverage Article" (LCA))*
For Medicare, ICD-10-CM Codes that Support Medical Necessity

The level of the subluxation must be specified on the claim and must be listed as the *primary diagnosis*. The neuromusculoskeletal condition necessitating the treatment must be listed as the *secondary diagnosis*.

- **Primary Diagnosis: Names of Vertebrae**
- **Secondary Diagnosis: Symptom/Condition Codes**

Download the PDF. Use the 'Ctrl' and 'F' keys for a search box.

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BCBSM Benefit Explainer

How to search for diagnosis codes that BCBSM considers 'medically necessary' and, therefore, payable for specific procedure codes.

1. Log in to **Availity**.
2. Under **Payer Spaces**, select BCBSM/BCN.
3. Scroll down and select **Benefit Explainer**. A new window should open.
4. Select the **Commercial Policy** tab.
5. Click on **Topic**, then under **Unique Identifier** select **HCPCS Code**, enter the *CPT code*.
6. Click **Finish**, then **Search.**
7. Scroll down and select **Coverage Limitations**.
8. Under **Payment Limitations**, select ***Location Code, Primary Diagnosis, Provider Specialty, Provider Type***
   - When searching 98940-98942, you'll see "Misaligned vertebrae or strain of muscles" are *Payable*.
   - When searching for 97140 (or other therapies), you'll see that diagnosis codes for "Neuromusculoskeletal Function Loss" are *Payable.*
8. Click on the blue hyperlinked Primary Diagnosis title to open a list of the payable diagnosis codes.
9. Scroll down to see the list of ICD-10 codes that BCBSM considers medically necessary for the CPT you searched.
10. Use the **Search for Code in Rule Cell** to look for specific codes on the list. (D*o not use the decimal point here if you search for a code*.)

** Depending on the code you search for, these steps may vary slightly. Sometimes, you might need to click around to find the information you are looking for, but it is usually available!*

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Fall 2025 Convention
Port Huron, MI

CA SUCCESS 101

Stephanie Davidson
Insurance Relations Director

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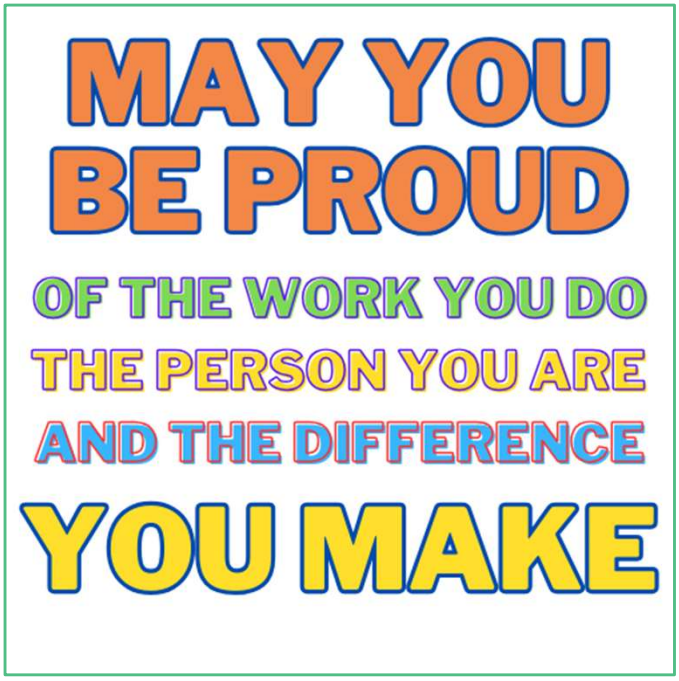

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Foundations of Insurance

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

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

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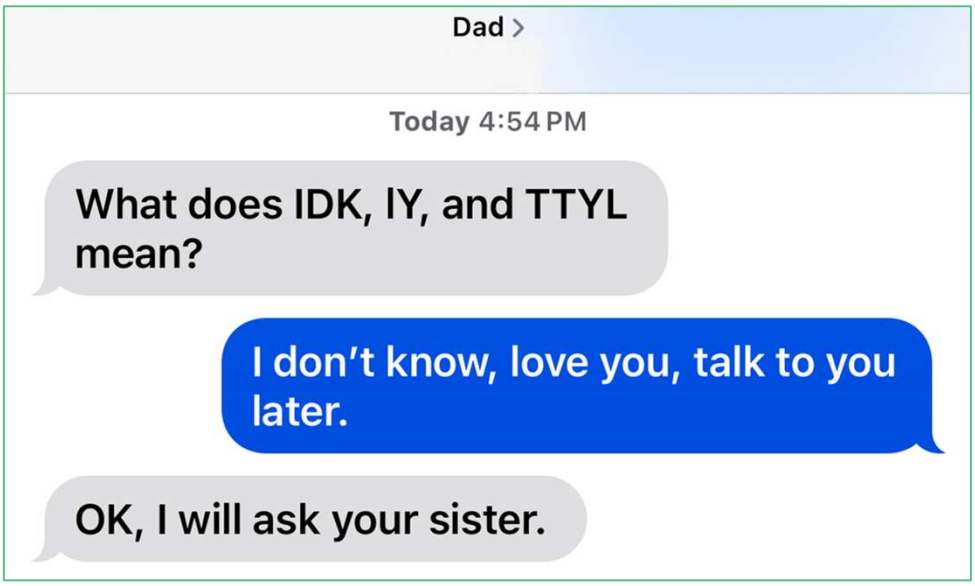

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Coding Systems

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; not common in chiropractic.*

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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)

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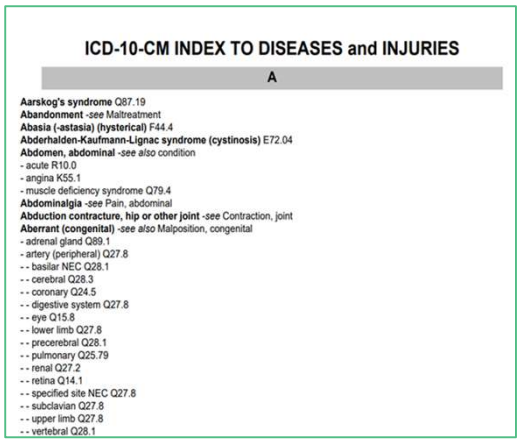
ICD-10 - Manual Layout; 2 Sections

Alphabetical Index

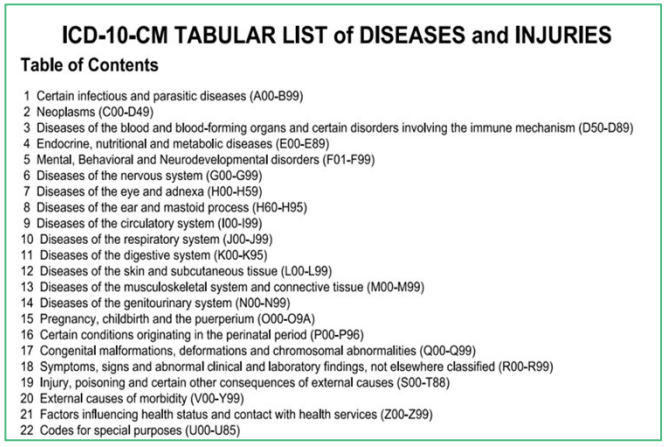


ICD-10-CM INDEX TO DISEASES and INJURIES

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

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)

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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."

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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).

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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 show Excludes1 notes, so double-check using a trusted coding manual or tool.*

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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."***

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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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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.*

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Basic 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

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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***

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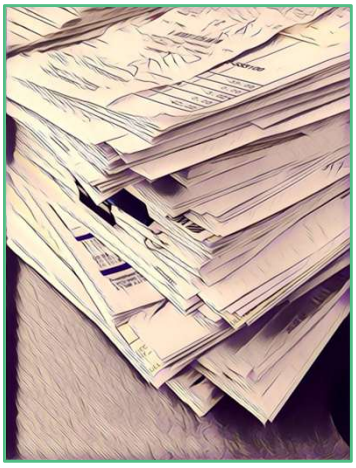
Patient/Beneficiary Plan Document

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



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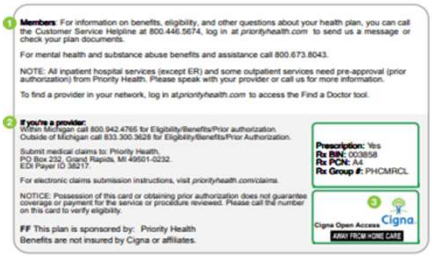
Insurance Card – Front & Back

- **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



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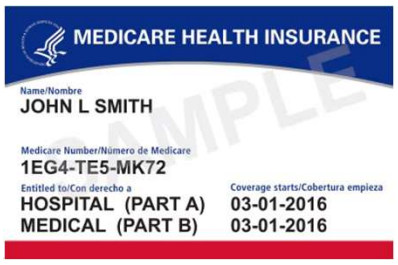

The card shows:

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.

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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.

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Evidence of Coverage (EOC) or Certificate of Coverage (COC)

*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)*

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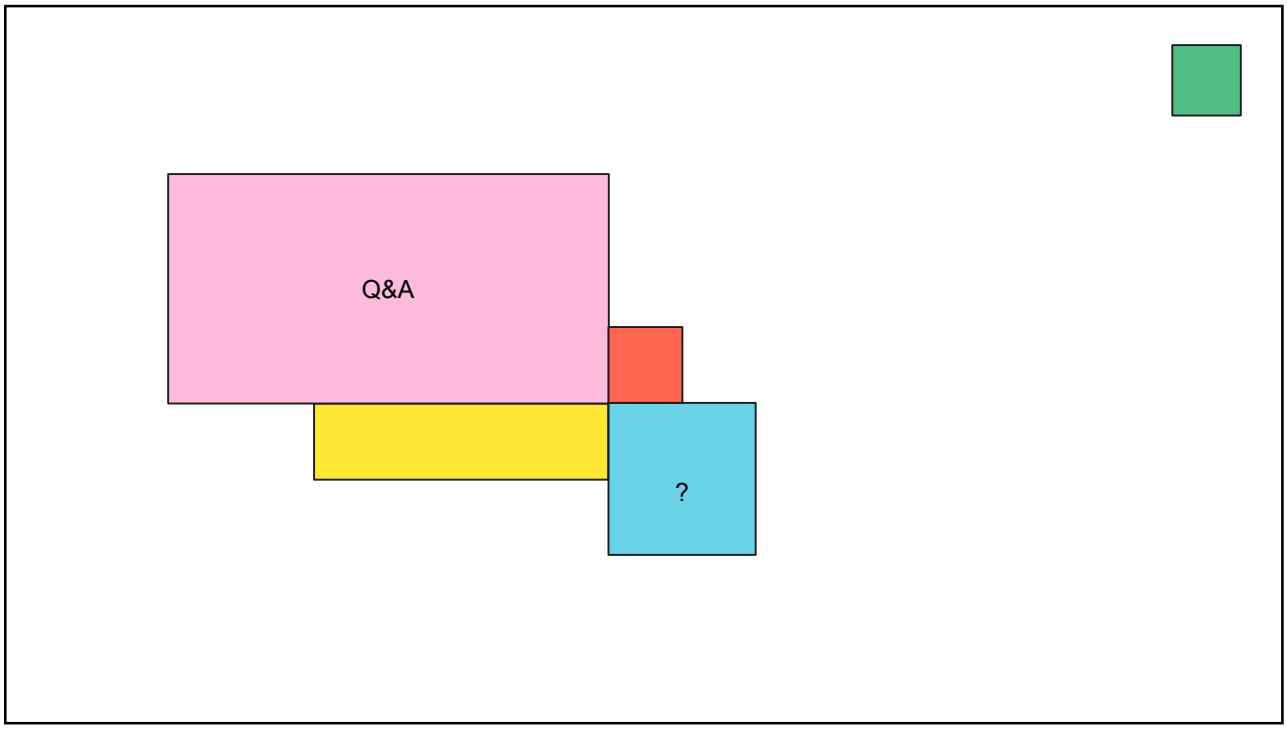

