



Medical Business Services

"GIVING DOCTORS THE FREEDOM TO BE DOCTORS"



MICHIGAN ASSOCIATION OF CHIROPRACTORS

NAVIGATING MEDICARE AND **MEDICARE ADVANTAGE**

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What's Medicare?

Medicare is health insurance for:

- People 65 or older
- Under 65 with certain disabilities
- People of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)



THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) **PROVIDES HEALTH COVERAGE TO OVER 100 MILLION PEOPLE** THROUGH MEDICARE, MEDICAID, THE CHILDREN'S HEALTH INSURANCE PROGRAM, AND THE HEALTH INSURANCE MARKETPLACE.

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THE 'A-B-C-D' OF MEDICARE



Medicare & You 2026

The official U.S. government Medicare handbook

**Medicare Beneficiaries
receive this publication
annually**

**Written in layman's terms
vs. "government"
language**

**Great training tool for
office staff and clinicians**



Part A (Hospital Insurance)

Helps cover:

- Inpatient care in hospitals
- **Skilled nursing facility care**
- Hospice care
- Home health care

WHAT ARE THE PARTS OF MEDICARE?

- Part A is automatic upon reaching eligibility for Medicare
- Paid for by 40 quarters of employee contributions, no monthly premium
- If contribution requirement not met, Part A is available by paying a monthly premium

WHAT ARE THE PARTS OF MEDICARE?



Part B (Medical Insurance)

Helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
- Many **preventive services** (like screenings, shots or vaccines, and yearly “Wellness” visits)

- Part B is automatic upon reaching eligibility for Medicare
- Requires additional monthly premium.
- Requires patient to opt out or REPLACE coverage

MEDICARE B COVERAGE

- Medicare covers 80% of the allowable fee on **COVERED SERVICES** (After Part B Deductible is met)
- Patient Responsible for 20%. Patients with Supplemental Medigap plans may have the 20% cost share covered by the plan.
- Medigap plans only pay the cost share gap on **COVERED Services**.

2026 Medicare and You

PLAN F

Benefits	Medigap plans									
	A	B	C	D	F*	G*	K	L	M	N
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%***
Blood benefit (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
							Out-of-pocket limit in 2025**			
							\$7,220	\$3,610		

Supplemental Plans are designed to “gap” Medicare Coverage. If Medicare pays 80%, the supplemental plan takes care of the 20% at the rate indicated by the medigap plan.

Medigap plans do NOT pay for services that Medicare does not cover.

Most Supplemental plans are “crossover” plans, and billing is not necessary. Medicare B forwards the claim info to the Medigap plan directly

WHAT ARE THE PARTS OF MEDICARE?



Part D (Drug coverage)

Helps cover the cost of prescription drugs (including many recommended shots or vaccines).

Plans that offer Medicare drug coverage (Part D) are run by private insurance companies that follow rules set by Medicare.

PATIENTS WHO ELECT TO ENROLL IN ORIGINAL MEDICARE WILL USUALLY PURCHASE A PART D DRUG PLAN AND A SUPPLEMENTAL MEDIGAP PLAN





Medicare Part C (also known as Medicare Advantage)

Medicare Advantage Plans (like HMOs or PPOs) provide your Part A and Part B coverage and many times offer additional benefits. Private insurance companies approved by Medicare run these plans. Generally, you must see doctors in the plan. Most Medicare Advantage Plans cover prescription drugs (Medicare Part D). You choose the Medicare Advantage Plan (with or without prescription drug coverage) and pay a monthly premium. Costs vary by plan.

WHAT ARE THE PARTS OF MEDICARE?




COMPARISON OF ORIGINAL MEDICARE AND MEDICARE ADVANTAGE

ORIGINAL MEDICARE

- Part A 
- Part B 
- You can add:
 - Part D 
- You can also add:
 - Supplemental coverage** 

This includes Medicare Supplement Insurance (Medigap). See Section 5 (starting on page 75) to learn more about Medigap. Or, you can use coverage from a former employer or union, or Medicaid.

MEDICARE ADVANTAGE

- Part A 
- Part B 
- Most plans include:
 - Part D 
- Some extra benefits**

Original Medicare vs. Medicare Advantage



Doctor and hospital choice

Original Medicare	Medicare Advantage
You can go to any doctor that accepts Medicare.	In most cases, you'll need to use doctors who are in the plan's network (for non-emergency or non-urgent care). Ask your doctor if they participate in any Medicare Advantage Plans.
In most cases you don't need a referral to see a specialist.	You may need to get a referral to see a specialist.

DIFFERENCE BETWEEN
MEDICARE A/B AND MEDICARE
ADVANTAGE

CHOICE OF HOSPITALS AND/OR
HEALTH CARE PROVIDERS

 **Coverage**

Original Medicare	Medicare Advantage (Part C)
Original Medicare covers most medically necessary services and supplies in hospitals, doctors' offices, and other health care facilities. Original Medicare doesn't cover some benefits like eye exams, most dental care, and routine exams. Go to page 55.	Plans must cover all medically necessary services that Original Medicare covers. Plans may also offer some extra benefits that Original Medicare doesn't cover —like certain vision, hearing, and dental services.
You can join a separate Medicare drug plan to get Medicare drug coverage (Part D).	Medicare drug coverage (Part D) is included in most plans. In most types of Medicare Advantage Plans, you can't join a separate Medicare drug plan.
In most cases, you don't need approval for Original Medicare to cover your services or supplies.	In many cases, you may need to get approval from your plan before it covers certain services or supplies.

**DIFFERENCE BETWEEN
MEDICARE A/B AND MEDICARE
ADVANTAGE**

COVERAGE AND BENEFITS

← **Medicare Advantage plans may have prior auth requirements**



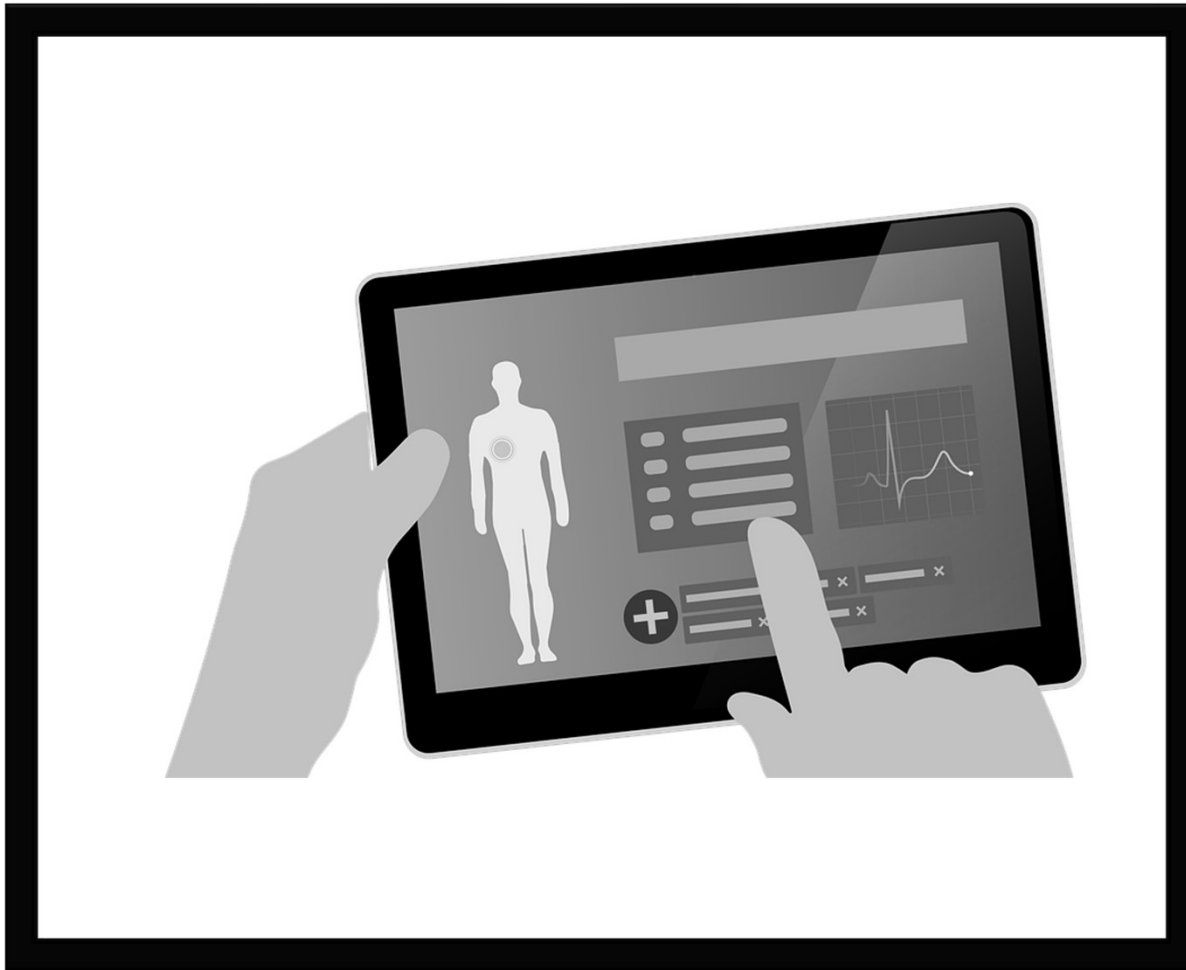
Cost

Original Medicare	Medicare Advantage (Part C)
For Part B-covered services, you usually pay 20% of the Medicare-approved amount after you meet your deductible. This amount is called your coinsurance.	Out-of-pocket costs vary —plans may have lower or higher out-of-pocket costs for certain services.
You pay a premium (monthly payment) for Part B . If you choose to join a Medicare drug plan, you'll pay a separate premium for your Medicare drug coverage (Part D).	You pay the monthly Part B premium and may also have to pay the plan's premium . Some plans may have a \$0 premium and may help pay all or part of your Part B premium. Most plans include Medicare drug coverage (Part D).
There's no yearly limit on what you pay out of pocket, unless you have supplemental coverage—like Medicare Supplement Insurance (Medigap).	Plans have a yearly limit on what you pay out of pocket for services Medicare Part A and Part B cover. Once you reach your plan's limit, you'll pay nothing for services Part A and Part B cover for the rest of the year.
You can choose to buy Medigap to help pay your remaining out-of-pocket costs (like your 20% coinsurance). Go to page 77. Or, you can use coverage from a current or former employer or union, or Medicaid.	You can't buy Medigap.

