



MICHIGAN ASSOCIATION OF CHIROPRACTORS

Stephanie Davidson - MAC Director of Insurance



From Symptom *to Claim*



ICD-10-CM Diagnosis Coding for Chiropractors

ICD-10-CM:

International Classification of Diseases, 10th Revision, Clinical Modification

- ICD-10-CM was implemented in the U.S. in 2015, replacing ICD-9-CM.
- This was a **major overhaul**, significantly expanding the specificity and number of diagnosis codes.
- ICD-10-CM contains approximately 75,000 diagnosis codes, compared with approximately 14,000 under ICD-9-CM.
- **ICD-10-CM codes are updated annually, effective October 1.**
- Updates may include new, revised, and deleted codes
- **If diagnosis-related denials suddenly occur outside of the annual update period, an ICD code change is probably *not* the cause.**
*** Diagnosis-level denials can occur for many other reasons.

ICD-10

Manual Layout 2 Sections

Alphabetic Index:

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

The Tabular Index:

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

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

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)

Your EHR is *not* your codebook.

You NEED a Reliable, Current, ICD-10 Resource.

Centers for Disease Control & Prevention (CDC)

<https://icd10cmtool.cdc.gov/?fy=FY2026>

- 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.

Here are 2
FREE options!

Centers for Medicare & Medicaid

<https://www.cms.gov/medicare/coding-billing/icd-10-codes>

- Scroll down to ICD-10 Files, click on **2027 ICD10 CM & PCS Files**
- Select **2027 Code Tables, Tabular, and Index (ZIP)**
- This will automatically download to your *Downloads* folder
- Then open the PDF: “icd10cm_tabular_2027”
- 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.*

4 Checkpoints Before You Code an ICD-10 Code:

Scope:

Must be in scope to diagnose, treat, and bill.

Michigan Public Health Code, MCL 333.16401 ...

Documentation:

- **Document the diagnosis in words** (exam findings, clinical reasoning, and the diagnostic statement).
- **Find the main term** in the Alphabetic Index.
- **Verify the code** in the Tabular List, checking notes and Excludes.
- **Report the code** on the CMS 1500 claim (electronic record)

ICD-10 Code Rules →

Payer Rules →

Medical necessity is the payer's definition, not yours.

We'll review:

- Medicare LCA
- BCBSM



ICD-10 Code Rules → “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).



How to Locate Excludes1 Notations

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

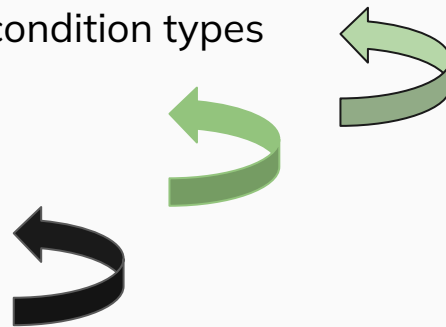
Start at the specific ★ **Code** → **Subcategory** → **Category** → **Chapter**.

Chapter level: Applies broadly across condition types

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

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

★ **SPECIFIC CODE LEVEL:** Full code (e.g., M54.50)



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



1. Start at the Specific Code You Plan to Bill

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



Example:

M54.2 Cervicalgia

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

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



2. Expand to the Subcategory Level

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



Example:

M54 Dorsalgia

Excludes1: psychogenic dorsalgia (F45.41)

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



3. Check the Broader Category Level

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

 **Example:**

Other dorsopathies (M50-M54)

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

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



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

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

Chapter 13

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

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



M54.2 Cervicalgia

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

M54.3 Sciatica

Excludes1: intervertebral disc degeneration, lumbar region with lower extremity pain only (M51.361)
intervertebral disc degeneration, lumbosacral region with lower extremity pain only (M51.371)
lesion of sciatic nerve (G57.0)
sciatica due to intervertebral disc disorder (M51.1-)
sciatica with lumbago (M54.4-)

M54.30 Sciatica, unspecified side

M54.31 Sciatica, right side

M54.32 Sciatica, left side



M54.5 Low back pain

Excludes1: intervertebral disc degeneration, lumbar region with discogenic back pain only (M51.360)
intervertebral disc degeneration, lumbosacral region with discogenic back pain only (M51.370)
low back strain (S39.012)
lumbago due to intervertebral disc displacement (M51.2-)
lumbago with sciatica (M54.4-)