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The Life Cycle of a Claim

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

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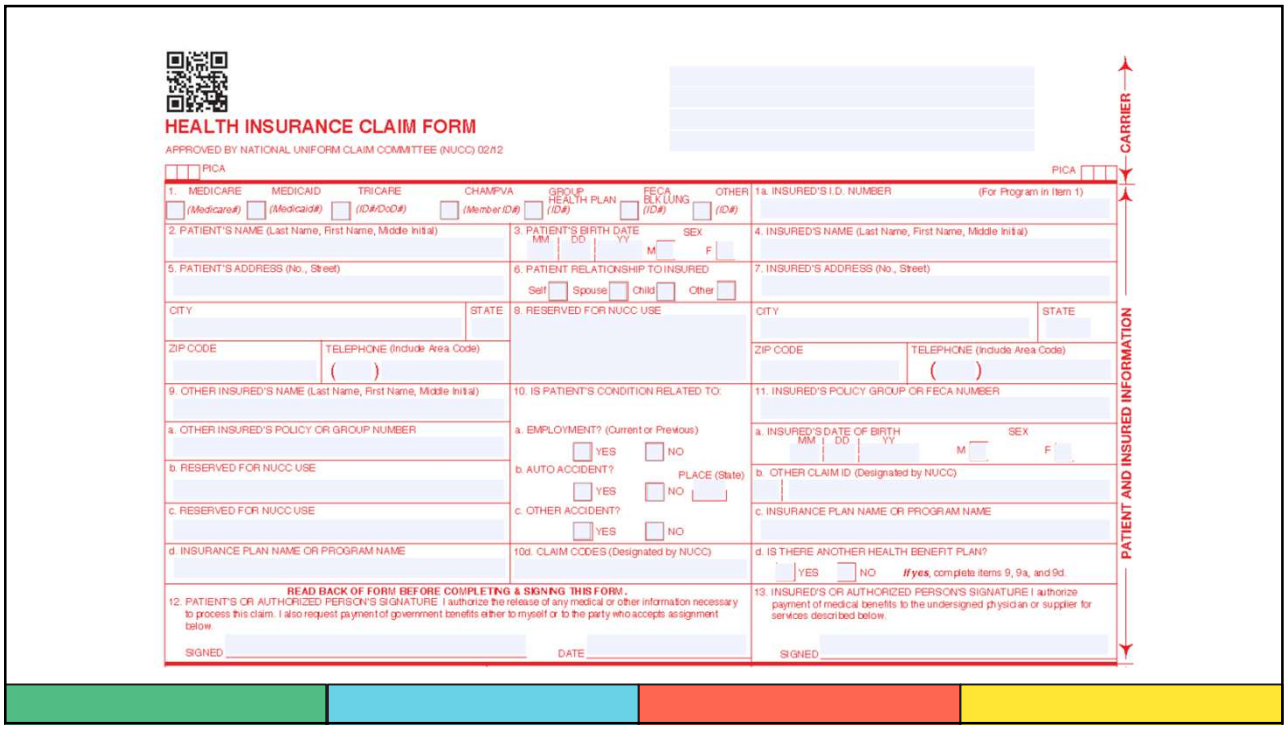

HEALTH INSURANCE CLAIM FORM

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

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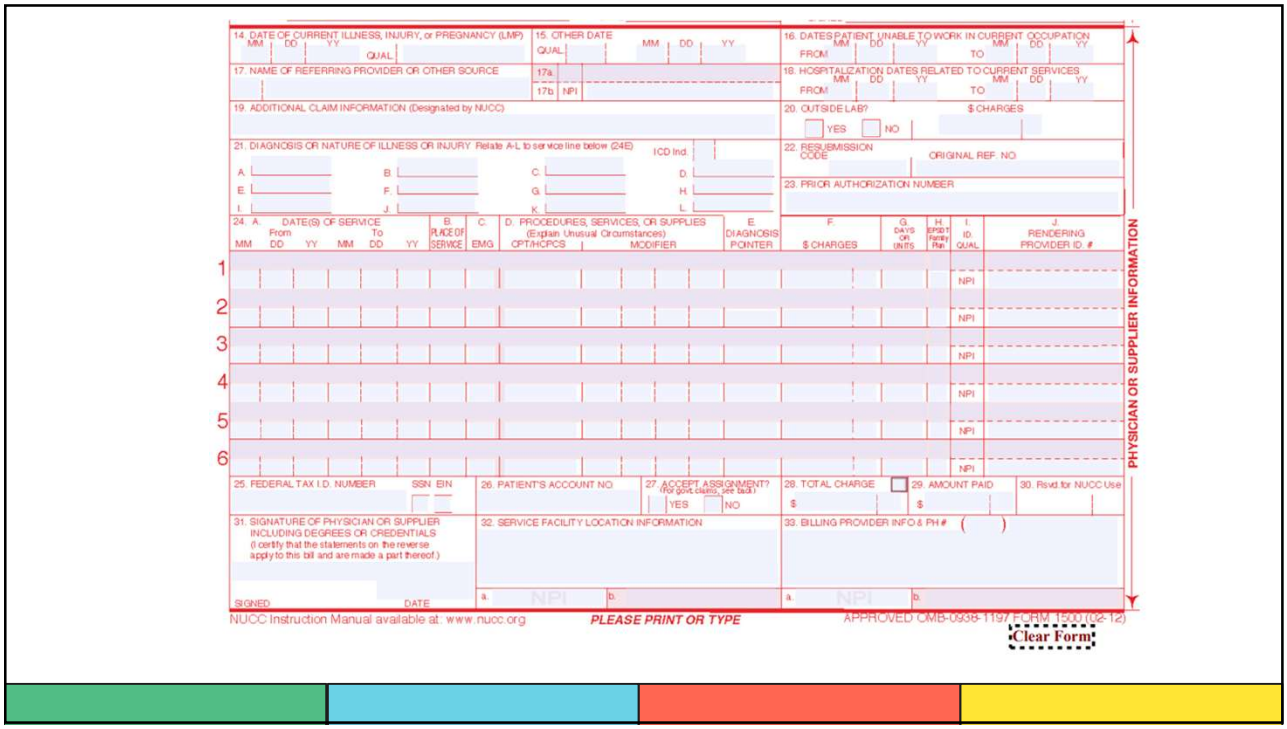


14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500(02-12)

Clear Form

PHYSICIAN OR SUPPLIER INFORMATION

38

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!***

39

Full Circle: What This All Means for Your Office

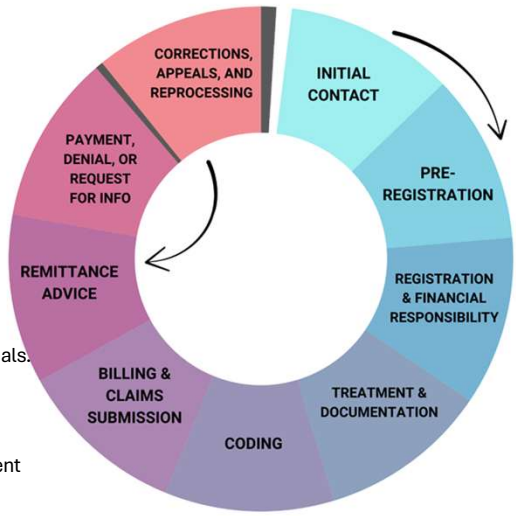
Every step matters.
Small errors at the start can lead to big problems later. Build strong front-end systems to reduce back-end headaches.

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.



40

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.

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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.

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When Do Denials Happen?

1) 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 can be preventable with solid a pre-registration processes.

43

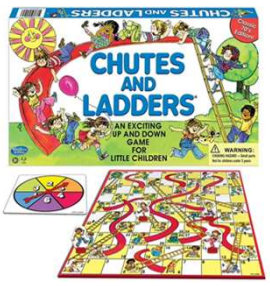
When Do Denials Happen?

2) 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



→ Require correction and resubmission.

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When Do Denials Happen?

Post-Payment Denials (Audits or Recoupments)

Payer paid initially, but later denies REVERSES their decision after review.

Examples:

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

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

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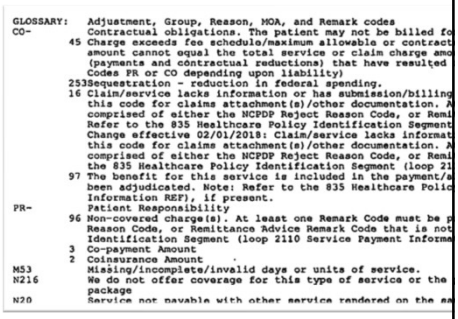
What Are CARC and RARC Codes?

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).*



```
GLOSSARY:   Adjustment, Group, Reason, MOA, and Remark codes
CO-         Contractual obligations. The patient may not be billed fo
         45 Charge exceeds fee schedule/maximum allowable or contract
            amount cannot equal the total service or claim charge amo
            (payments and contractual reductions) that have resulted
            Codes PR or CO depending upon liability)
        253 Sequestration - reduction in federal spending.
         16 Claim/service lacks information or has submission/billing
            this code for claims attachment(s)/other documentation. A
            comprised of either the NCPDP Reject Reason Code, or Remi
            Refer to the 835 Healthcare Policy Identification Segment
            Change effective 02/01/2018: Claim/service lacks informat
            this code for claims attachment(s)/other documentation. A
            comprised of either the NCPDP Reject Reason Code, or Remi
            the 835 Healthcare Policy Identification Segment (loop 21
         97 The benefit for this service is included in the payment/a
            been adjudicated. Note: Refer to the 835 Healthcare Polic
            Information REF), if present.
PR-         Patient Responsibility
         96 Non-covered charge(s). At least one Remark Code must be p
            Reason Code, or Remittance Advice Remark Code that is not
            Identification Segment (loop 2110 Service Payment Informa
          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
            package
N20         Service not payable with other service rendered on the sa
```

Think of it like this:

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

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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.