DIFFERENCE BETWEEN MEDICARE A/B AND MEDICARE ADVANTAGE PREMIUMS AND OUT OF POCKET COSTS

Medicare Advantage enrollees cannot buy secondary or supplemental coverage. (Dual Eligible exception)





CHIROPRACTIC COVERAGE AND CLINICAL DOCUMENTATION REQUIREMENTS

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MEDICARE COVERAGE OF CHIROPRACTIC (NATIONAL POLICY)

Medicare Benefit Policy Manual

Chapter 15 – Covered Medical and Other Health Services

Table of Contents
(Rev. 10639, 03-12-21)
(Rev. 10573, 03-24-21)

CHIROPRACTIC SERVICES SECTION 30.5 AND 240.1

MEDICARE COVERAGE OF CHIROPRACTIC

30.5 - Chiropractor's Services

(Rev. 23, Issued: 10-08-04, Effective: 10-01-04, Implementation: 10-04-04)

B3-2020.26

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

PART EXAM

240.1.2 - Subluxation May Be Demonstrated by X-Ray or Physician's Exam

2. Demonstrated by Physical Examination

Evaluation of musculoskeletal/nervous system to identify:

Pain/tenderness evaluated in terms of location, quality, and intensity;

Asymmetry/misalignment identified on a sectional or segmental level;

Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility);
and

Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

**ESTABLISH
MEDICAL
NECESSITY**

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

240.1.2 - Subluxation May Be Demonstrated by X-Ray or Physician's Exam

An x-ray may be used to document subluxation. The x-ray must have been taken at a time reasonably proximate to the initiation of a course of treatment. Unless more specific x-ray evidence is warranted, an x-ray is considered reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of a course of chiropractic treatment. In certain cases of chronic subluxation (e.g., scoliosis), an older x-ray may be accepted provided the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent. A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated.

ESTABLISH MEDICAL NECESSITY

CONDITIONS THAT SUPPORT ACTIVE TREATMENT

- 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.

CONDITIONS THAT SUPPORT ACTIVE TREATMENT

- 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.

MAINTENANCE THERAPY

B. Maintenance Therapy

Under the Medicare program, Chiropractic maintenance therapy is not considered to be medically reasonable or necessary, and is therefore not payable. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to 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. For information on how to indicate on a claim a treatment is or is not maintenance, see §240.1.3.

HOW MANY VISITS?....

240.1.5 - Treatment Parameters

(Rev. 23, Issued: 10-08-04, Effective: 10-01-04, Implementation: 10-04-04)

B3-2251.5

The chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time. Acute subluxation (e.g., strains or sprains) problems may require as many as three months of treatment but some require very little treatment. In the first several days, treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained.

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

CODING AND BILLING

```
... for object to mirror_...  
mirror_mod.mirror_object = ...  
...  
_operation == "MIRROR_X":  
    mirror_mod.use_x = True  
    mirror_mod.use_y = False  
    mirror_mod.use_z = False  
...  
_operation == "MIRROR_Y":  
    mirror_mod.use_x = False  
    mirror_mod.use_y = True  
    mirror_mod.use_z = False  
...  
_operation == "MIRROR_Z":  
    mirror_mod.use_x = False  
    mirror_mod.use_y = False  
    mirror_mod.use_z = True
```

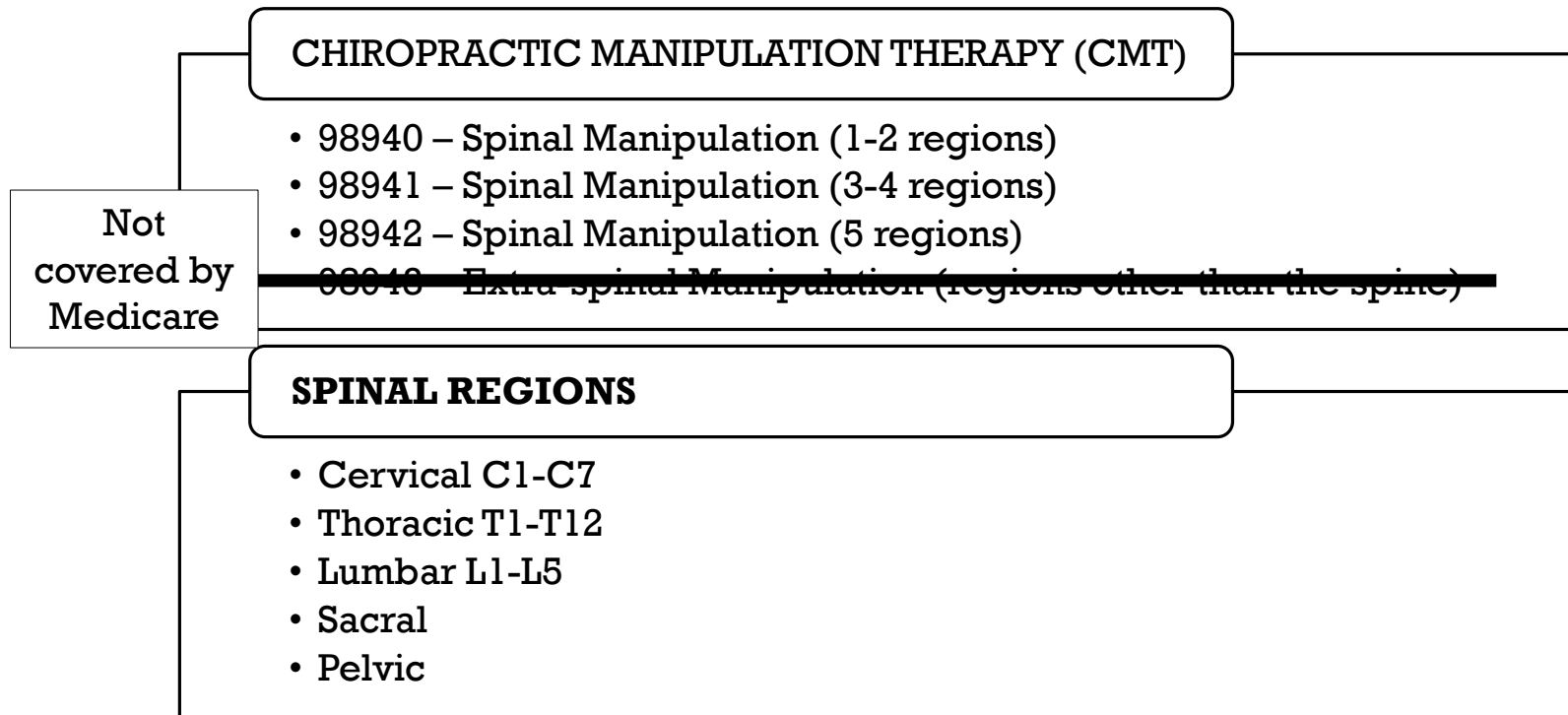
```
...  
...  
context.scene.objects.active = ...  
obj("Selected" + str(modifier_name))  
mirror_ob.select = 0  
bpy.context.selected_objects = ...  
data.objects[one.name].select = ...  
...  
print("please select exactly ...")
```

```
-- OPERATOR CLASSES -----  
...  
... types.Operator):  
    ... X mirror to the selected  
    ... object.mirror_mirror_x"  
    ... mirror X"
```

CODE DEFINITIONS

- **CPT = CURRENT PROCEDURAL TERMINOLOGY**
 - Represents Medical, Diagnostic, Laboratory Procedures
 - Published, Maintained by the AMA
 - 40,000+ codes
- **ICD-10 = INTERNATIONAL CLASSIFICATION OF DISEASES, 10TH EDITION**
 - Represents Diagnoses/Conditions
 - Published, Maintained by WHO and the NCHS (National Center for Health Statistics)
 - 75,000+ codes (Chiros use about 100 of them!)
- **HCPCS = HEALTHCARE COMMON PROCEDURE CODING SYSTEM**
 - Represents Supplies, DME, Injectables, Grafts, etc.
 - Published, Maintained by CMS
- **MODIFIERS** = Codes that are appended to a CPT/HCPCS code to give more information and detail about the encounter/procedure

CHIROPRACTIC MANIPULATION CODES



HOW TO OBTAIN YOUR FEE SCHEDULE

**Through your
Medicare
Administrative
Contractor**

**Through the
CMS Website**

Medicare Part B deductible (annual)

2025: \$257

2026: \$283

2026 FEE SCHEDULE BY ENROLLMENT TYPE

Showing 1-3 of 3

HCPCS Code ▲	Modifier ▲	Short Description ◆	Mac Locality ▲	PAR		NON PAR			
				Non-Facility Price ◆	Facility Price ◆	Non-Facility Limiting Charge ◆	Facility Limiting Charge ◆	GPCI Work ◆	GPCI PE ◆
98940		Chiropract manj 1-2 regions	0820299	\$25.78	\$18.15	\$28.16	\$19.83	1.000	0.913
98941		Chiropract manj 3-4 regions	0820299	\$37.15	\$27.69	\$40.58	\$30.25	1.000	0.913
98942		Chiropractic manj 5 regions	0820299	\$48.24	\$37.57	\$52.70	\$41.04	1.000	0.913

Download CSV

Copy link

Feedback

BASED ON LOCALITY 99 – REST OF MICHIGAN.

DIFFERENT FEE SCHEDULE FOR LOCALITY 01 - Macomb, Oakland, Washtenaw, and Wayne Counties

ABOUT THE NON-PAR LIMITING CHARGE

- **Limiting Charge:** Only applies when the provider chooses not to accept assignment. (Patient pays up front)
- **The Limiting Charge** is the maximum amount a nonparticipating provider may legally charge a beneficiary when filing an unassigned claim.

SOURCE: <https://medicarepaymentandreimbursement.com/>

NON-PAR/NON-ASSIGNED REIMBURSEMENT

- Patient Pays the Limiting Charge for Covered Service
- Provider Bills Medicare up to the Limiting Charge as a NON ASSIGNED CLAIM
- Patient is Reimbursed by Medicare, based on 80% of the PAR Allowable, after deductible met

MEDICARE ICD10 CODES

PRIMARY DX CODES

- M99.01 Segmental/Somatic Dysfunction – CERVICAL**
- M99.02 Segmental/Somatic Dysfunction – THORACIC**
- M99.03 Segmental/Somatic Dysfunction – LUMBAR**
- M99.04 Segmental/Somatic Dysfunction – SACRAL**
- M99.05 Segmental/Somatic Dysfunction – PELVIC**



WHAT ABOUT THE “SECONDARY” DX CODES?