M54.50 Low back pain, unspecified

Loin pain
Lumbago NOS

M54.51 Vertebrogenic low back pain

Low back vertebral endplate pain

M54.59 Other low back pain

M54.6 Pain in thoracic spine

Excludes1: pain in thoracic spine due to intervertebral disc disorder (M51.-)

Payer Rules →



Billing and Coding Article

Article - Billing and Coding: Chiropractic Services (A56273)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

NOT AN LCD REFERENCE ARTICLE
This article is not in direct support of an LCD. [Learn more](#)

Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
Wisconsin Physicians Service Insurance Corporation	MAC - Part B	05102 - MAC B	J - 05	Iowa
Wisconsin Physicians Service Insurance Corporation	MAC - Part B	05202 - MAC B	J - 05	Kansas
Wisconsin Physicians Service Insurance Corporation	MAC - Part B	05302 - MAC B	J - 05	Missouri - Entire State
Wisconsin Physicians Service Insurance Corporation	MAC - Part B	05402 - MAC B	J - 05	Nebraska
Wisconsin Physicians Service Insurance Corporation	MAC - Part B	08102 - MAC B	J - 08	Indiana
Wisconsin Physicians Service Insurance Corporation	MAC - Part B	08202 - MAC B	J - 08	Michigan

Article Information

General Information

Article ID
A56273

Article Title
Billing and Coding: Chiropractic Services

Article Type
Billing and Coding

Original Effective Date
03/19/2019

Revision Effective Date

CPT codes, descriptions and other data only are copyright 2023 American Medical Association. All Rights Reserved. Applicable FARS/HHSARS apply.

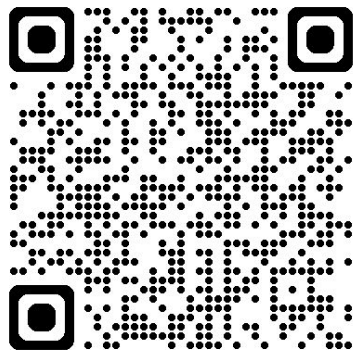
Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Current Dental Terminology © 2023 American Dental Association. All rights reserved.

Copyright © 2024, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the American Hospital Association (AHA) copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UBC04 codes and descriptions may not be removed, copied, or utilized within any software, product, service,

CMS Billing and Coding: Chiropractic Services (A56273)

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





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.

All diagnosis codes must be coded to the highest level of specificity, and the primary diagnosis must be supported by an x-ray or documented by physical examination. These are the only covered diagnosis codes that support medical necessity:

Primary Diagnosis: Names of Vertebrae

Group 1 Paragraph: The precise level of subluxation must be listed as the primary diagnosis (M99.00 – M99.05)

Secondary Diagnosis: Symptom/Condition Codes

Group 2 Paragraph: Short-Term Treatment

Group 3 Paragraph: Moderate-Term Treatment

Group 4 Paragraph: Long-Term Treatment

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

Payer Rules →





Explainer

[Home](#) [BPR](#) [Commercial Policy](#) [Manage Favorites](#) [Communications](#)

Commercial Policy

Date Range / Date of Service09/24/2026

Topic▼HCPCS Code - 98940 - Chiro., manip., spinal., one to two regions

RequiredOptional

Search

Medical/Payment Policy Report

98940 - Chiro. manip., spinal, one to two regions (T20734) - Code effective 01/01/1997 To Present

▸ Topic Details

Included Codes

▸ Coverage Status

▸ Coverage Limitations



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, then enter the CPT code in the open field.
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 that "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.
9. Click on the blue hyperlinked Primary Diagnosis title to open a list of the payable diagnosis codes.
10. Scroll down to see the list of ICD-10 codes that BCBSM considers medically necessary for the CPT you searched.
11. Use the Search for Code in Rule Cell to look for specific codes on the list. (Do 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!



MAC Fall 2026 Journal

A Win for Michigan Chiropractic Patients and Their Providers! MAC Advocacy Results in Expanded BCBSM Diagnosis Coverage!



By: The MAC Insurance Relations Team

Good news to share: Due to advocacy from the MAC Insurance Committee, BCBSM has agreed to expand the list of diagnosis codes it recognizes as medically necessary for chiropractic care. This is a direct result of pushing back on a payer policy that hasn't kept pace with how you actually diagnose and treat patients. It's a meaningful step forward, and it's worth understanding both what changed and why the MAC fought for it.