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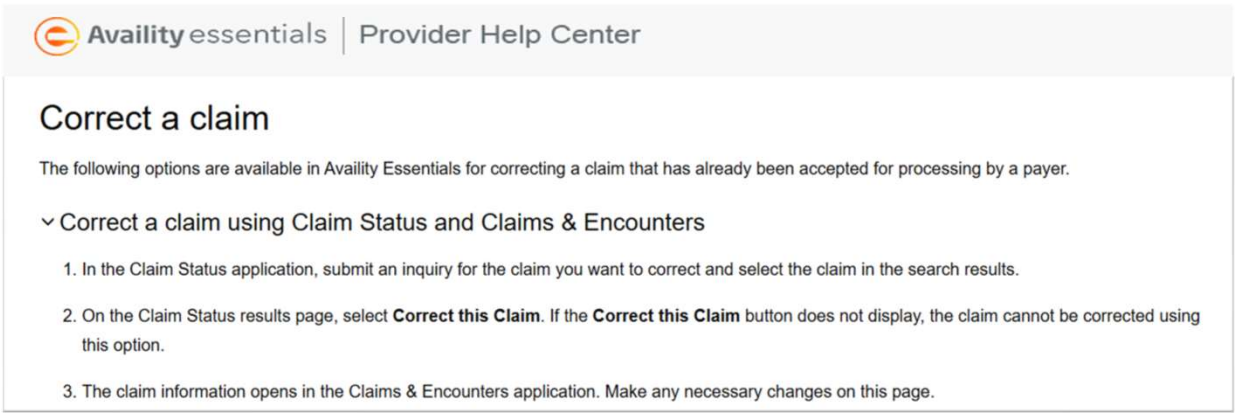
📌 **Tip:** For each payer that you bill, create a resource listing their process, timeframe, requirements, etc. for correcting or appealing claims.

For example, payers that use Availity:



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.

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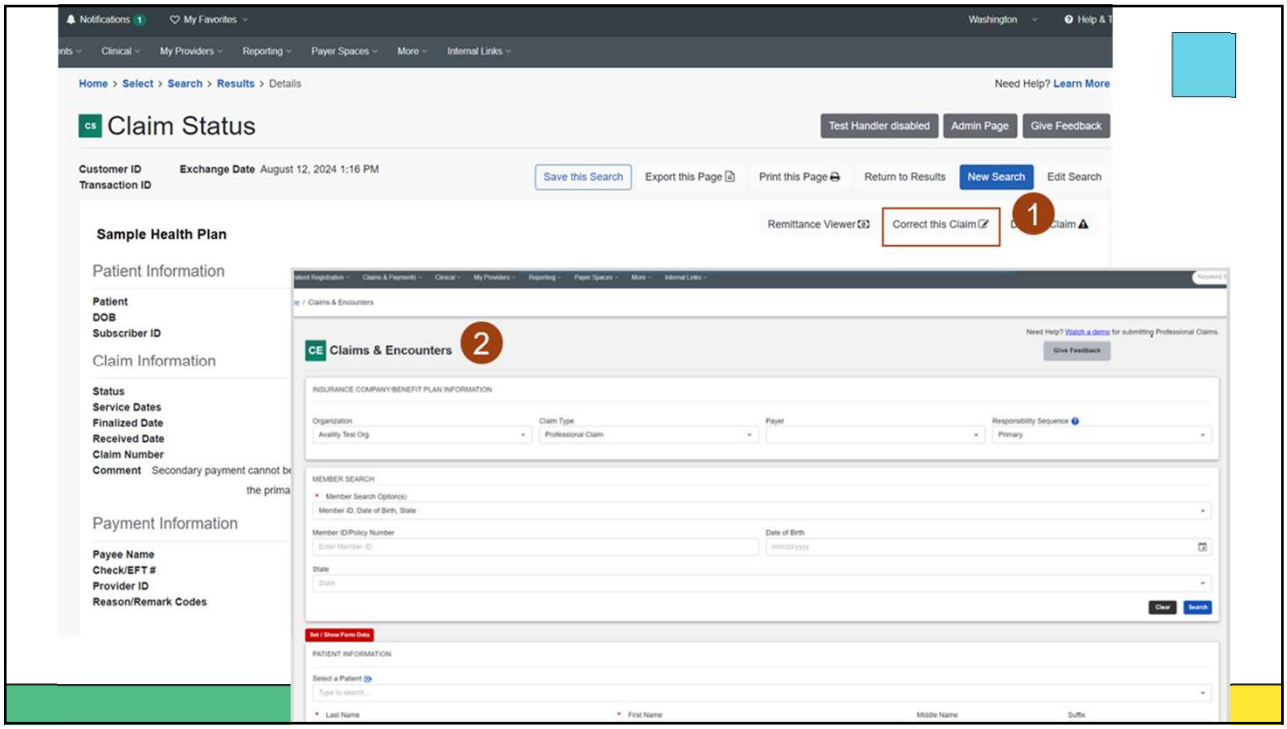

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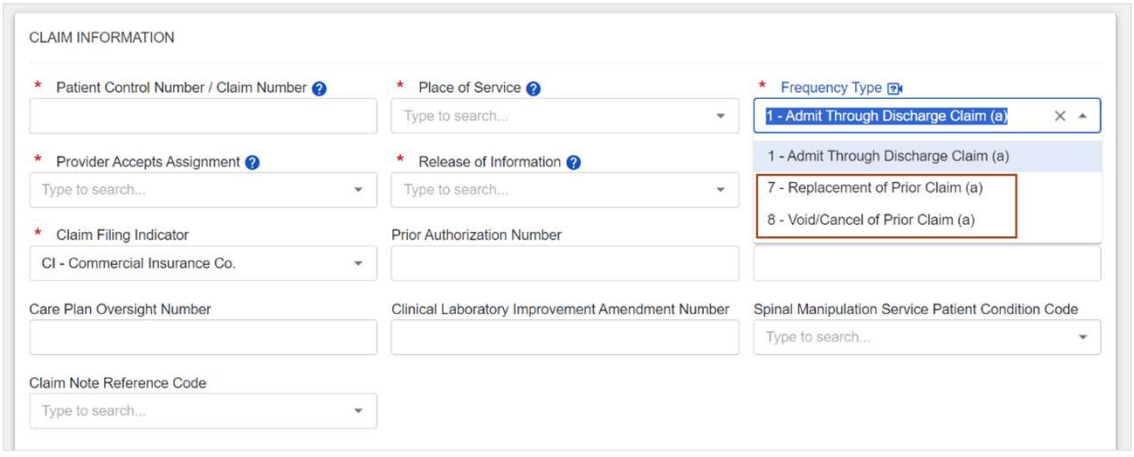
Note: In the **Frequency Type** field in the Claim Information section, select **7 - Replacement of Prior Claim** or **8 - Void/Cancel of Prior Claim** for a claim correction:



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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.

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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

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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)*

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

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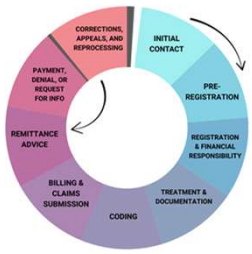
"Appeal" Tips

- **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**
  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!



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What to Include in an Appeal Letter:

**First and Foremost – FOLLOW THE PAYORS REQUIRED INFO.*

This may include:

1. **Clear and concise appeal**
   - 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)

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

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

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

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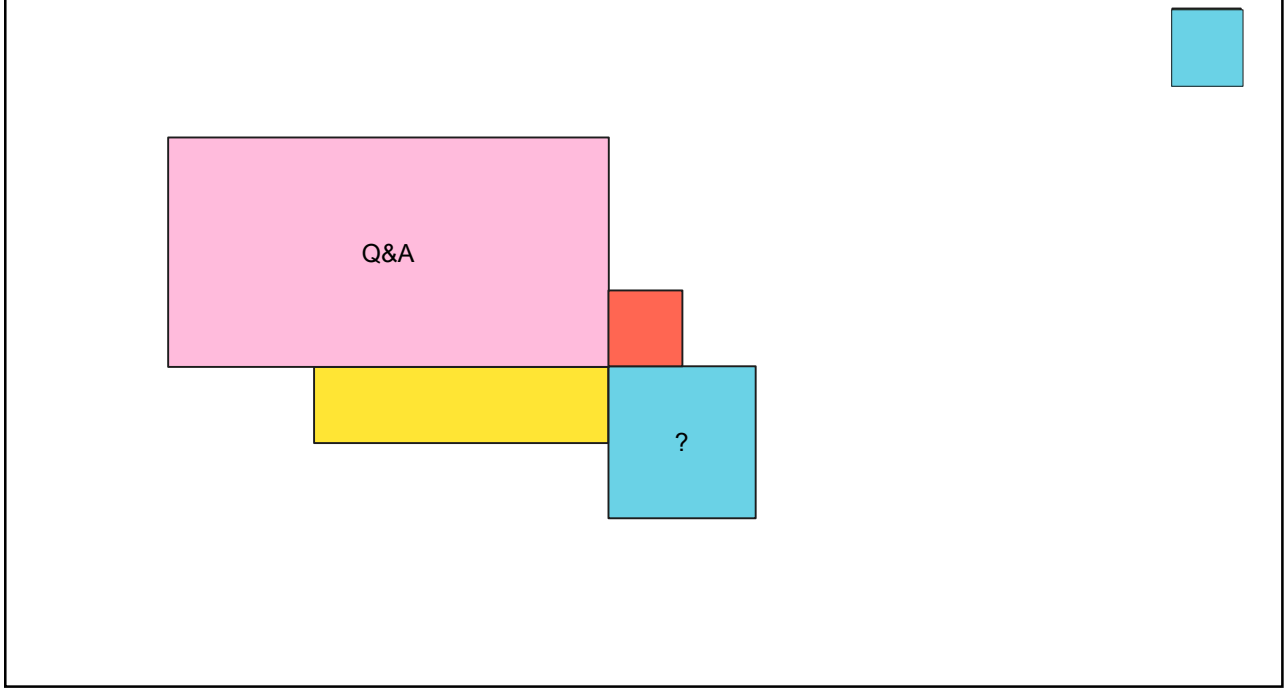

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Mastering Managed Care

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

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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

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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.***

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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

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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, Medicaid, etc.)* - confirm your participation scope!

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🤔 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

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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.*

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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

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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.

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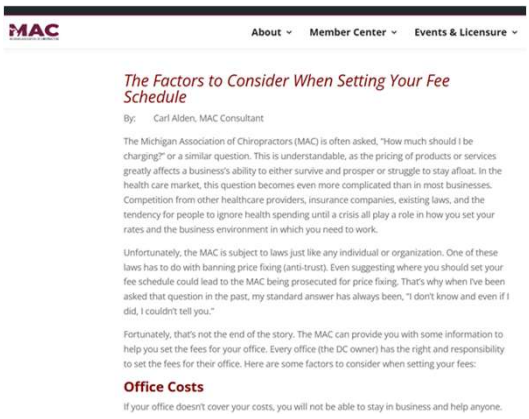
MAC Article by Carl Alden

📌 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.

68

“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 by the **Chiropractic Future Strategic Plan.**

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Q&A

?

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Understanding *Fraud, Waste, & Abuse*

And How to Help Stay Compliant in Chiropractic

MICHIGAN ASSOCIATION OF CHIROPRACTORS

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Why This Matters

Improper billing impacts **providers, patients, payers, … taxpayers, and more.**

Can lead to audits, recoupments, penalties, and loss of trust.