- Certain Local Coverage Articles (through the MAC) may list secondary dx codes, and categorize them into conditions that require SHORT, MODERATE, or LONG TERM Treatment.

Generally,

- Short = up to 12 visits
- Moderate = up to 20 visits
- Long = up to 30 visits, chronic conditions

EXAMPLE OF SECONDARY DX CODES IN THE SHORT TERM TREATMENT CATEGORY

M54.2	Cervicalgia
M54.50	Low back pain, unspecified
M54.51	Vertebrogenic low back pain
M54.59	Other low back pain
M54.6	Pain in thoracic spine
M62.49	Contracture of muscle, multiple sites
M62.838	Other muscle spasm

<https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=56273>

EXAMPLE OF SECONDARY DX CODES IN THE MODERATE TERM TREATMENT CATEGORY

M54.11	Radiculopathy, occipito-atlanto-axial region
M54.12	Radiculopathy, cervical region
M54.13	Radiculopathy, cervicothoracic region
M54.14	Radiculopathy, thoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region

<https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=56273>

EXAMPLE OF SECONDARY DX CODES IN THE LONG TERM TREATMENT CATEGORY

M50.31	Other cervical disc degeneration, high cervical region
M50.320	Other cervical disc degeneration, mid-cervical region, unspecified level
M50.321	Other cervical disc degeneration at C4-C5 level
M50.322	Other cervical disc degeneration at C5-C6 level
M50.323	Other cervical disc degeneration at C6-C7 level
M50.33	Other cervical disc degeneration, cervicothoracic region
M51.24	Other intervertebral disc displacement, thoracic region
M51.25	Other intervertebral disc displacement, thoracolumbar region

<https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=56273>

MEDICARE MODIFIERS

The following modifiers should be reported with CPT codes 98940, 98941, and 98942 as is appropriate to each patient's situation:

- AT – Acute treatment
- GA – Waiver of liability statement issued as required by payer policy, individual case. Authorization has been provided to notify the beneficiary of the likelihood that services rendered will be denied as not reasonable and medically necessary under Medicare guidelines.
- GZ – Item or service expected to be denied as not reasonable and necessary

GA MODIFIER ONLY USED IF PATIENT CHOOSES OPTION 1 ON THE ABN FORM. CLAIM WILL BE DENIED, AND THE BALANCE WILL BE ASSIGNED TO THE PATIENT'S RESPONSIBILITY

GZ MODIFIER USED IF YOU ARE BILLING A MAINTENANCE VISIT AND DID NOT GET AN ABN FORM SIGNED. CLAIM WILL BE DENIED AND THE BALANCE WILL BE ASSIGNED AS A CONTRACTUAL WRITE OFF FOR FAILURE TO OBTAIN AN ABN

OTHER MODIFIERS

- **-GY Statutorily Non-Covered**
 - Append to CPT codes when you bill Medicare for Statutorily **NON-COVERED SERVICES**
 - Claim will be denied, but applied to Patient Responsibility
- **-GP Patient under a Physical Therapy Plan of Care**
 - Append to Therapy Codes (97xxx, G0283)
- **-59 Distinct Procedural Service**
 - Use when billing code pairs that are subject to NCCI code pair edits
 - Example: 98940 and 97140. Append -59 Mod to 97140
 - For Medicare: 98940-AT, 97140-GY-59-GP

BILLING

THE CMS 1500 FORM



Medicare Administrative Contractor
payer ID

HEALTH INSURANCE CLAIM FORM

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

PICA		PICA	
1. MEDICARE <input checked="" type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) MEDICARE ID NUMBER	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE JOHN		3. PATIENT'S BIRTH DATE SEX 01 01 55 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 123 MAIN ST		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY ANYTOWN STATE TX		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER MEDIGAP		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME MEDIGAP		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? (MEDIGAP) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>	
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 SIGNATURE ON FILE DATE MM/DD/YY		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. (LEAVE BLANK FOR NON-PAR) SIGNED SIGNATURE ON FILE	

CARRIER ↑ PATIENT AND INSURED INFORMATION ↓

CMS1500 CLAIM FORM

33 "BOXES"

BOX 1-13 ABOUT THE PATIENT

ELECTRONIC CLAIMS: BOXES ARE CONVERTED TO LOOPS AND SEGMENTS

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 01 01 2024 QUAL. 431				15. OTHER DATE QUAL. 453 (ACUTE MANIFESTATION OF A CHRONIC CONDITION) MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) DATE OF XRAY (IF USING TO PROVE SUBLUXATION)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				22. RESUBMISSION CODE ORIGINAL REF. NO.							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. M99.XX B. COND DX C. M99.XX D. COND DX E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				23. PRIOR AUTHORIZATION NUMBER				24. A. DATE(S) OF SERVICE B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #							
1 01 05 24 01 05 24 11				98940 AT				A 65 00 1 NPI rendering NPI							
2 CLAIM IS THE SAME FOR NON-PAR EXCEPT BOX 13 BLANK, BOX 27 NO AND 24F IS THE LIMITING CHARGE								NPI							
3								NPI							
4								NPI							
5								NPI							
6								NPI							
25. FEDERAL TAX ID. NUMBER SSN EIN billing ein <input type="checkbox"/> <input checked="" type="checkbox"/>				26. PATIENT'S ACCOUNT NO. DOEJ123				27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. TOTAL CHARGE \$ 65 00 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.) RENDERING PROVIDER SIGNED DATE				32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.				33. BILLING PROVIDER INFO & PH # () PAY-TO ENTITY a. BILLING NPI b.							

PHYSICIAN OR SUPPLIER INFORMATION

**BOX 14-24
ABOUT THE
ENCOUNTER**

**BOX 25-33
ABOUT THE
ENTITY AND
PAY-TO**

When billing for Chiropractic services:

- Report the initial treatment or date of exacerbation. CMS1500 BOX 14
- Specify the precise spinal location and level of subluxation. PATIENT'S CHART
- Report the date of X-ray if an X-ray is used to demonstrate subluxation. CMS1500 BOX 19
- Report the level of subluxation using the appropriate ICD-10-CM code. CMS1500 BOX 21, 24E (A) = M99.XX
- In addition to reporting the ICD-10-CM code for the level of subluxation, report any other pertinent ICD-10-CM codes. CMS1500 BOX 21, 24E (B) = SECONDARY DX
- All treatments must be categorized as acute subluxation, chronic subluxation or maintenance therapy. An exacerbation of a previous injury should be categorized into either "acute" or "chronic" (e.g., an identifiable re-injury would fall under acute). PATIENT'S CHART

Article - Billing and Coding: Chiropractic Services (A58345)

Reasons for Denial

Excluded from Medicare coverage is any service other than manual manipulation for the treatment of subluxation of the spine. The chiropractor is not required to bill excluded services. However, if the beneficiary requests Medicare be billed, the provider must bill services to Medicare in order to obtain a denial for secondary insurance purposes. The following are examples (not an all-inclusive list) of services excluded from Medicare coverage when performed by a chiropractor; the beneficiary is responsible for payment.

- Laboratory tests
- X-rays
- Office visits (history and physicals)
- Physiotherapy
- Traction
- Supplies
- Injections
- Drugs
- EKGs or any diagnostic study
- Orthopedic devices
- Nutritional supplements/counseling
- Any service ordered by the chiropractor

When billing Medicare B for Statutorily non-covered services, append CPT code with **GY modifier. Medicare will deny to patient responsibility and secondary plan can be billed correctly.**

IF YOU HAVE TO BILL FOR STATUTORILY NON-COVERED SERVICES.....

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)											ICD Ind.		22. RESUBMISSION CODE		ORIGINAL REF. NO.				
A. M99.XX			B. COND DX			C. M99.XX			D. COND DX										
E.			F.			G.			H.			23. PRIOR AUTHORIZATION NUMBER							
L.			J.			K.			L.										
24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	SUPPLIER INFORMATION
From		To					CPT/HCPCS	MODIFIER											
MM	DD	YY	MM	DD	YY														
01	05	24	01	05	24	11		99213	GY	25		A	85	00	1		NPI	rendering NPI	
DATE						11		97012	GY	GP		B	30	00	1		NPI	rendering NPI	
																	NPI		

UP TO 4 MODIFIERS ARE ALLOWED ON A CLAIM. MODIFIER ORDER SHOULD BE PRICING MOD'S FIRST, INFORMATIONAL MOD'S SECOND

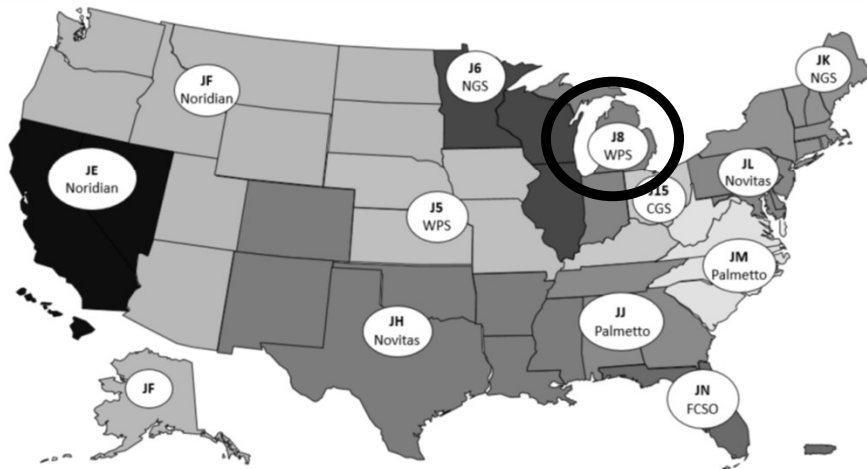
CLAIM SUBMISSION OPTIONS

- **Electronic Claims:** Through your billing software. Claim is routed to a clearinghouse which sorts and sends claims to the various payers. Results of adjudication and associated payments come back through your clearinghouse and into your billing software.
- **Electronic Claims:** PC-Ace Software. Free Software through CMS and your MAC <https://www.wpshealth.com/resources/provider-resources/edi/software.shtml>
- **Paper Claims:** For small practices, paper claims are an option, but not recommended. Hard to track, claims get “lost”. Payment can take up to 45-60 days