BCBSM, like most payers, determines coverage not only by service and procedure codes, but also by the number of visits allowed and even which diagnoses it will pay for. For BCBSM, this information lives in the provider "Secured Services" portal, in a section called the Benefit Explainer (what many of us still know as "the old Web DENIS").

Knowing how to find this information is important. Understanding what it means for coverage is even more important because it directly affects the "medical necessity" denials you may be seeing in your practice. Here's the frustrating reality: A denial for medical necessity may have

A Longstanding Problem for BCBSM Commercial Coding

Take M99.0, the code family for segmental and somatic dysfunction. BCBSM's list includes M99.00 through M99.04, head through sacral regions, but leaves out M99.05, the pelvic region. There's no clinical rationale for that omission. It's simply been overlooked.

Or consider knee and hip pain. BCBSM covers 98940-98942 when the primary diagnosis is right or left knee pain (M25.561, M25.562), but not right or left hip pain (M25.551, M25.552). It gets even more absurd with stiffness codes: Stiffness of the right knee (M25.661) is payable. Stiffness of the left knee is not.

These aren't isolated glitches. It's been the reality of BCBSM commercial coding. For years, Michigan chiropractic providers have dealt with this kind of inconsistency and unfortunately have often responded by simplifying their coding to get claims paid, rather than coding to the true clinical picture.

What the MAC Has Been Doing About It



G43.909	Migraine, unspecified, not intractable, without status migrainosus
G43.919	Migraine, unspecified, intractable, without status migrainosus
G55	Nerve root and plexus compressions in diseases classified elsewhere
G57.03	Lesion of sciatic nerve, bilateral lower limbs
G57.23	Lesion of femoral nerve, bilateral lower limbs
G57.93	Unspecified mononeuropathy of bilateral lower limbs
M25.511	Pain in right shoulder
M25.512	Pain in left shoulder
M25.551	Pain in right hip
M25.552	Pain in left hip
M25.571	Pain in right ankle and joints of right foot
M25.572	Pain in left ankle and joints of left foot
M50.120	Mid-cervical disc disorder, unspecified level
M50.121	Cervical disc disorder at C4-C5 level with radiculopathy
M50.122	Cervical disc disorder at C5-C6 level with radiculopathy
M50.123	Cervical disc disorder at C6-C7 level with radiculopathy
M50.220	Other cervical disc displacement, mid-cervical region, unspecified level
M50.221	Other cervical disc displacement at C4-C5 level



M50.222	Other cervical disc displacement at C5-C6 level	
M50.223	Other cervical disc displacement at C6-C7 level	
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	
M50.820	Other cervical disc disorders, mid-cervical region, unspecified level	
M50.821	Other cervical disc disorders at C4-C5 level	
M50.822	Other cervical disc disorders at C5-C6 level	
M50.823	Other cervical disc disorders at C6-C7 level	
M50.920	Unspecified cervical disc disorder, mid-cervical region, unspecified level	
M50.921	Unspecified cervical disc disorder at C4-C5 level	
M50.922	Unspecified cervical disc disorder at C5-C6 level	
M50.923	Unspecified cervical disc disorder at C6-C7 level	
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region	
M54.16	Radiculopathy, lumbar region	
M62.85	Dysfunction of the multifidus muscles, lumbar region	
M99.05	Segmental and somatic dysfunction of pelvic region	
R51.0	Headache with orthostatic component, not elsewhere classified	



Surprise Billing Rules



MICHIGAN LEGISLATURE

Michigan Compiled Laws Complete Through PA 103 of 2026

Senate adjourned until Wednesday, September 30, 2026 10:00 AM

[Home](#) [Legislature](#) [Laws](#) [More](#)

[Sign Up](#) [Log In](#)

MCL - 368-1978-18

[Download Division](#) | [View Division Index](#)

Search within this Division



[Chapter 333](#)

[Act 368 of 1978](#)

[◀ Previous Division](#) [Next Division ▶](#)

PUBLIC HEALTH CODE (EXCERPT)

Act 368 of 1978

Article 18

SURPRISE MEDICAL BILLING

Michigan Surprise Medical Billing Statutory Provisions



Michigan has Specific GFE Requirements.

A **nonparticipating provider** who is providing a health care service to a **nonemergency patient** shall provide a disclosure to the patient at the time of the nonparticipating provider's **first contact**.

The provider must:

- Give the statutory disclosure.
- Use at least **12-point type**.
- Obtain the patient's or representative's signature.
- Give the patient a **good-faith estimate of the cost of the services**.
- Retain the disclosure for **at least seven years**.