Office Managers, CAs, and Billers can be a great first line of defense.

72

What is "*Fraudulent*" Billing?

Term	Definition	Chiropractic Example	Key Point
Fraud	Intentional deception or reckless disregard	Routinely billing for services not performed	Highest penalties
Waste	Overuse or misuse of resources	Routinely ordering services *(i.e., mechanical traction)* for all patients regardless of documented clinical need	Costly, not always intentional *("It's what we do in our office.")*
Abuse	Practices inconsistent with standard guidelines	Billing 98942 when 98940 is supported	Subject to penalties
Potentially Not Fraud, Waste, or Abuse…			
Error	Unintentional mistakes	Wrong diagnosis code or modifier	Must be corrected; repeated errors look like fraud

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Who Regulates Fraud?

Federal:

- Department of Justice (DOJ)
- Department of Health & Human Services Office of Inspector General (OIG)
- Centers for Medicare & Medicaid Services (CMS)

State:

- Attorney General's Health Care Fraud (HCF) Division

Private Payers:

- Special Investigation Units (SIUs)

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Federal Fraud & Abuse Laws

Three important **federal** fraud and abuse laws that apply to physicians:

False Claims Act (FCA)	• Prohibits the submission of false or fraudulent claims to the Government
Anti-Kickback Statute (AKS)	• Prohibits asking for or receiving anything of value in exchange for referrals of Federal health care program business
Physician Self-Referral Law (Stark law)	• Limits physician referrals when you have a financial relationship with the entity

Office of Inspector General
A Roadmap for New Physicians: Avoiding Medicare & Medicaid Fraud & Abuse

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Information from a Commercial Insurance Payor's Provider Manual on Fraud Prevention

Our Investigations Department reviews reports of improper activity involving patients or providers. If the concern is verified, the matter may be referred for internal administrative steps or legal action.
Information is gathered from multiple sources, including advanced data analytics, to determine when an investigation is necessary.
Often, a fraud case begins with a suspicious billing pattern identified through data analysis and later confirmed during an audit or investigation. In other cases, it may start with a tip from a patient, another provider, or a government agency.
When issues are identified, the situation is reviewed with the provider to explain their responsibilities. If questionable practices continue, what begins as abuse may escalate into fraud.

One of the best ways to safeguard your practice is to submit claims correctly.

Additional tips for avoiding fraud include:

- For new patients, compare the insurance identification card with a photo ID, such as a driver's license.
- Report only those services you personally performed or directly supervised.
- Use only the provider identification numbers assigned to you. Never allow another provider to use your PIN or NPI.

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Department of Justice Press Release

Louisiana Chiropractor Convicted of Health Care Fraud and Unemployment Insurance Fraud

A Louisiana chiropractor, falsely billed Blue Cross Blue Shield of Louisiana over $2.3 million for thousands of chiropractic services never performed, including during times he was on vacation or incarcerated, and fabricated patient records to cover the fraud.

In addition, he falsely claimed unemployment benefits during this period, receiving $12,952 to which he was not entitled.

The chiropractor was convicted of six counts of health care fraud and one count of wire fraud, illustrating how falsifying claims and records can result in significant legal consequences.

He faces a maximum penalty of 20 years in prison on the wire fraud count and 10 years in prison on each health care fraud count.

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Potential *Errors* in Chiropractic Offices

Anytime a claim is submitted with false information and payment is accepted

Examples include:

- Billing services under an improper NPI
- Billing for services not provided or documented
- Misrepresenting covered services
  - *Active care vs. Maintenance care*
  - *Moderate level E/M vs. Low level E/M*

Key Point:

- Even *without intent*, liability exists if you should have known the claim was false.
- Providers can be penalized if they act with **deliberate ignorance** or **reckless disregard of the truth**.

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How Fraudulent Billing Can Happen with NPIs

Scenario:

- Dr. Abraham is credentialed with BCBS.
- Dr. Bernard is not credentialed *(new hire, application pending)*.
- The office bills all visits under Dr. Abraham's Type 1 NPI even when Dr. Bernard treats the patient.
- This is fraud because the claim misrepresents who provided the service.

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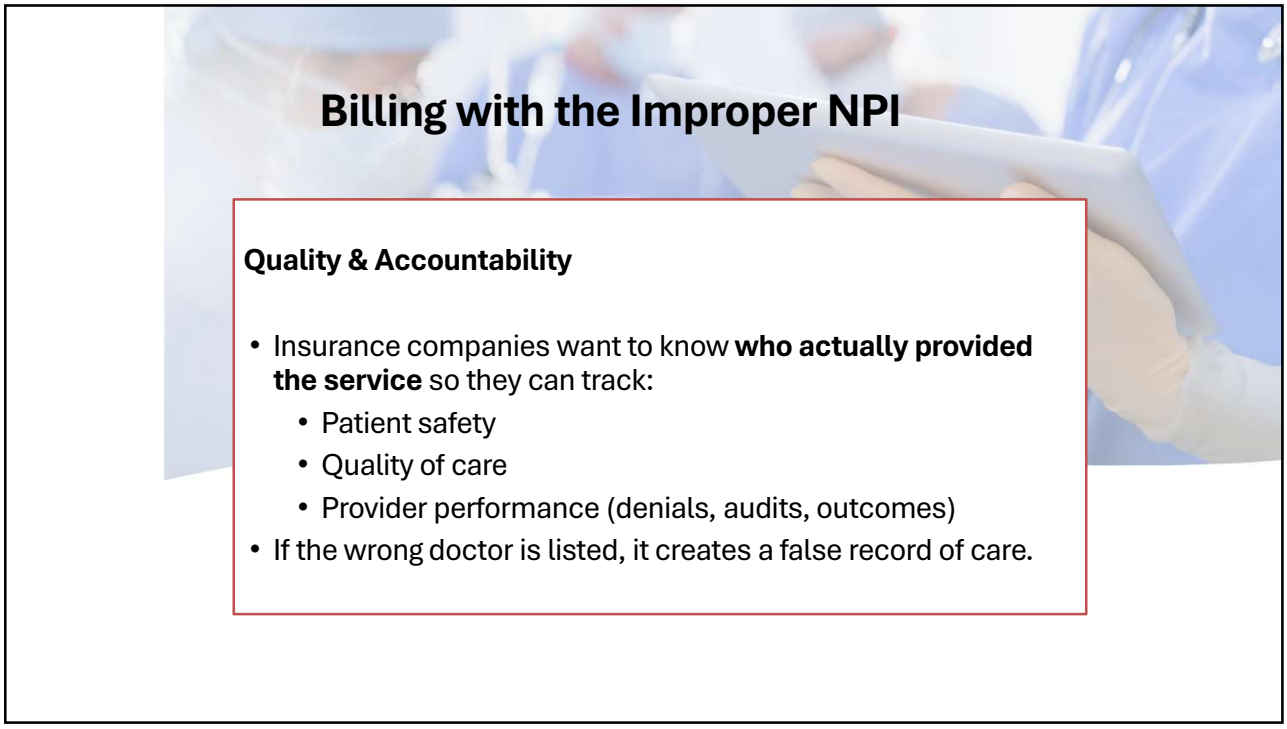

Billing with the Improper NPI

Quality & Accountability

- Insurance companies want to know **who actually provided the service** so they can track:
  - Patient safety
  - Quality of care
  - Provider performance (denials, audits, outcomes)
- If the wrong doctor is listed, it creates a false record of care.

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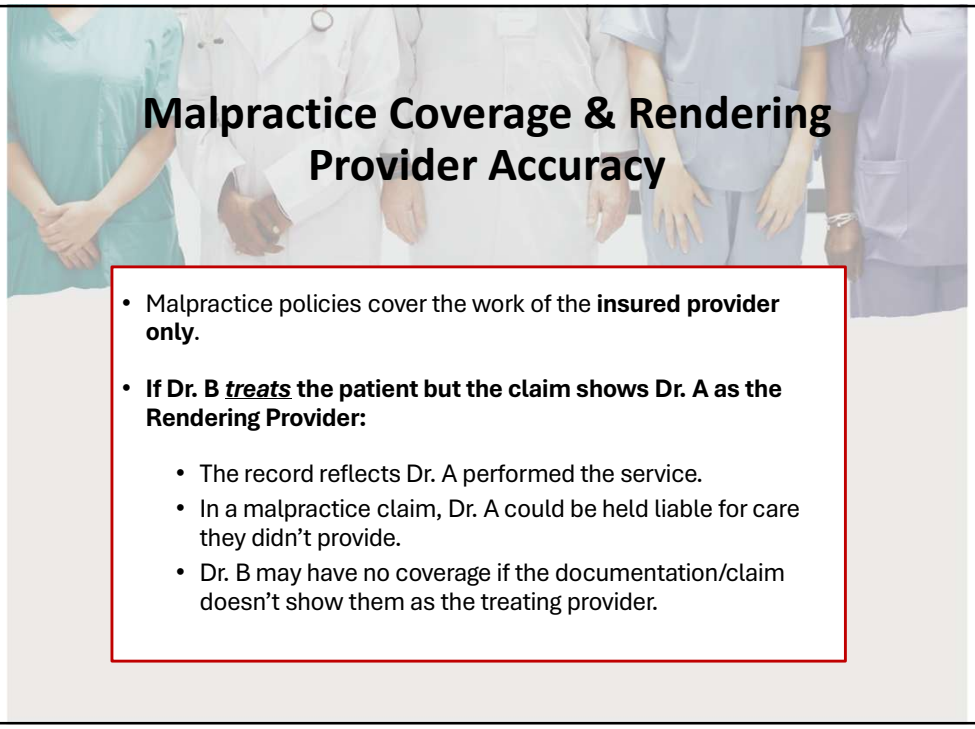

Malpractice Coverage & Rendering Provider Accuracy

- Malpractice policies cover the work of the **insured provider only**.
- **If Dr. B *treats* the patient but the claim shows Dr. A as the Rendering Provider:**
  - The record reflects Dr. A performed the service.
  - In a malpractice claim, Dr. A could be held liable for care they didn't provide.
  - Dr. B may have no coverage if the documentation/claim doesn't show them as the treating provider.

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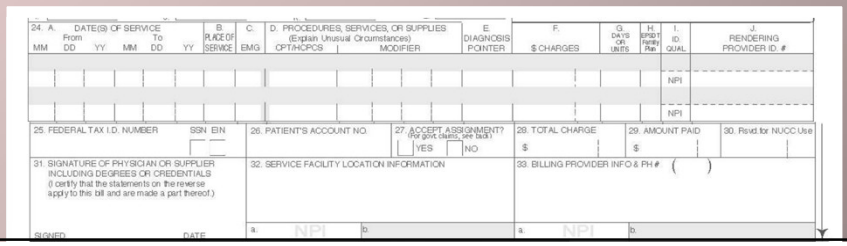
Common Sources of Confusion: Individual vs. Group NPIs

Individual NPI (Type 1):
- Assigned to each *healthcare provider personally*
- Identifies **who actually rendered the service**
- Must always be used to show *which provider treated the patient*

Group NPI (Type 2):
- Assigned to the *practice or organization*
- Identifies the **billing entity** that gets paid
- Used in conjunction with the individual NPI

The claim shows:
- ***Rendering provider*:** Individual chiropractor (Type 1 NPI)
- ***Billing practice/organization*:** Group (Type 2 NPI)



82

What About *Locum Tenens* & NPI?