MEDICARE PART B
PROCESSING TIME
FOR A CLEAN
ELECTRONIC CLAIM

**14 BUSINESS
DAYS FROM THE
DATE IT IS
ACCEPTED FOR
ADJUDICATION**

A/B MAC Jurisdictions
as of June 2021



**WHO IS MY MEDICARE
PART B
ADMINISTRATIVE
CONTRACTOR?**

**WISCONSIN PHYSICIAN
SERVICES J8**

[HTTPS://WWW.WPSGHA.COM/](https://www.wpsgha.com/)

**MEDICARE B
AND
MEDICARE
ADVANTAGE
TIMELY FILING**

**MEDICARE B
1 YEAR**

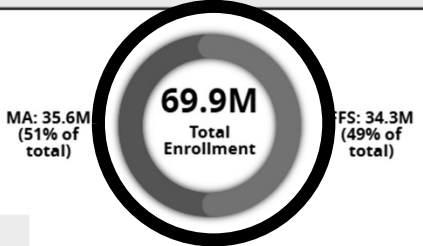
**MA-PAYER
SPECIFIC**

**FROM DATE
OF SERVICE**

MEDICARE PART C

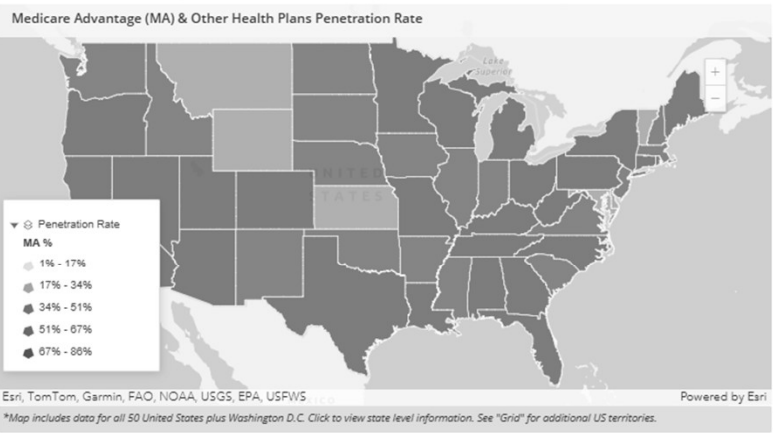
Medicare Enrollment for December 2025

- Hospital/Medical
- Prescription Drug

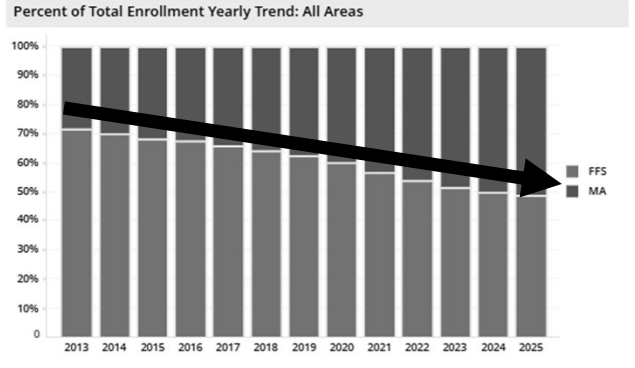
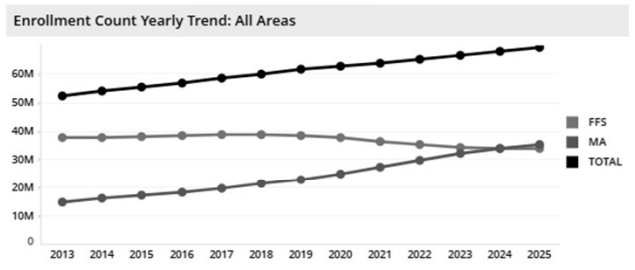


- Map/Graphs
- Grid

- All Areas
- Counties

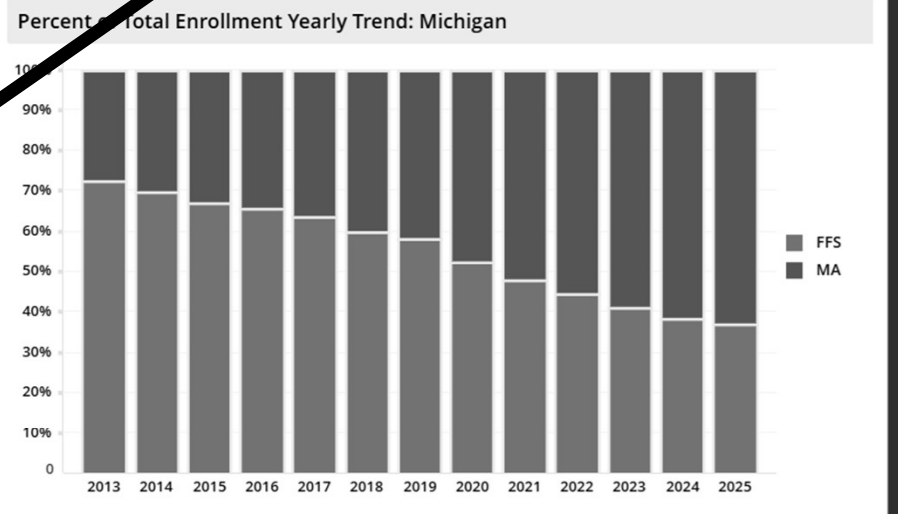
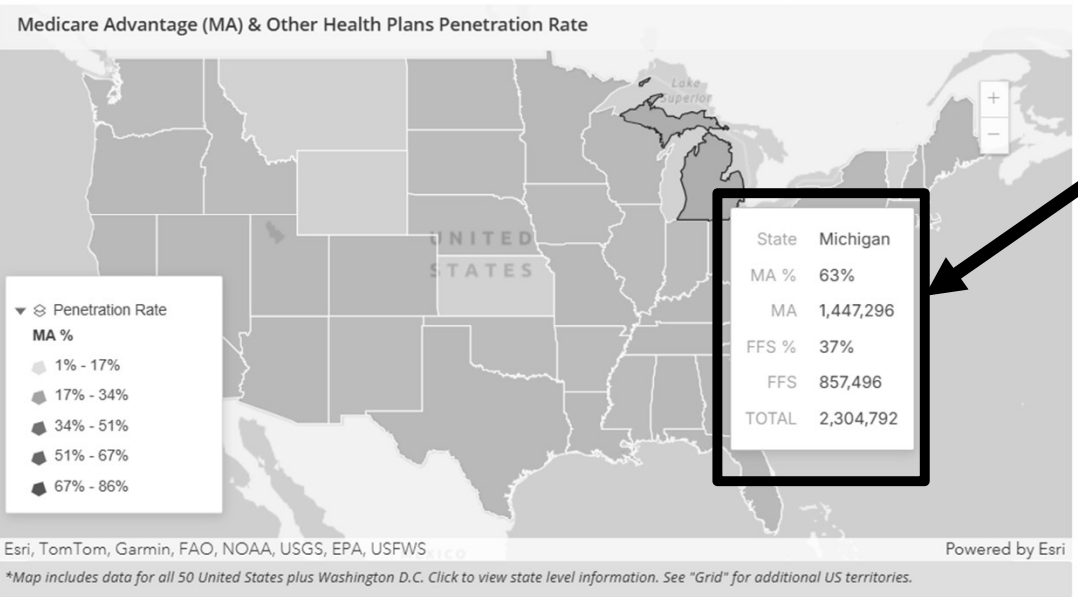


- Yearly Trend
- 12-Month Trend



PROVIDERS CAN SEARCH BY STATE AND COUNTY FOR MEDICARE ADVANTAGE SATURATION NUMBERS

All Areas Michigan Counties



**PROVIDER ENROLLMENT IN MEDICARE
ADVANTAGE PLANS**

ENROLLMENT

- **Provider must be enrolled in Original Medicare to Qualify for MA Enrollment**
- **Provider should review the Payer's contracts to decide which plans they want to be in-network with**
- **Providers do not have to be in-network with any MA plans**
- **Providers may need to register as an OON provider**

BILLING MEDICARE ADVANTAGE

Medicare Managed Care Manual Chapter 4 - Benefits and Beneficiary Protections

Table of Contents
(Rev. 121, Issued: 04-22-16)

- MA REGULATIONS: <https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms019326>

MA plans must provide their enrollees with all basic benefits covered under original Medicare. Consequently, plans may not impose limitations, waiting periods or exclusions from coverage due to pre-existing conditions that are not present in original Medicare.

- Benefits: MA plans must provide or pay for medically necessary Part A (for those entitled) and Part B covered items and services.
- Access: MA enrollees must have access to all medically necessary Part A and Part B services. However, MA plans are not required to provide MA enrollees the same access to providers that is provided under original Medicare (see accessibility rules for MA plans *under section 110* of this chapter).

- Cost-Sharing: With the exception of the services listed at 42 CFR 422.100(j) and certain preventive services graded A or B by the United States Preventive Services Task Force and covered by original Medicare without cost-sharing (co-insurance), MA plans may impose cost-sharing for a particular item or service that is above or below the original Medicare cost-sharing for that service, provided the overall cost-sharing under the plan is actuarially equivalent to that under original Medicare and the plan cost-sharing structure does not discriminate against sicker beneficiaries, as discussed in sections 10.5.2 and 10.5.3 of this chapter. MA plans may require enrollees to pay higher cost-sharing amounts for services furnished out-of-network.

- Billing and Payment: MA plans need not follow original Medicare claims processing procedures. MA plans may create their own billing and payment procedures as long as providers – whether contracted or not – are paid accurately, timely and with an audit trail. MA plans may not require enrollees to pay providers – whether contracted or not – for original Medicare services and then be reimbursed by the plan. See *section 110.1.3* of this chapter for rules governing payment to non-contracted providers for original Medicare non-emergent services.

30.1 – Definition of Supplemental Benefit

(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

A supplemental benefit is an item or service not covered by original Medicare, that is primarily health related and for which the MA plan must incur a non-zero direct medical cost. These criteria are defined below.