Michigan has Specific GFE Requirements.

The law says the disclosure must be *“in substantially the following form”*:

"Your health benefit plan may or may not provide coverage for all of the health care services you are scheduled to receive or the providers providing those services. You may be responsible for the costs of the services that are not covered by your health benefit plan.

The nonparticipating provider must provide a good-faith estimate of the cost of the health care services to be provided. A good-faith estimate does not take into account unforeseen circumstances, which may affect the cost of the health care services provided.

You also have a right to request that the health care services be performed by a provider that participates with your health benefit plan, and may contact your carrier to arrange for those services to be provided at a lower cost and to receive information on in-network providers who can perform the health care services that you need.

I have received, read, and understand this disclosure."



What happens if a disclosure isn't provided?

If the Michigan law applies and the nonparticipating provider fails to provide the required disclosure, the provider must submit the claim to the carrier within **60 days** and accept the statutory payment methodology as payment in full, subject to the patient's applicable in-network cost sharing.

The statutory payment methodology is generally the greater of:

- **Carrier's median negotiated amount**

OR

- **150% of the Medicare fee-for-service amount**

excluding applicable in-network coinsurance, copayment, or deductible.

The provider cannot then collect the remaining balance from the patient.



The Federal No Surprises Act

Effective January 1, 2022, the federal No Surprises Act added several consumer billing protections.

For purposes of the chiropractic office, we are focusing on:

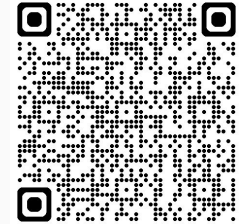
Good Faith Estimates (GFE) for Uninsured and Self-Pay Patients

Federal law requires providers to give a Good Faith Estimate when a patient:

- Does **not** have health insurance, OR
- **Has health insurance but does not intend to have a claim submitted** for the item or service.

That means a patient can have insurance and still be considered "**self-pay**" under the federal GFE rules.

The Federal No Surprises Act



Federal law looks at whether insurance is being used for the care.

Examples:

- Patient has no insurance → **GFE**
- Patient has insurance but chooses not to use it → **GFE**
- Patient has insurance, but the service is not covered and the patient is paying privately → **GFE**
- Patient intends to submit the service to their insurance → **Federal law/GFE does not apply**

Providers are required to inquire about whether the individual has health coverage and, if so, whether the individual is seeking to have a claim submitted.



When Does the Federal GFE Have to Be Provided?

When Care Is Scheduled	Federal Requirement
Less than 3 business days before care	GFE not required based on scheduling
3–9 business days before care	GFE within 1 business day after scheduling
10+ business days before care	GFE within 3 business days after scheduling
Patient requests a GFE	GFE within 3 business days of request

CMS confirms that a GFE isn't required based on scheduling when the service is scheduled fewer than three business days in advance.

****But remember Michigan: Michigan requires the disclosure/GFE at the **first contact regarding the service** when its requirements apply.***



What Must Be Included in the Federal GFE?

The GFE should clearly identify:

- Patient information
- Provider information
- Items/services reasonably expected to be provided
- Applicable diagnosis codes, if known
- Applicable service/procedure codes, if known
- Expected charge for each item/service
- Total expected charges
- Required federal disclaimers and patient-rights information

The estimate must be provided in **clear and understandable language** and is an estimate, not a bill.

It should reflect what you reasonably expect will be provided based on the information available when the GFE is created.



"But I Don't Know What I'm Going to Do Until I Examine Them!"

That's okay. It is a Good Faith ESTIMATE.

The estimate is based upon the services **reasonably expected at the time the estimate is created.**

For a new chiropractic patient, you may reasonably anticipate:

- New patient examination
- X-rays, if reasonably expected
- CMT
- Other services reasonably expected as part of the scheduled care

Treatment may change based upon the examination, clinical findings and patient decisions.

The GFE is not a guarantee of the final treatment plan or final charge.

CMS describes the GFE as an itemized estimate of the expected charges associated with the scheduled care.



What About an Ongoing Chiropractic Plan of Care?

Federal guidance allows a GFE to address recurring services.

For recurring items or services, the estimate can identify:

- Expected frequency
- Expected timeframe
- Expected number of visits/services
- Expected charges

A recurring GFE may cover a period of **up to 12 months**.