What is a *Locum Tenens* Provider:

- A healthcare professional who ***temporarily*** fills in for another provider.
- Used when the regular provider is ***unavailable*** due to vacation, illness, parental leave, or other temporary absences.
- Works as a ***contractor***, not an employee of the organization.
- Bills under the absent provider's NPI for covered services *(with time limits, appropriate modifiers, and specific regulations).*
- Must be fully ***licensed***.
- Intended as a short-term solution, not a permanent staffing replacement.

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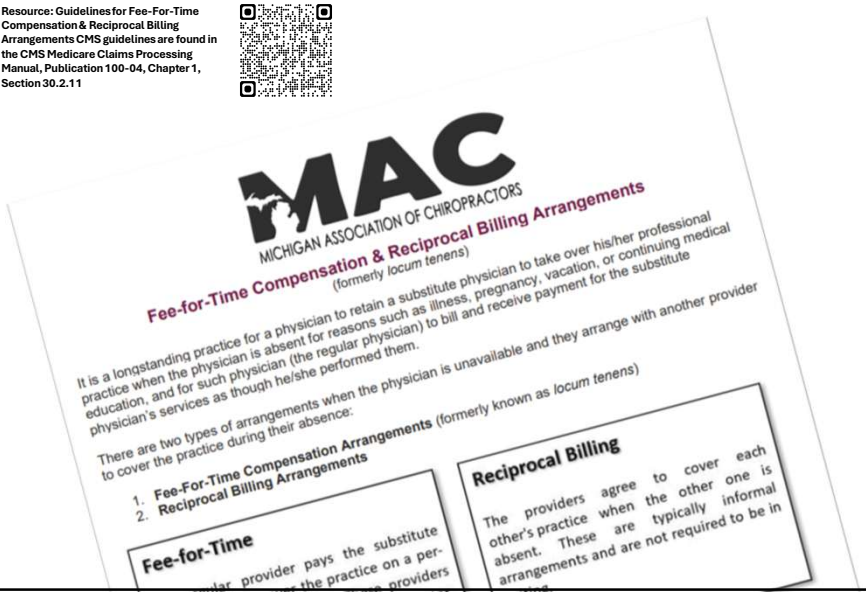
What About *Locum Tenens* & NPI?

Resource: Guidelines for Fee-For-Time Compensation & Reciprocal Billing Arrangements CMS guidelines are found in the CMS Medicare Claims Processing Manual, Publication 100-04, Chapter 1, Section 30.2.11



MAC

MICHIGAN ASSOCIATION OF CHIROPRACTORS

Fee-for-Time Compensation & Reciprocal Billing Arrangements

(formerly *locum tenens*)

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

There are two types of arrangements when the physician is unavailable and they arrange with another 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

provider pays the substitute

the practice on a per-

providers

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

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Medicare Improper Payment Data

Part B Services	Projected Improper Payments	Improper Payment Rate	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
			No Doc	**Insuffic. Doc**	Medical Necessity	Incorrect Coding	Other	
Chiropractic	$214,123,439	**39.3%**	5.4%	**92.4%**	0.6%	1.6%	0.0%	0.7%

According to **the 2023 Medicare Fee-for-Service Supplemental Improper Payment Data**, the improper payment rate for chiropractic services is **39.3%,** with a projected improper payment amount of $214.1 million.

A Comprehensive Error Rate Testing (CERT) Program review in **2024 found errors in **33.6%** of chiropractic claims.*

**Approximately 150 claims were reviewed in these studies.*

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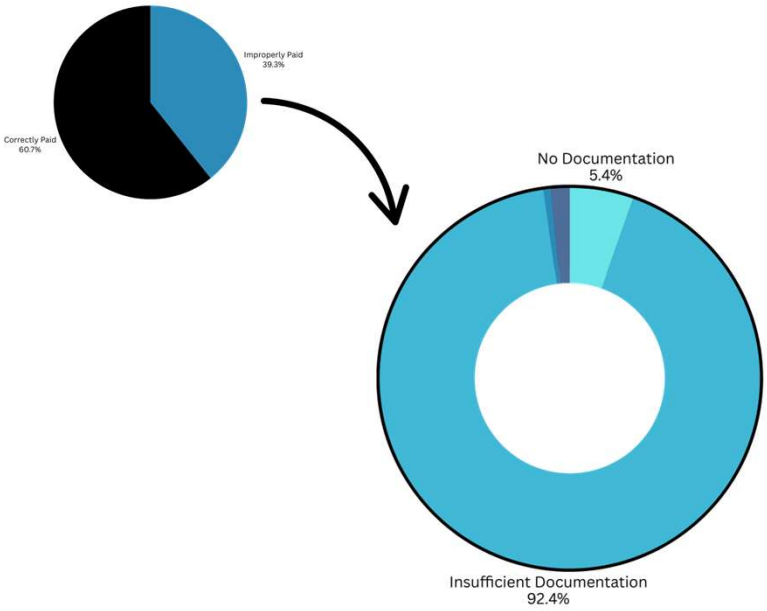
2023 Medicare Improper Payment Data for Chiropractic



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Best Practices: Coding Accuracy Matters

AMA CPT Guidance:

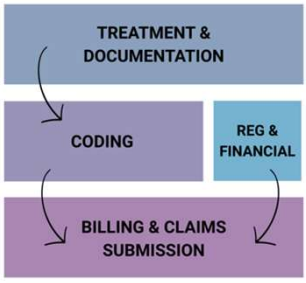
*"Select the procedure/service that **accurately** identifies what was performed. Do not choose a code that **merely** approximates the service. If no such code exists, use an unlisted code."*

Key Point:

- "Close enough" is not compliant.
- Wrong code = error → abuse → potential fraud.

Documentation Connection:

- The **written documentation** tells the story of what was performed.
- The **coder/biller's job** is to translate that story into the **accurate CPT code**.
- If the words don't support the code, the claim doesn't stand.



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Protecting Your Office

- ✓ Perform periodic internal audits (cross-check records vs. claims)
  - Most errors can be corrected if caught early
- ✓ Train staff and attend educational conferences
- ✓ Use payer portals to verify rules/coverage
- ✓ Document, document, document!

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MEDICARE ADVANCE BENEFICIARY NOTICES

THE ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

FORM CMS-R-131

MICHIGAN ASSOCIATION OF CHIROPRACTORS

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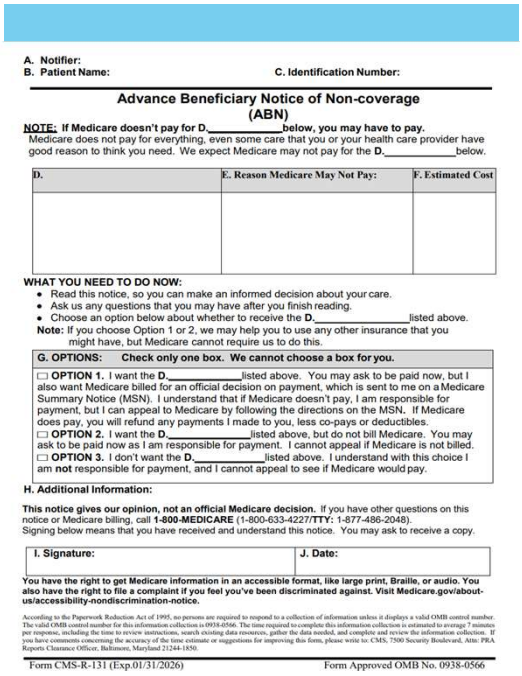
ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE

ABN

Form CMS-R-131

Expires 1/31/2026



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

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D._____below.

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

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____listed above.

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

G. OPTIONS: Check only one box. We cannot choose a box for you.

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

H. Additional Information:

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

I. Signature:	J. Date:

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

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

Form CMS-R-131 (Exp.01/31/2026) Form Approved OMB No. 0938-0566

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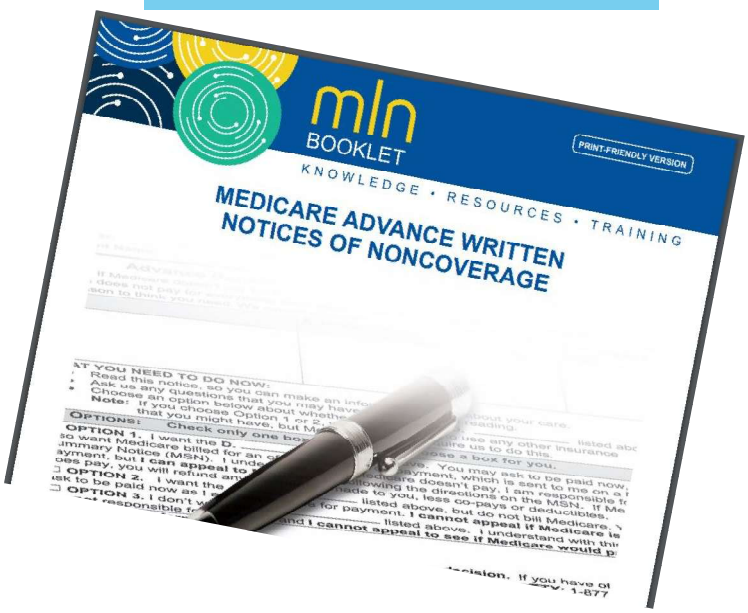
The information in this webinar is directly from CMS.

It applies *only* to the **Medicare Fee-For-Service** Program (also known as **Original Medicare**).



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What is an ABN?

Advance Beneficiary Notice of Noncoverage (ABN) = written notice given to a **Medicare Fee-for-Service (FFS) beneficiary** before providing a service that is **usually covered by Medicare** but is **likely to be denied** in this situation (e.g., not medically necessary).

What is Medicare Fee-for-Service?

Part A	Part B	Part C	Part D	Medigap
Hospital Insurance	**Medical Insurance**	**Medicare Advantage (MA Plans)**	**Prescription Drug Coverage**	**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***

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What is the Purpose of the ABN?

The ABN allows the patient to make an informed decision:

- Decide whether to receive the service, and
- Accept financial responsibility if Medicare does not pay.

If you do not issue an ABN when required:

- The patient generally cannot be held responsible, and
- You may be financially liable.

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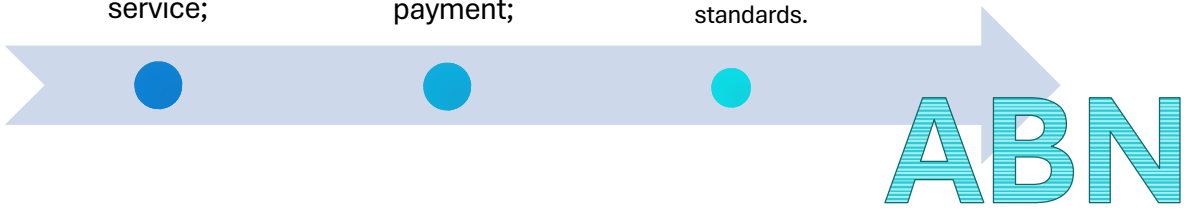
When You Must Issue an ABN:

Medicare Part B usually covers the service;

Medicare is expected to deny payment;

The covered service isn't considered reasonable or necessary under CMS standards.