- (1) A supplemental benefit may not be a Medicare Part A or Part B covered service;
- (2) The item or service must be primarily health related; that is, the primary purpose of the item or service is to prevent, cure or diminish an illness or injury. If the primary purpose of the item or service is comfort, cosmetic or daily maintenance, then it is not eligible as a supplemental benefit. The primary purpose of an item or service is determined by national typical usages of most people using the item or service, or by community patterns of care; and

Table III: Medicare Covered Benefits with Related Supplemental Benefit Fields in the PBP

Medicare Covered Benefits	Benefits Eligible to be offered as a Supplemental Benefits
Inpatient Hospital-Acute	Additional Days <i>Non-Medicare covered stays</i> Upgrades
Inpatient Hospital-Psych	Additional Days <i>Non-Medicare covered stays</i>
Skilled Nursing Facility	Additional Days
Emergency Care	Worldwide Emergency/ <i>Urgent Coverage</i>
Chiropractor	Routine Care/ <i>Other*</i>

**“Other” refers to any Non-Medicare covered service*

Routine Chiropractic Services

MA plans may choose to offer routine chiropractic services as a supplemental benefit as long as the services are provided by a state-licensed chiropractor practicing in the state in which he/she is licensed and is furnishing services within the scope of practice defined by that state's licensure and practice guidelines. The routine services may include conservative management of neuromusculoskeletal disorders and related functional clinical conditions including, but not limited to, back pain, neck pain and headaches, and the provision of spinal and other therapeutic manipulation/adjustments.

X-rays or other diagnostic or therapeutic services furnished or ordered by a chiropractor may be covered by the *MA* plan as a supplemental benefit as long as the chiropractor is state-licensed and is practicing within the states' licensure and practice guidelines.

MA PLANS AND THEIR FINANCIAL RELATIONSHIP WITH OON PROVIDERS

Table VII: Plan Type and Access Attributes for Non-emergent Non-urgent care Services

<i>Plan Type</i>	<i>Is a gatekeeper¹ allowed?</i>	<i>Is a network required?</i>	<i>Must benefits be provided In-network and OON?</i>	<i>May Cost-sharing requirements differ In-network/OON</i>
<i>HMO</i>	<i>Optional</i>	<i>Must contract</i>	<i>Must provide In-network only</i>	<i>Not applicable</i>
<i>HMOPOS</i>	<i>Optional</i>	<i>Must contract</i>	<i>Must provide in-network; must provide specific OON</i>	<i>May have higher cost-sharing OON</i>
<i>PPO, RPPO</i>	<i>Optional, In-network; Prohibited Out-of-network (OON)</i>	<i>Must contract²</i>	<i>Must provide both in-network/OON</i>	<i>May have higher cost-sharing OON</i>
<i>MSA and PFFS</i>	<i>Prohibited</i>	<i>May use full, partial, or non-network model</i>	<i>Must provide both in-network/OON</i>	<i>May have higher cost-sharing OON</i>

IF PATIENT HAS AN MA HMO PLAN, THERE ARE NO OON BENEFITS

**PROVIDER NOTIFIES PATIENT IN ADVANCE
PATIENT PAYS CASH**

HMOPOS, PPO, RPPO, MSA AND PFFS PLANS MAY HAVE OON BENEFITS – VERIFY COVERAGE!

IF THERE IS OON COVERAGE FOR COVERED SERVICES (IE:98941-AT), PROVIDER MUST BILL AND COLLECT OON COST SHARE FROM PATIENT

OON BILLING REQUIREMENTS

- Out Of Network Providers must bill MA plans for COVERED Services
- OON Providers must collect the OON cost share
- OON Provider must follow billing rules (ie: Prior Auth)
- If the plan type has no OON Benefits, provider does not have to bill (ie: HMO Plans with no OON Benefits)

BILLING MEDICARE ADVANTAGE PLANS

- Understand your contracts: Are you IN or OUT of Network with the MA plan?
- **ALWAYS** verify coverage and benefits
- **NOTIFY** patient in advance if you are OON and there are no benefits
- All MA Plans must follow Medicare Guidelines, **some have expanded coverage, aka ROUTINE or SUPPLEMENTAL BENEFITS**

KEY REASONS FOR MA REVENUE LOSS

- **HMO PLANS – PROVIDER NOT IN NETWORK**
- **PATIENT SEEKING TREATMENT OUT OF THEIR SERVICE AREA**
- **FAILURE TO OBTAIN PRIOR AUTH**
- **BILLING TO THE WRONG PAYER – Remember, MA plans are NOT secondary policies.**
- **NOT BILLING FOR PROCEDURES THAT MIGHT BE COVERED UNDER THE MA PLAN..**

UHC MEDICARE ADVANTAGE PA RULES

- As of Sept 1, 2024, UHC is requiring PA for chiropractic services on MA Plans IF YOU ARE IN NETWORK WITH UHC MA.
- The first SIX visits are approved, BUT it is still required to submit an auth
- After the 6th visit, providers have 10 days from subsequent dates of service to obtain PA
- Easiest way to apply for PA is online through either UHC Online or Optum

UnitedHealthcare Medicare Advantage chiropractic and acupuncture coverage

Quick reference guide



Chiropractic services

What's covered?

Chiropractic (Medicare-covered)

Medicare covers only manual manipulation of the spine to correct subluxation.

Chiropractic (routine)

Routine chiropractic is a supplemental benefit offered on some UnitedHealthcare Medicare Advantage plans that covers chiropractic services that aren't covered under Original Medicare. This benefit allows members to visit chiropractors for pain relief, neuromusculoskeletal disorders and nausea.

When verifying coverage, always ask if the patient has ROUTINE Chiropractic Coverage, or Medicare Covered Chiropractic Coverage

Chiropractic CPT codes

Medicare-covered: Chiropractic manipulations for subluxation*	
98940	Chiropractic manipulative treatment; spinal (1 to 2 regions)
98941	Spinal (3 to 4 regions)
98942	Spinal (5 regions)
Modifier: AT	<ul style="list-style-type: none"> • This modifier should be used when reporting service 98940, 98941, 98942 • This modifier shouldn't be used when providing maintenance therapy

* For more information on Medicare-covered chiropractic services, including links to supporting policies on cms.gov, visit UHCprovider.com > Resources > Health plans, policies, protocols and guides > For Medicare Advantage Plans > Coverage Summaries for Medicare Advantage Plans > Complementary, Alternative Medicine, and Chiropractic Services – Medicare Advantage Coverage Summary.

Routine: Chiropractic manipulations and other services for indications other than subluxation	
98940	Chiropractic manipulative treatment; spinal (1 to 2 regions)
98941	Spinal (3 to 4 regions)
98942	Spinal (5 regions)
98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions
Modifier: AT	<ul style="list-style-type: none"> • Routine chiropractic claims shouldn't contain the AT modifier
Other routine chiropractic common codes (not a complete list)	
Therapeutic	
97110	Therapeutic exercise (15 minutes)
97112	Neuromuscular re-education
97140	Manual therapy (for example, myofascial release; 15 minutes)
Radiology	
72010	Spine, entire, survey study, A-P and lateral
72040	Spine, cervical (2 or 3 views)
72070	Spine, thoracic (2 views)
72100	Spine, lumbosacral (2 or 3 views)

UnitedHealthcare Medicare Advantage chiropractic and acupuncture coverage

Quick reference guide



Chiropractic and acupuncture services

To check:

- Eligibility
- Benefits
- Claims

Chiropractic and acupuncture (Medicare-covered)

- **Phone:** Call the Provider Services number on the member's ID card
- **Online:** Go to UHCprovider.com and click Sign In

Chiropractic and acupuncture (routine)

- **Phone:** 800-873-4575
- **Hours:** Monday–Friday, 8 a.m.–8 p.m. ET
Interactive Voice Response, 24 hours a day
- **Online:** myoptumhealthphysicalhealth.com

When verifying coverage by phone, always ask if the patient has **ROUTINE Chiropractic Coverage**, or **Medicare Covered Chiropractic Coverage**

UnitedHealthcare Medicare Advantage chiropractic and acupuncture coverage

Quick reference guide

To check:

- Authorizations

Chiropractic and acupuncture (Medicare-covered)

- **Phone:** Call the Provider Authorization number on the member's ID card
- **Online:** Visit [UHCprovider.com](https://www.uhcprovider.com) > Prior Authorization and Notification

UnitedHealthcare Medicare Advantage chiropractic and acupuncture coverage

Quick reference guide

To submit appeals and grievances

Chiropractic and acupuncture (Medicare-covered)

- **Online:** Go to UHCprovider.com and click Sign In
- **Address:** Use the medical claims address on the UnitedHealthcare member ID card

Chiropractic and acupuncture (routine)

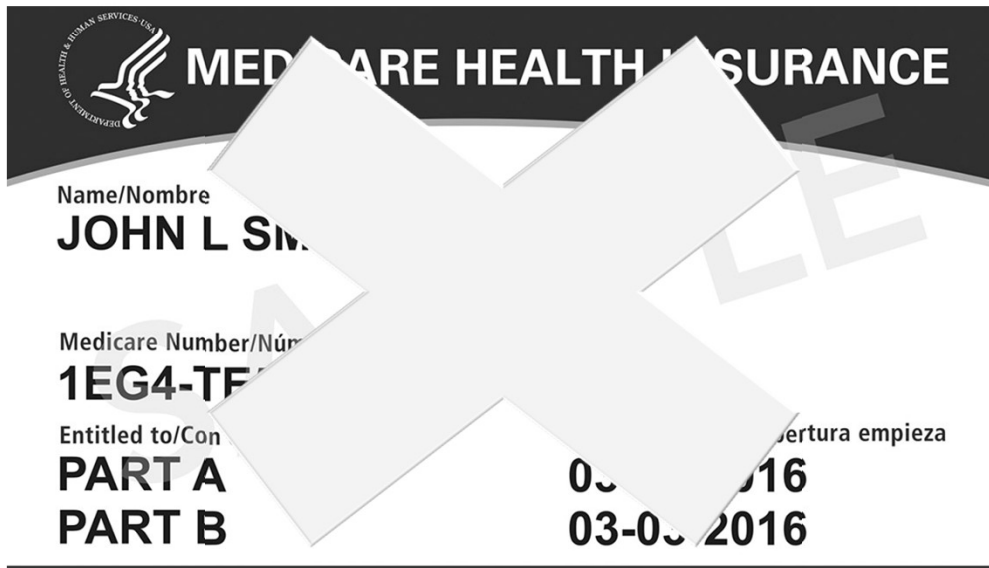
- **Address:** OptumHealth Physical Health
P.O. Box 212
Minneapolis, MN 55440-0212
- **Phone:** 800-873-4575

BEST PRACTICES WHEN DEALING WITH MA PLANS

1. Check insurance card for type of plan (ie: HMO, PPO, RPPO, etc)
2. Verify Coverage
 1. Is coverage based on Medicare B (Standard Coverage)
 2. Are there extended Benefits (ie: Routine Benefits). If YES, check on the codes you may want to bill
 3. Is Provider In-Network with the Plan
 4. What are the Patient Cost Share amounts (Based on Provider Enrollment Status)
 5. Is Prior Authorization Required
3. Notify Patient. Provide them with an estimated cost of care.
4. Obtain necessary Auths
5. Be mindful of Timely Filing Requirements

A row of white wooden figures, resembling a line of people, with a single dark grey figure in the center. The figures are arranged in a slightly curved line, receding into the background. The dark grey figure is positioned in the center of the frame, standing out from the rest of the group. The background is a plain, light-colored surface.

COORDINATING BENEFITS



**ALL BENEFICIARIES ARE
ISSUED THIS CARD
WHEN THEY BECOME
ELIGIBLE**

**NOT USED FOR BILLING
PURPOSES WITH MA
PLANS**

Blue Cross Group
Medicare Advantage
Flex (PPO)SM Member
ID Card

 **BlueCross BlueShield
of Texas** Blue Cross Medicare Advantage (PPO)SM

Name: SAMPLECARD Office Visit: S
ID: ZGD123456789 Specialist: S
Plan (80840): 9101000260 Emergency Room: S

SAMPLE

RxBin: RXBIN Plan: Blue Cross Medicare
RxPCN: RXPCN Advantage Flex (PPO)
RxGrp: RXGROUP
RxID: RXID

H4801 014  MedicareRx
Prescription Drug Coverage

www.getbluetx.com/mapd



Provider: File medical claims with your Pharmacy Line: 1-877-277-7898
local BCBS Plan. Customer Service: 1-877-774-8592
TTY/TDD: 711
Nurse Advice Line: 1-800-631-7023

Medicare Limiting Charges Apply

 **BlueCross BlueShield
of Texas**

PPO plans provided by Blue Cross and Blue Shield of Texas, which refers to HCSC Insurance Services Company (HISC) and GHS Insurance Company (GHSIC). HCSC, HISC and GHSIC are independent licensees of the Blue Cross and Blue Shield Association. HCSC, HISC and GHSIC are Medicare Advantage organizations with a Medicare contract.

IDENTIFYING MEDICARE ADVANTAGE PLANS

Medicare Advantage

ID Cards

<i>Member ID cards for Medicare Advantage products display one of the benefit product logos shown here.</i>	 MEDICARE ADVANTAGE HMO	Health Maintenance Organization
	 MEDICARE ADVANTAGE MSA	Medical Savings Account
	 MEDICARE ADVANTAGE PFFS	Private Fee-for-Service
	 MEDICARE ADVANTAGE POS	Point of Service
	 MA PPO MEDICARE ADVANTAGE	Network Sharing Preferred Provider Organization.

HOW TO IDENTIFY MA PLANS ON AN INSURANCE CARD

Understanding the different types of MA plans will help you manage your patient populations better

Some MA plans “travel”, offering benefits outside a patient’s coverage area.

Look for the SUITCASE with the MA/PPO logo



This is a Medicare B
Supplemental Plan,
aka Medigap

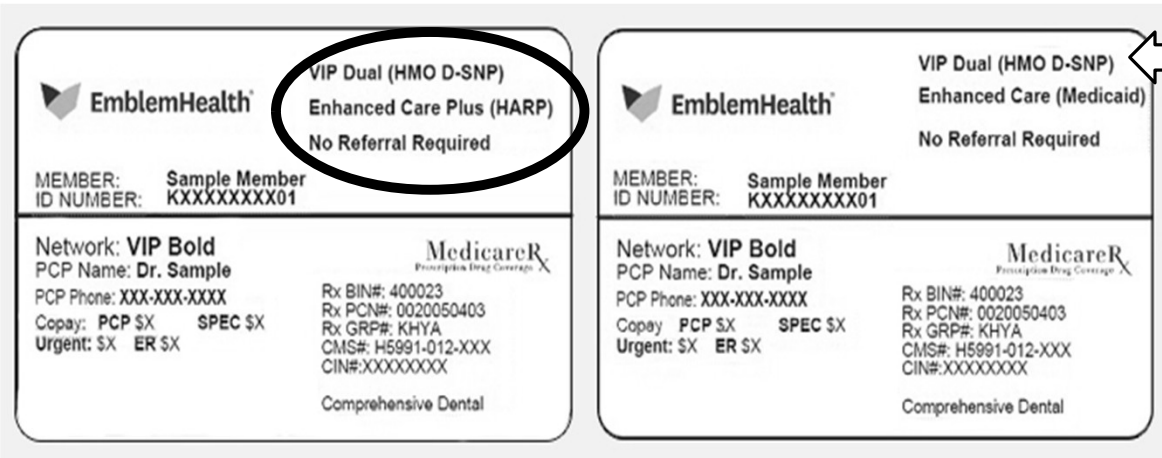
It is Supplemental to
Medicare Part B

**An MA Patient will
not have a Medigap
Plan**

DUAL ELIGIBLE

- Dual-eligible beneficiaries are individuals who receive both Medicare and Medicaid benefits. The two programs cover many of the same services, but **Medicare pays first** for the Medicare-covered services that are also covered by Medicaid.
- Dual-eligible patients may not be balance billed for any cost shares on services that are covered by Medicare. Whether you are a Medicaid provider or not has no bearing on this rule.
- Patients covered under Medicare Advantage plans may also qualify as Dual Eligible.

<https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/51064>



LOOK FOR LANGUAGE ON THE INSURANCE CARD THAT MAY INDICATE A PATIENT IS MEDICARE DUAL ELIGIBLE:

QMB= Qualified Medicare Beneficiary

SNP= Special Needs Plan

Dual Eligible

Dual Complete

DUALLY ELIGIBLE PATIENTS MAY HAVE MEDICARE B + MEDICAID OR MEDICARE ADVANTAGE + MEDICAID

CHECK BENEFITS TO SEE WHAT THE CONFIGURATION IS!

Name/Nombre

JOHN L SMITH

Medicare Number/Número de Medicare

1EG4-TE5-MK72

Entitled to/Con derecho a

Coverage starts/Cobertura empieza

**IF A PATIENT HAS A MEDICARE ADVANTAGE
PLAN, DO NOT ENTER THIS CARD IN THE BILLING
SYSTEM- JUST KEEP A COPY ON FILE**

TRUE SECONDARY PLANS

- Some retirement and union plans provide true secondary policies.
- These plans may offer expanded coverage such as payment for exams, x-rays and therapies
- If the insurance card is not clearly a Medigap or MA plan, verify benefits
- These types of plans may also not crossover directly from Medicare. Manual secondary billing may be necessary

Member ID Card

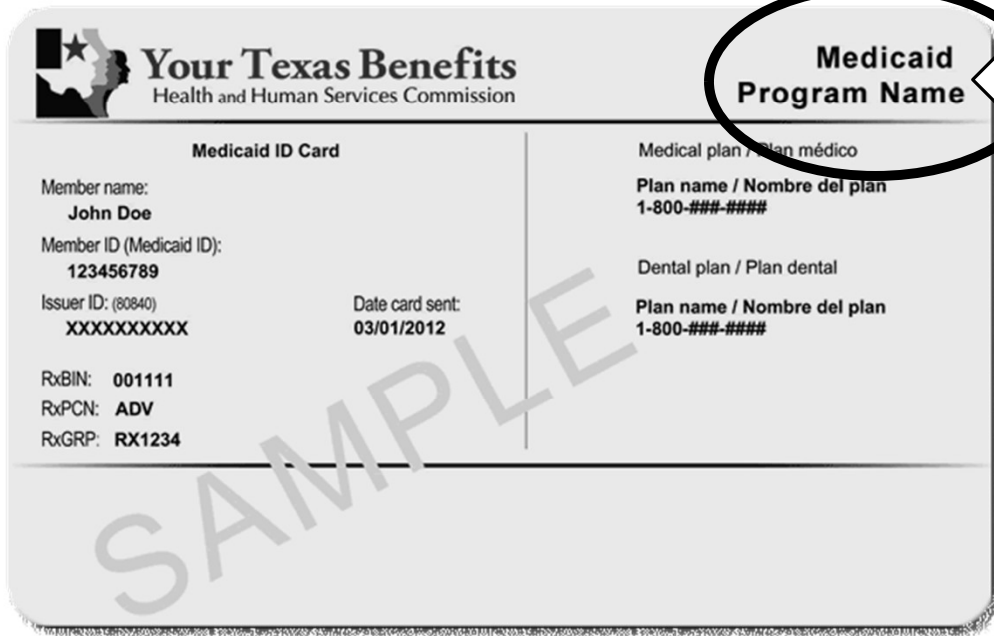
Below is an example of a Blue Cross and Blue Shield (BCBS) ID card with the three-character prefix highlighted:

	BlueCross BlueShield	Blue Product	ALPHA Employer Group
Geography			
Member Name		Dependents	
Member Name		Dependent One	
Member ID		Dependent Two	
XYZ123456789		Dependent Three	
Group No.	023457	Plan	PPO
BIN	987654	Office Visit	\$15
Benefit Plan	HIOPT	Specialist Copay	\$15
Effective Date	00/00/00	Emergency	\$75
		Deductible	\$50
 			

DUAL ELIGIBLE

- Dual-eligible beneficiaries are individuals who receive both Medicare and Medicaid benefits. The two programs cover many of the same services, but **Medicare pays first** for the Medicare-covered services that are also covered by Medicaid.
- **Dual-eligible patients may not be balance billed for any cost shares on services that are covered by Medicare.** Whether you are a Medicaid provider or not has no bearing on this rule.
- Patients covered under Medicare Advantage plans may also qualify as Dual Eligible.