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Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services
240 - Chiropractic Services

240.1.3 - Necessity for Treatment

- ❑ The patient must have a **significant health problem in the form of a neuromusculoskeletal condition** necessitating treatment.
- ❑ The manipulative services rendered **must have a direct therapeutic relationship** to the patient's condition and **provide reasonable expectation of recovery or improvement of function**.
- ❑ **The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam, (P.A.R.T. exam).**

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Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services
240 - Chiropractic Services

According to CMS, most spinal joint problems fall into the following categories:

Acute Subluxation

A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.

Chronic Subluxation

A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

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Remember: Medicare says that the treatment must **provide reasonable expectation of recovery or improvement of function**. When is does not, the treatment becomes **Maintenance Therapy**.

Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services
240 - Chiropractic Services

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 the chiropractic treatment becomes *supportive rather than corrective* in nature, the treatment is then considered maintenance therapy.

The **AT modifier** *must not be placed* on the claim when maintenance therapy has been provided. Claims without the AT modifier will be considered as maintenance therapy and denied.

Chiropractors who give or receive from beneficiaries an ABN shall follow the ABN instructions in full and include a GA modifier on the claim.

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Best Practices:

Flowchart Steps (First Visit + Ongoing Care)

1) First Visit

1. Discuss Medicare's Chiropractic Coverage Policy with the patient:
   - Medicare **only covers spinal manipulation** for **active treatment**.
   - (Medicare does **not cover exams, x-rays, therapies, or maintenance care**. – ABN is not required for these services.)
2. If patient is in **Active Treatment**:
   1. **Introduce the ABN form** as an educational tool (do not have them sign yet).
   2. Explain: *"When your care shifts from Active Treatment to Maintenance Care, Medicare will no longer cover it. At that time, I'll ask you to review and sign the ABN so you can choose how to proceed."*

2) During Care

- Regularly assess whether the patient is still in Active Treatment or has shifted to Maintenance Care (based on Medicare definitions and documentation).

3) Transition Point: Active → Maintenance

1. Present the ABN form **at the first Maintenance Care visit**.
2. Explain options on the ABN; do not direct or instruct the patient to sign a particular box.

4) Ongoing Care

- Update ABN only if there is a change in care status or if it expires (usually one year or if treatment plan changes).

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Prohibitions

Routine Notice Prohibition

- You *may not* issue an ABN on a routine basis or when there is no reasonable basis to expect that Medicare may not cover the item or service.
- You must ensure a reasonable basis exists for noncoverage associated with the issuance of each ABN.

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Completing the ABN

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

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

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Completing the ABN

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

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Completing the ABN

- **Option 1:** This option allows the beneficiary to receive the items and/or services at issue and requires the notifier to submit a claim to Medicare.
  - Per CMS guidelines, the *AT modifier* is removed from 98940-98942.
  - The **GA modifier** is appended to indicate a properly issued and signed ABN form was received.
- **Option 2:** This option allows the beneficiary to receive the non-covered items and/or services and pay for them out of pocket. No claim will be filed and Medicare will not be billed.
- **Option 3:** This option means the beneficiary does not want the care in question. By checking this box, the beneficiary understands that no additional care will be provided.

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Refusal to Sign the ABN

When the Beneficiary Refuses to Choose an Option, or Sign the ABN

- If the beneficiary refuses to choose an option or sign the ABN, you should annotate the original copy of the ABN indicating the refusal to choose an option or sign the ABN. You may list any witnesses to the refusal on the ABN, although a witness is not required.
- If a beneficiary refuses to sign a properly issued ABN, you should consider not furnishing the service.

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When the Beneficiary Changes Their Mind

- After completing and signing the ABN, if the beneficiary changes their mind, you should present the completed ABN to the beneficiary and request they annotate it.
- The annotation must be signed and dated, and include a clear indication of their new option selection.

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Continuous Non-covered Care

An advance written notice of non-coverage remains effective after delivery if there's no change in:

- Care described on the original notice
- Patient's health status
- Medicare coverage guidelines for the items or services in question (for example, updates or changes to the policy of an item or service)

Once an ABN is issued, it is no longer required to be issued annually. If there are ANY changes, and a period of billing Chiropractic Active Treatment occurs again, a new ABN is required for the NEXT course of Chiropractic Maintenance Care.

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Claim Reporting Modifiers

Modifier	When to Use the Modifier
GA Waiver of Liability Statement Issued as Required by Payer Policy, Individual Case	Report when you issue a mandatory ABN for a service as required and **it is on file**. You do not need to submit a copy of the ABN, but you must have it available on request.
GX Notice of Liability Issued, Voluntary Under Payer Policy	Report when you issue a **voluntary** ABN for a service Medicare never covers because it is statutorily excluded or is not a Medicare benefit. You may use this modifier in combination with modifier GY.
GY Item or Service Statutorily Excluded, Does Not Meet the Definition of Any Medicare Benefit	Report that Medicare **statutorily excludes** the item or service or the item or service does not meet the definition of any Medicare benefit. You may use this modifier in combination with modifier GX.
GZ Item or Service Expected to Be Denied as Not Reasonable and Necessary	Report when you expect Medicare to deny payment of the item or service due to a lack of medical necessity and **no ABN was issued**.

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Financial Liability

- When issued properly, you can collect your full fee from the patient, ***OR*** continue billing patient at the CMS rate, if Medicare determines that the care you provided is not reasonable or necessary.

- Without a properly executed ABN on file:
  - You cannot collect funds from the beneficiary.
  - You will have to refund any money that Medicare and/or the patient paid.

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Special Instructions: QMB Patients

Page 5

*** Special guidance for people who are dually enrolled in both Medicare and Medicaid, also known as dually eligible individuals (has a Qualified Medicare Beneficiary (QMB) Program and/or Medicaid coverage) ONLY:**

Dually Eligible beneficiaries must be instructed to check **Option Box 1** on the ABN in order for a claim to be submitted for Medicare adjudication.

Strike through **Option Box 1** as provided below:

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

The provider cannot bill the dual eligible beneficiary when the ABN is furnished. Providers must refrain from billing the beneficiary pending adjudication by both Medicare and Medicaid in light of federal law affecting coverage and billing of dual eligible beneficiaries. If Medicare denies a claim where an ABN was needed in order to transfer financial liability to the beneficiary, the claim may be crossed over to Medicaid or submitted by the provider for adjudication based on State Medicaid coverage and payment policy. Medicaid will issue a Remittance Advice based on this determination.

Once the claim is adjudicated by both Medicare and Medicaid, providers may only charge the patient in the following circumstances:

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Special Instructions: Non-PAR Providers

Page 7

***Special guidance for non-participating suppliers and providers (those who don't accept Medicare assignment) ONLY:**

Strike the last sentence in the Option 1 paragraph with a single line so that it appears like this: ~~If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.~~

This single line strike can be included on ABNs printed specifically for issuance when unassigned items and services are furnished. Alternatively, the line can be hand-penned on an already printed ABN. The sentence should be stricken and can't be entirely concealed or deleted. There is no CMS requirement for suppliers or the beneficiary to place initials next to the stricken sentence or date the annotations when the notifier makes the changes to the ABN before issuing the notice to the beneficiary.

When this sentence is stricken, the supplier should include the following CMS-approved unassigned claim statement in the (H) Additional Information section:

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PLEASE NOTE:

- **Under no circumstance can the ABN form be used by providers not enrolled in Medicare** *(for example, "Cash Practices")*.
- **Medicare does not allow chiropractors to Opt-Out of Medicare.**
- **If you have questions about this, please contact the MAC office.**

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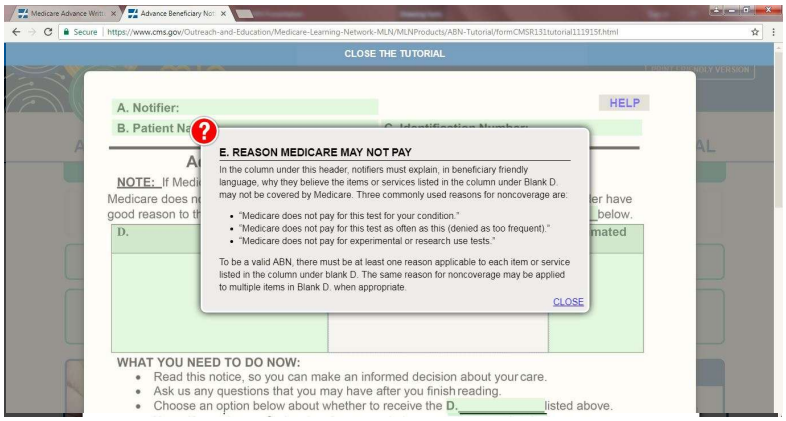
ABN INTERACTIVE TUTORIAL

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ABN-Tutorial/formCMSR131tutorial111915f.html



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MICHIGAN ASSOCIATION OF CHIROPRACTORS

FAST FACTS: ABN FORM

The **Advance Beneficiary Notice of Noncoverage (ABN)**, Form CMS-R-131, is issued by providers to Original Medicare (Part B) beneficiaries in situations where Medicare payment is expected to be denied.

WHEN IS IT ISSUED TO THE PATIENT?

When *Active Treatment* has ended and *Maintenance Therapy* begins. The patient's signature (Box I) and signed date (Box J) should correlate to the timeframe when the patient enters *Maintenance Therapy*.

If the patient's condition returns to *Active Treatment*, the form should remain in the patient's medical record, but is no longer valid for future *Maintenance Therapy* visits.

A new ABN form must be issued if the patient's condition returns to *Maintenance Therapy*.

The form should be kept on file in accordance with the Michigan Medical Records Retention Act (Public Act 481 of 2006).

DOWNLOAD THE ABN FORM & INSTRUCTIONS
https://www.cms.gov/medicare/medicare-general-information/bni/abn

MANDATORY ABN USAGE

The ABN form must be given when Medicare is expected to deny payment for a contractually covered service *(for chiropractic: 98940-98942)* because it is not reasonable and necessary under Medicare Program standards *(i.e. does not meet Medicare's definition of active treatment to treat acute or chronic subluxation)*.

ABNs are not required for services that are statutorily excluded from Medicare coverage *(for chiropractic: E/M service, X-rays, modalities, therapies, etc.)*.

BENEFICIARY OPTIONS

Beneficiaries cannot be instructed as to which option to check.
Only one box can be checked.

OPTION 1

Allows the beneficiary to *receive the covered, non-payable service and pay out-of-pocket.* Requires the doctor to submit a claim to Medicare. A payment decision can be appealed. Secondary insurance can be billed. Append the GA modifier to chiropractic manipulation code (98940-98942) and remove the AT modifier.