<https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/51064>



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QMB= Qualified Medicare Beneficiary

SNP= Special Needs Plan

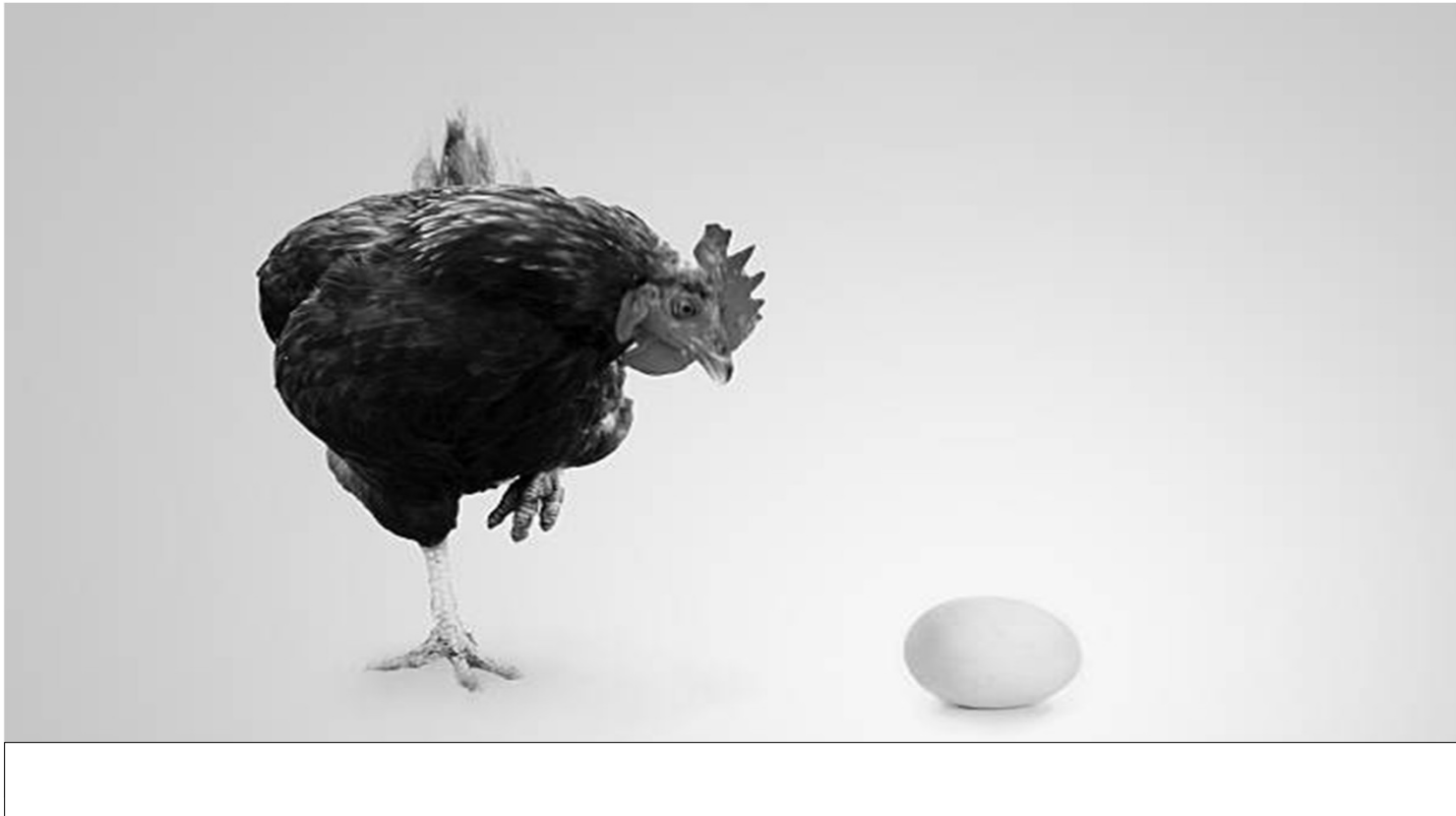
Dual Eligible

Dual Complete

STAR+PLUS

STAR+PLUS is a Texas Medicaid-managed care program for adults who have disabilities or are age 65 or older. Adults in STAR+PLUS get Medicaid healthcare and long-term services and support through a health plan that they choose

MEDICARE AS A SECONDARY PAYER



How does my other insurance work with Medicare?

When you have other insurance and Medicare, there are rules for whether Medicare or your other insurance pays first.

If you have retiree insurance (insurance from your or your spouse's former employment)...	Medicare pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has 20 or more employees ...	Your group health plan pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has fewer than 20 employees ...	Medicare pays first.
If you're under 65 and have a disability, have group health plan coverage based on your family member's current employment, and the employer has 100 or more employees ...	Your group health plan pays first.
If you're under 65 and have a disability, have group health plan coverage based on your or a family member's current employment, and the employer has fewer than 100 employees ...	Medicare pays first.
If you have Medicare because of End-Stage Renal Disease (ESRD)...	Your group health plan will pay first for the first 30 months after you become eligible to enroll in Medicare. Medicare will pay first after this 30-month period.

Instances where
Medicare may be
secondary

65+, Employer with
over 20 employees

SSID, Employer with
over 100 employees

OTHER INSTANCES IN WHICH MEDICARE IS SECONDARY

Non-Group Health Plan (NGHP) MSP

- Workers' compensation is primary to Medicare
- Example of workers' compensation
 - Warehouse worker suffers a back injury while on the job
 - All related medical bills are the primary payment responsibility of the workers' compensation insurer

Note: Liability insurance (including self-insurance), no-fault insurance, and workers' compensation known as Non-Group Health Plan, or NGHP

Workman's Compensation

Non-Group Health Plan (NGHP) MSP

- Includes liability insurance (including self-insurance), no-fault insurance, and workers' compensation
- Liability insurance example
 - Medicare beneficiary injured in an auto accident
 - Beneficiary files a claim against the alleged responsible party and receives payment
 - Medicare is secondary to the liability insurance payment

Personal Injury

ABN'S (ADVANCE BENEFICIARY NOTICES) are used to inform patients that certain services and procedures may not be covered, and they may be financially liable.

ABN's are used in all practice settings, with all types of insurance companies, including Medicare B, Medicare Advantage, and Commercial Payers.

Failure to Notify patients in advance that a service might not be covered could result in the provider having to write off the entire claim, if not paid

ABN'S

THE MEDICARE ABN

BACKGROUND

You must issue an ABN:

- When an item or service is not reasonable and necessary under Medicare Program standards, including care that is:
 - Experimental and investigational or considered “research only”
 - **Not indicated for diagnosis or treatment in this case**
 - Not considered safe and effective
 - More than the number of services Medicare allows in a specific period for the corresponding diagnosis

Excerpt from MLN: **ICN MLN909183 July 2020**

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

ABN RULES AS OF 10/14/21

- Providers must use the updated and revised ABN guidelines found in Chapter 30, Section 50 of the *Medicare Claims Processing Manual*. A few of the key provisions that were revised include:
 - (i) the events that trigger the furnishing of an ABN,
 - (ii) general notice preparation requirements,
 - (iii) the furnishing of ABNs to dual eligible individuals, and (iv) the period of effectiveness.

Prior to the July 14, 2021, revisions, ABNs were effective for up to one year. However, as of the Effective Date of revised provisions, **a valid ABN will remain effective indefinitely** so long as there is no change in:

- the patient's plan of care;
- the beneficiary's health status that would require a change in treatment for the non-covered condition; and/or
- there are changes to the Medicare coverage guidelines for the items or services in question.

If any of the above-mentioned criteria changes during the course of treatment, the supplier must issue a new ABN to the beneficiary. If the beneficiary is receiving items or services that are repetitive or continuous in nature, the supplier may issue another ABN after the first year, but it will no longer be required to do so.

THE MEDICARE ABN AND CHIROPRACTIC

- ONLY MEDICARE PART B
- ONLY FOR SPINAL MANIPULATIONS
- OTHER SERVICES UNDER A VOLUNTARY ABN
- USE THE MOST CURRENT FORM Form CMS-R-131 (Exp.03/31/2029)
- ISSUE ABN WHEN YOU BELIEVE MEDICARE WILL STOP PAYING
- ISSUE NEW ABN IF THERE IS A NEW TX PLAN/NEW DX
- NO LONGER NECESSARY TO FILL OUT ANNUALLY (AS OF OCT 15TH 2021)

PART 1

- LIST COVERED SERVICES THAT MAY NOT BE PAYABLE
- PROVIDE REASON FOR NON COVERAGE
- LIST FEES ASSOCIATED WITH THOSE SERVICES

Patient name:
Identification number: *(optional)*

*Notifier name
Notifier address
Notifier phone (including TTY)*

Advance Beneficiary Notice of Non-coverage (ABN)

Medicare doesn't pay for everything, even some care you or your health care provider think you need. **We expect Medicare may not pay for the item, test, service or care listed below.** If Medicare doesn't pay, you may have to pay.

Item, test, service or care	Reason Medicare may not pay	Estimated cost
98940: 1-2 Region Spinal Manipulation	Medicare only covers chiropractic treatment to correct a spinal misalignment (subluxation). Maintenance treatment is not a covered service.	98940 - \$40.00
98941: 3-4 Region Spinal Manipulation		98941 - \$55.00
98942: 5 Region Manipulation		98942 - \$70.00 (your fees here)

What to do now

- Read this notice to make an informed decision about your care.
- Ask any questions you have.
- Choose one option below to let us know if you still want to get the item, test, service or care.

PART 2: PATIENT ELECTION

Choose ONE option below. We can't choose for you.

If you choose Option 1 or 2, we may help you use any other insurance you might have, but Medicare can't require us to do this.

- Option 1: I want the item, test, service or care listed above, and I want Medicare to be billed for an official decision on payment, which I'll get on a Medicare Summary Notice (MSN).** You can ask to be paid now. I understand that if Medicare doesn't pay, I'm responsible to pay, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you'll refund any payments I made to you, minus co-pays or deductibles.
- Option 2: I want the item, test, service or care listed above, but don't bill Medicare.** You can ask to be paid now and I'm responsible to pay. I understand that I can't appeal, since Medicare isn't billed.
- Option 3: I don't want the item, test, service or care listed above.** I understand I'm not responsible for payment and I can't appeal to see if Medicare would pay.

You cannot make the choice for the patient. You can only explain what each choice means , if the patient asks.

PART 3 – PATIENT SIGNATURE. KEEP ON FILE AND GIVE A COPY TO THE PATIENT

Additional information:

This notice gives our opinion, not an official Medicare decision. For other questions about this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Signing below means you received and understand this notice. You can ask to get a copy.

Signature

Date (mm/dd/yyyy)

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](https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice).

PRA Disclosure Statement: 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. This information collection is for providers, suppliers, Hospice and Religious Non-medical HealthCare Institutes and Home Health Agencies to notify original Medicare beneficiaries of their potential financial liability under specific conditions. The time required to complete this information collection is estimated to average less than 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory under Section 1879 of the Social Security Act, 42 CFR 411.404(b) and (c) and 411.408(d)(2) and (f). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

ALWAYS USE THE MOST RECENT VERSION OF THE ABN FORM

I	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSON Family Plan	L. ID. QUAL.	J. RENDERING PROVIDER ID. #	SUPPLIER INFORMATION
	From	To	CPT/HCPCS		MODIFIER													
MM	DD	YY	MM	DD	YY													
1	01	05	24	01	05	24	11		98940	GA	A	65	00	1		NPI	rendering NPI	
2																NPI		
3																NPI		
4																NPI		

IF THE PATIENT CHOOSES **OPTION 1** ON THE ABN FORM, YOU MUST CONTINUE TO BILL MEDICARE FOR 9894X CODES AND **REPLACE THE AT** MODIFIER WITH **GA**

**IF YOU ARE A NON-PAR PROVIDER
IF YOU HAVE A DUAL ELIGIBLE PATIENT**

ABN's are filled out slightly different than the Par-Provider ABN

Email: info@goldstarmedical.net for examples

AN ABN IS NOT REQUIRED FOR NON-COVERED SERVICES

You may use the CMS R-131 ABN form as a VOLUNTARY ABN

OR Create your own Notification Document/Form

WHAT ABOUT ABN'S FOR MEDICARE ADVANTAGE PLANS?

- **MA plans do not recognize the Medicare ABN.** You must follow the Payer's rules for Advance Notice of Non Coverage

<NAME OF CLINIC/ ADDRESS/CITY/STATE ZIP>
<NAME OF DOCTOR/PROVIDER>

NOTICE OF MEDICARE NON COVERED SERVICES

There are items and services for which Medicare Part B will not pay. Please be aware of the following:

- Medicare Part B coverage of Chiropractic Services is limited to Spinal Manipulation to correct a subluxation (misaligned vertebrae).
- **All other services that are performed by, or referred by a Doctor of Chiropractic are not covered by Medicare Part B. Medicare requires an examination and/or xray to prove Medical necessity of your condition, but Medicare B will not pay for it.**
- Your Provider may recommend services that are not covered by Medicare Part B to accelerate healing and promote overall health. Services/Supplies may include, but are not limited to manipulation to body parts other than the spine, therapeutic modalities, rehabilitation exercises and Spinal Braces or Supports. **These services are not covered by Medicare Part B and you will be financially liable for the services and supplies.** Please let your Provider know ahead of time if you do not wish to have these services.
- If you have a Medicare Supplemental Plan, aka Medigap Plan, it will only reimburse for services that Medicare B covers, according to your plan's provisions. If Medicare B does not cover, the supplemental plan will not pay.
- If you have a Retirement plan that supplements Medicare Part B, the plan MAY pay for services Medicare B does not cover. But this is rare, and you will need to get confirmation from your plan of such coverage, and provide proof of coverage to us.
- Most **Medicare Advantage/Medicare Replacement** plans follow the same Medicare Part B rules as stated above. However some patients purchase expanded coverage that may pay for services Medicare B does not cover. But this is rare, and you will need to get confirmation from your plan of such coverage, and provide proof of coverage to us.

I have been given this Notice of Exclusion of Medicare Coverage and understand the provisions of the notice. I understand and agree to be financially responsible for all services and charges that are Statutorily Excluded from Medicare under the Chiropractic Benefit. I understand that I am required to have an examination and/or xray to prove medical necessity of my spinal condition and that Medicare B will not cover either the exam or xray. I understand that other services recommended by my Provider other than Manipulation of the Spine to correct a Subluxation are Statutorily excluded from Medicare and I will be financially responsible for payment of such services. If I do not wish to have these services, I will let my provider know before services are rendered. I understand that refusal of these services may affect the speed of healing and effectiveness of the care given to me at <NAME OF PRACTICE> by <NAME OF PROVIDER>

NAME OF PATIENT: _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT) _____

PATIENT DATE OF BIRTH: _____

Signature of Patient

Date Signed

**EXAMPLE OF A
VOLUNTARY
CHIROPRACTIC ABN
“HOMEMADE”

NOTIFIES PATIENTS OF
SERVICES THAT ARE NOT
COVERED BY MEDICARE

INFORMATIONAL ONLY,
PATIENT DOES NOT NEED
TO CHOOSE ANY OPTIONS**

<Print on your Letterhead>

Medicare Advantage Non-Covered Service Notice

[Your Practice Name & Logo]

Date: [Insert Date]

Patient Name: _____

Insurance Plan: _____

ID #: _____

Important Information About Your Coverage

You are enrolled in a Medicare Advantage plan. Our office is not contracted/out-of-network with your plan.

Your plan has informed us that there are no out-of-network chiropractic services.

Because of this, your plan will not pay for the services we provide today.

Since the plan will not pay, you will be personally responsible for the cost of your care at our office.

Services Not Covered

Chiropractic spinal manipulation for acute subluxation

Chiropractic spinal manipulation for maintenance care

Other services provided by this office that are excluded from your plan's out-of-network benefits

Your Financial Responsibility

You agree to pay our office's full fee for these services.

These charges are not limited to the Medicare fee schedule because your plan does not provide out-of-network coverage for this service.

Patient Acknowledgment

Please review and sign below to confirm that you understand:

My Medicare Advantage plan will not pay for out-of-network chiropractic care.

I will be responsible for paying the full fee for the services I receive.

I had the opportunity to ask questions and receive answers before signing.

Patient Signature: _____

Date: _____

Staff Witness: _____

**SAMPLE Medicare Advantage
Notice of Non-Coverage**



**TO OBTAIN COPIES OF THE ABN
TEMPLATES**

FROM CMS

<https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-abn>

OR

**SEND EMAIL TO
INFO@GOLDSTARMEDICAL.NET**

**Available in Spanish and Large
Print**

LIST OF CMS PUBLICATIONS/REFERENCES RELATING TO CHIROPRACTIC TREATMENT

Refer to the following Medicare Internet online Manuals (IOMs) for coverage of Chiropractic services:

Publication 100-02 Medicare Benefit Policy Manual

Chapter 15 Covered Medical and Other Health Services:

- § 30.5 Chiropractor's Services
- § 40.4 Definition of Physician /Practitioner.
- § 220 Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance
- §240 Chiropractic Services - General
- §240.1.1 Manual Manipulation
- §240.1.2 Subluxation May Be Demonstrated by X-Ray or Physician's Exam
- §240.1.3 Necessity for Treatment
- §240.1.4 Location of Subluxation
- §240.1.5 Treatment Parameters

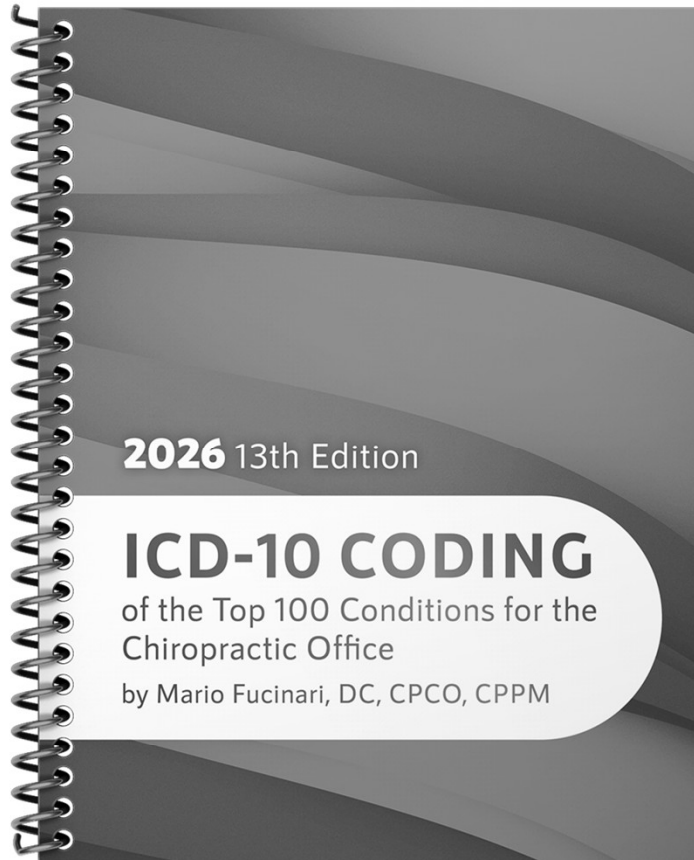
Publication 100-04 Medicare Claims Processing Manual

Chapter 12 Physicians/Nonphysician Practitioners

- §220 - Chiropractic Services

Chapter 23 Fee Schedule Administration and Coding Requirements

- §20.9.1.1 Instructions for Codes with Modifiers (A/B MACs (B) Only)



RECOMMENDED CODING BOOK FOR CHIROPRACTORS

DX coding Rules and Tips
Full list of “Secondary” Dx Codes
for Medicare Claims

www.askmario.com

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*** indicates required fields

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First Last

Email *

Address *

Street Address

City State / Province / Region

ZIP / Postal Code

SUBMIT

ChiroHealthUSA[®] ChiroAcademy ChiroArmor

MEDICARE PLAYBOOK
for Chiropractic
3rd Edition

ChiroHealthUSA[®] ChiroAcademy ChiroArmor

NEED HELP?

73°F Cloudy Search 10:33 AM 4/15/2026

Free Resource from
ChiroHealthUSA

Great Training tool
for Chiropractic
Offices and Billers

<https://www.chirohealthusa.com/student-s/medicare-playbook/>



THANK YOU FOR YOUR ATTENDANCE!

QUESTIONS?

CONCERNS?

NEED HANDOUTS?

NEED FORMS?

NEED ADVICE?

NEED HELP?

**BILLING SERVICES
TRAINING
CREDENTIALING
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COMPLIANCE**

- Call Gold Star Medical Business Services for a **Complimentary Consultation**
- Phone: 866-942-5655
- Self Service Scheduling:
<https://calendly.com/lmaciejewski/consult>
- Email: info@goldstarmedical.net
- Visit website: www.goldstarmedical.net
- Facebook: www.facebook.com/goldstarmedical