OPTION 2

Allows the beneficiary to *receive the covered, non-payable service and pay out-of-pocket.* No claim will be filed and Medicare will not be billed. An appeal cannot be made.

OPTION 3

Documents the beneficiary's choice to *not receive the covered, non-payable service*. By checking this box, the beneficiary understands that this service will not be provided.

- Only healthcare providers and suppliers who are **enrolled in Medicare** can issue the ABN to beneficiaries.
- There are additional instructions for **Non-Par Providers** and **Dually-Eligible** patients *(enrolled in Medicare and Medicaid)*.
- The ABN form is not intended for **Medicare Advantage (Part C)** patients. Refer to the payers' provider manuals for guidelines on providing non-covered services to these patients.

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RESOURCES

Medicare Advance Written Notices of Non-coverage Booklet

ABN Form Instructions

ABN Tutorial

WPS GHA: Chiropractic Claims

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MICHIGAN ASSOCIATION OF CHIROPRACTORS

WWW.CHIROMI.COM

info@chiromi.com

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Modifier Basics:

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

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Why Do Modifiers Matter?

- Demonstrates Coding Knowledge
- Minimizes Audit Risk
- Supports Medical Necessity and Documentation
- Prevents Denials
- Ensures Correct and Timely Reimbursement

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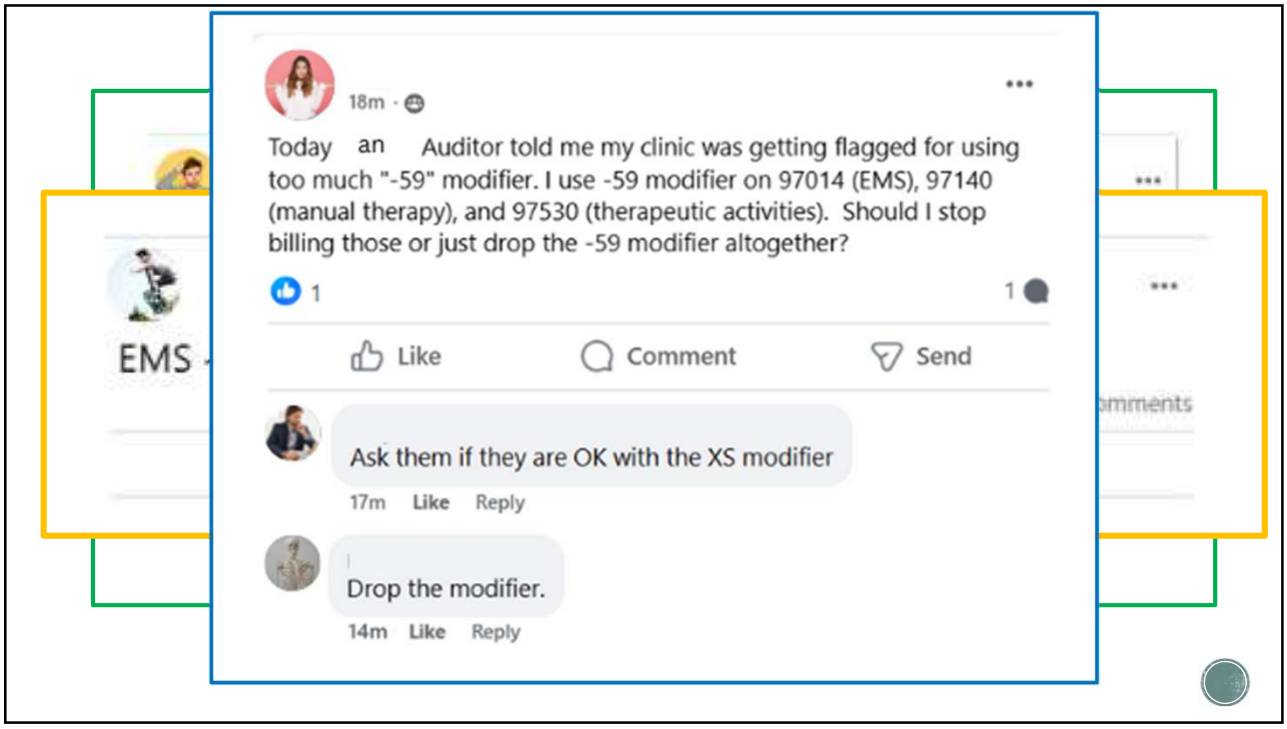

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Application of Modifiers

- Procedure code definitions may be *modified* under certain circumstances to **more accurately represent** the service.
- Modifiers are used to **add information** or to **change the description** to improve coding accuracy and reimbursement specificity.
- The **documentation** in the patient record must clearly support the use of any modifier appended to a claim.

The use of modifiers in medical billing eliminates the need for the AMA to create thousands of separate codes to account for every possible detail or circumstance.

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Who determines the use of a modifier?

National Correct Coding Initiative (NCCI)

- NCCI is a Centers for Medicare & Medicaid Services (CMS) program that consists of coding policies and edits.
- The coding policies of NCCI are based on coding conventions from:
  - The American Medical Association's (AMA) Current Procedural Terminology (CPT),
  - National and local Medicare policies and edits,
  - Guidelines from national medical/surgical societies, and
  - Review of current coding practices.

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What is an NCCI "Edit"?

1) **NCCI PTP (Procedure-to-Procedure) edits:** prevent improper coding **combinations** by flagging services that normally shouldn't be reported together.

2) **NCCI MUE (Medically Unlikely Edits):** prevent **improper units** of service by flagging when a provider bills more units of a service than would be reasonable for one patient, on one date of service.

Together, PTP and MUE edits are CMS **safeguards** to prevent duplicate, inconsistent, or medically unnecessary payments.

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NCCI Edits & Other Insurers

- CMS NCCI edits are public information, so many insurers adopt them.
- Includes commercial plans, Medicaid managed care, and Medicare Advantage organizations
- CMS does not control how private insurers apply the edits.
- Misinterpretation by the insurer can lead to denials.
- Knowing modifier rules = ability to defend against inaccurate denials

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Basic Steps to Reduce Audits

Via ChiroCode DeskBook

1. Use the most current versions of the CPT, ICD-10-CM, and HCPCS 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 matches the NCCI standards. Thus, In the event of an appeal, these NCCI guidelines can demonstrate that 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 the 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.

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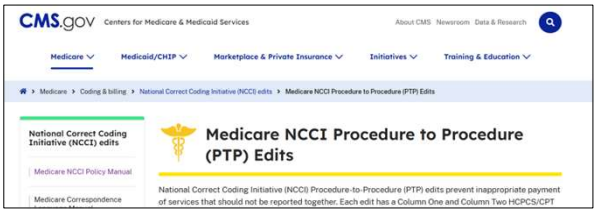
Information that we will review:

CMS.gov NCCI Website:

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



https://www.cms.gov/medicare/coding-billing/ncci-medicare

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Medicare NCCI Policy Manual

Medicare Full-Complete Manual (One File) (PDF)

Effective Jan. 1, 2025
Posted Feb. 28, 2025

CMS updates the NCCI Policy Manual for Medicare Services once a year. The NCCI Policy Manual should be used by Medicare Administrative Contractors (MACs) as a general reference tool that explains the rationale for NCCI edits. Additions and revisions to the manual are noted in red font. Additional prior versions of the National Correct Coding Initiative Policy Manual for Medicare Services are available in the Medicare NCCI Policy Manual Archive.

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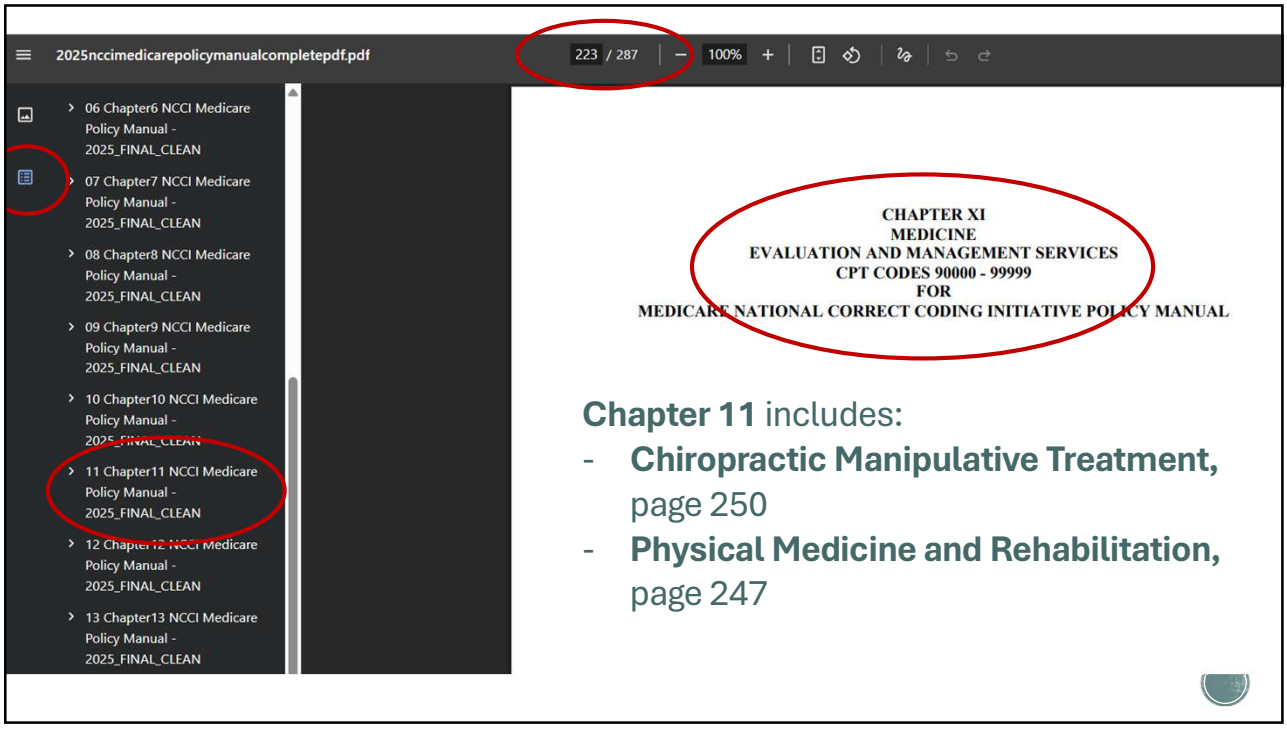

Chapter 11 includes:

- **Chiropractic Manipulative Treatment,** page 250
- **Physical Medicine and Rehabilitation,** page 247

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MEDICARE NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL

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***, the provider/supplier may report CMT and the above codes using modifier 59 or XS.

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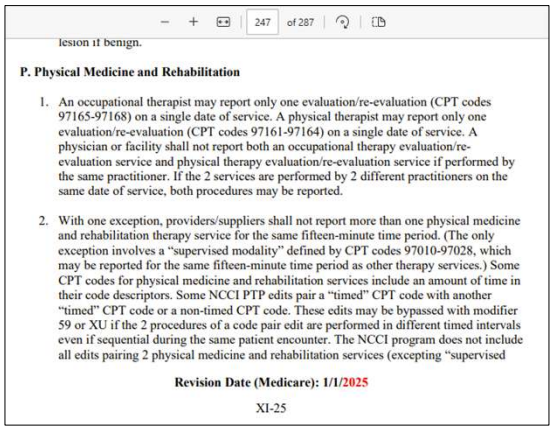
NCCI Manual
Physical Medicine and Rehabilitation, page 247



Physical Medicine and Rehabilitation

If your offices performs these services, review this section of the NCCI manual to determine if NCCI edits apply to the 97XXX codes you perform in your office.

In comparison to the *Chiropractic Manipulative Treatment* section, discussed on the previous slide, there are numerous edits in this section that could possibly affect coding.

Some of the edits in this section may not apply to chiropractic physicians or services typically performed in a chiropractic office.

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MEDICARE NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL

Physical Medicine and Rehabilitation

2. Providers shall not report more than one physical medicine and rehabilitation therapy service for the same fifteen-minute time period.

(The only exception involves a "supervised modality" defined by CPT codes 97010-97028, which may be reported for the same fifteen-minute time period as other therapy services.)

Some CPT codes for physical medicine and rehabilitation services include an amount of time in their code descriptors. Some NCCI PTP edits pair a "timed" CPT code with another "timed" CPT code or a non-timed CPT code. These edits may be bypassed with modifier 59 or XU if the 2 procedures of a code pair edit are performed in different timed intervals even if sequential during the same patient encounter.

The NCCI program does not include all edits pairing 2 physical medicine and rehabilitation services (excepting "supervised modality" services) even though they shall not be reported for the same fifteen-minute time period.

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Key Notes: CMT, Physical Medicine, and NCCI Rules

- The NCCI Manual / CMT section references CMT when performed with **97124, 97112, or 97140.**
- If these therapy codes are performed in a **different spinal region than CMT**, a modifier 59 (or XS) may be reported.
- No other CPT codes need modifier 59 to unbundle from 98940–98942.
- If **two *timed* Physical Medicine services** are performed, they must be performed in **separate, non-overlapping time intervals**, and may be reported with modifier 59 (or XE).

But what is the definition of modifier 59 *and why am I appending it the therapies?* ***And what are the X modifiers?***

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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 not ordinarily encountered or performed on the same day by the same individual. 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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The X Modifiers

"Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

The modifiers are defined as follows:

- ***XE* – Separate Encounter**
  - A service that is distinct because it occurred during a separate encounter. This modifier should only be used to describe separate encounters on the same date of service.
- ***XS* – Separate Structure**
  - A service that is distinct because it was performed on a separate organ/structure.
- ***XP* – Separate Practitioner**
  - A service that is distinct because it was performed by a different practitioner.
- ***XU* – Unusual Non-Overlapping Service**
  - The use of a service that is distinct because it does not overlap usual components of the main service.

*NOTE: Individual Payer Policies may have specific requirements as to whether to use the 59 **or** X modifiers.*

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Finding the PTP Edit Files

Practitioner PTP Edits

Practitioner PTP Edits v313r0 (675,009 Records) 0001A/0591T--25505/J2001 -
Posted Sep 1, 2025

Practitioner PTP Edits v313r0 (675,130 Records) 25525/01810--37700/G0471 -
Posted Sep 1, 2025

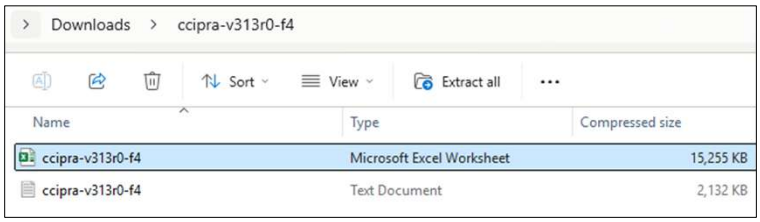
Practitioner PTP Edits v313r0 (674,866 Records) 37718/0213T--62369/G0453
Posted Sep 1, 2025

Practitioner PTP Edits v313r0 (602,358 Records) 62370/0213T--U0003/U0004
Posted Sep 1, 2025

https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-procedure-procedure-ptp-edits

The 4th file opens CPT codes 62370 – U0004, which contains:

- X-Ray,
- Physical Medicine,
- Chiropractic Manipulative Treatment,
- E/M codes.



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NCCI Coding Edits

	A	B	C	D	E	F	G	H
1	CPT only copyright 2017 American Medical Association. All rights reserved.							
2	Column1/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		

Column One/Column Two

Column 1:
Comprehensive or major code

Column 2:
Secondary or component code

Modifier: Indicates if use of a modifier is permitted.

0: Codes **should never be reported together** by the same provider for the same beneficiary on the same date of service; if reported on the same date of service, the column one code is eligible for payment and the column two code is denied

1: Codes may be **reported together only in defined circumstances** by use of NCCI-associated modifier

9: **Not applicable**

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Column1/Column2 Edits

Column 1	Column 2	Modifier 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
98941	98940	0	More extensive procedure
98941	92012	9	CPT Manual or CMS manual coding instruction
98941	99202	1	CPT Manual or CMS manual coding instruction
98941	97112	1	Standards of medical/surgical practice
98941	97124	1	Standards of medical/surgical practice
98941	97140	1	Standards of medical/surgical practice

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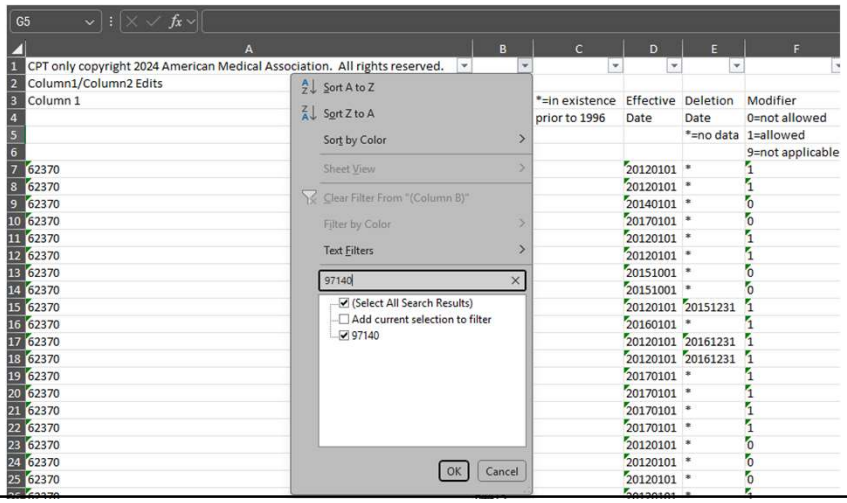
Filtering the PTP Data Tables

The fastest and most accurate way you can search any of the edit tables for a particular value is by using the Excel Filter feature.



**Remember to search the code in question in both the Column 1, then the Column 2 filter.*

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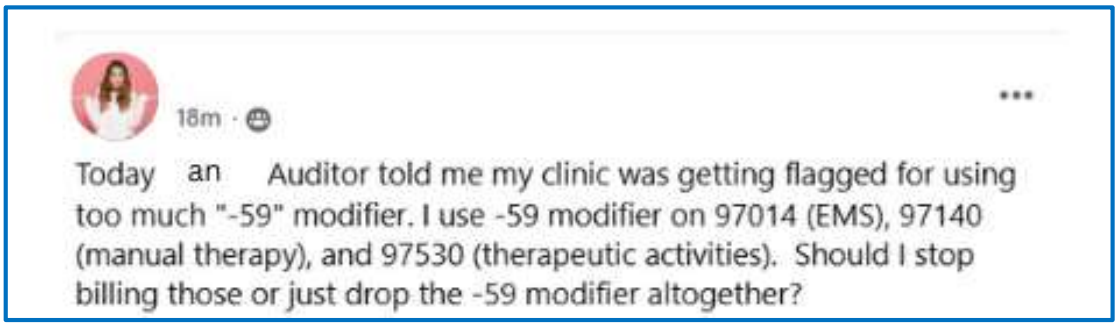

97014 – Application of a modality to 1 or more areas; **electrical stimulation (unattended)**

97140 – **Manual therapy techniques** (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes

97530 – **Therapeutic activities**, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes

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Example 9: Column 1 Code / Column 2 Code - 97140/97530

>CPT Code 97140 – Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
>CPT Code 97530 – Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes

Modifier 59 may be reported if the two procedures are performed in distinctly different 15 minute time blocks. For example, one service may be performed during the initial 15 minutes of therapy and the other service performed during the second 15 minutes of therapy. Alternatively, the therapy time blocks may be split. For example, manual therapy might be performed for 10 minutes, followed by 15 minutes of therapeutic activities, followed by another 5 minutes of manual therapy. CPT code 97530 should not be reported and modifier 59 should not be used if the two procedures are performed during the same time block.

443407	97140	97530		20000605	*	1	Mutually exclusive procedures

When crosschecking the PTP edits of 97014, 97140, and 97530, the only edits that appears is as stated above. Therefore, the 59 is not required on 97014 or 97140 for the coding combination on the previous slide. (This is assuming 98940-98942 was not performed on the same date of service.)

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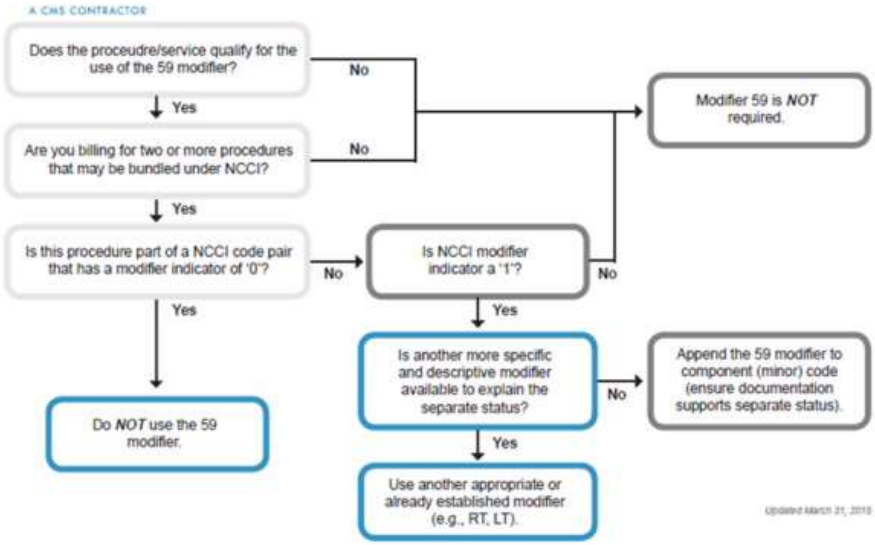
Modifier 59



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Billing Reminders

- It is very important that medical records include documentation to support the use of modifier 59 (or any other modifier).
  - Documentation provides a clinical picture of what was done and why a modifier was appropriate.
  - Documentation should correctly record the parameters of treatment such as location, method of application, intensity, and time.
  - Often, the documentation received lacks evidence/clinical circumstance to substantiate its use, resulting in a denial.

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MAC

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