Example:

CMT 98941

2 visits/week × 6 weeks

Estimated 12 visits

\$___ per visit

Estimated total: \$____

If the expected course of care materially changes, consider providing an updated GFE.



The "\$400 Rule"

If the patient's final bill is at least \$400 MORE than the GFE...

The uninsured/self-pay patient may be eligible to initiate the federal:

Patient-Provider Dispute Resolution (PPDR) Process

If a consumer chooses to dispute a charge for an item or service, the provider will be asked to provide:

- The good faith estimate they provided their patient.
- The bill they sent to their patient.
- Any supporting documents that help to explain why the bill is higher than the estimate.

Providers will be emailed a link to the federal dispute resolution portal where they can upload the requested documents.

During the patient-provider dispute resolution process, the provider and patient can continue to negotiate the bill. During this process, providers:

- May not move the bill into collections or threaten to do so.
- Must pause collections if the bill is already in collections.
- Can't collect late fees on unpaid amounts.
- Can't threaten to take any retaliatory action against the patient for initiating the patient-provider dispute resolution process.

Patient's Plan Type	Primary Law that Applies	Notice & Consent Rule (To Legally Balance-Bill)	Payment Dispute Resolution Portal
Individual Marketplace / ACA Plans (e.g., BCBSM or Priority Health bought on healthcare.gov)	Michigan Law (with Federal floor protections)	First-Contact Rule: Must provide written disclosure at the very first contact regarding the service (MCL 333.24509(1)(b)).	Michigan DIFS State Arbitration
Fully-Insured Employer Plans (Small or medium businesses where the insurance company pays the claims)	Michigan Law (with Federal floor protections)	First-Contact Rule: Must provide written disclosure at the very first contact regarding the service.	Michigan DIFS State Arbitration
Uninsured / Self-Pay Patients	Federal NSA Only	Requires a Federal Good Faith Estimate prior to care.	Federal Patient-Provider Dispute Resolution
Self-Funded Employer Plans (ERISA) (Federally Regulated)	Federal NSA Only	Federal NSA Notice & Consent does not apply to routine nonemergency care furnished in an independent chiropractic/physician office.	Neither Michigan DIFS Arbitration nor Federal NSA IDR applies to ordinary OON services in an independent chiropractic office.
Medicare / Medicaid / TRICARE	Neither (Governed by separate federal statutory fee structures)	Not applicable.	Not applicable.



Where It Gets Complicated...

What if the patient is insured AND you are nonparticipating?

Now you need to determine:

1. Is this a **Michigan-regulated health plan**?
2. Are you a **nonparticipating provider**?
3. Is the patient using their insurance?
4. Is the patient instead electing to self-pay?
5. Which disclosure/GFE requirements apply?

A patient's situation can move them from the **Michigan requirement** into the **federal uninsured/self-pay requirement** depending upon whether the patient intends to use their health coverage.



MAC's Approach: One Combined GFE Template

Michigan + Federal Requirements

The MAC has developed a **Good Faith Estimate template** that merges the applicable Michigan and federal requirements into one form.

Because these rules overlap and the trigger can depend on:

- The patient's insurance status
- Whether the patient is using insurance
- Whether the provider participates with the plan
- State versus federal requirements
- When the appointment was scheduled or estimate requested

MAC recommends using the combined GFE approach rather than trying to determine at every encounter which individual GFE provisions apply.

When in doubt, provide the Good Faith Estimate.

There is little downside to giving the patient advance information about anticipated charges. There can be significant consequences for failing to provide a required disclosure or estimate.



Make the GFE part of your normal financial workflow.

At scheduling/intake (the first point of contact, per the Michigan law):

1. Determine whether the patient has insurance.
2. Determine whether the patient intends to use insurance.
3. Determine whether the office participates with the patient's plan.
4. Verify benefits when insurance will be used.
5. Provide the **GFE**.
6. Obtain required signatures.
7. Retain the documentation.

Don't wait until there is a billing dispute to figure out whether a GFE should have been provided.

Good Faith Estimate & Disclosure Form

Patient Name:	Date of Birth:
---------------	----------------

You are receiving this Good Faith Estimate because one or more of the following may apply:

- You do not have health insurance;
- You have health insurance but do not intend to have a claim submitted to your health plan for these services; or
- Our practice does not participate with your health benefit plan.

If you have health insurance and our practice does not participate with your health benefit plan, the following Michigan-required disclosure applies:

Your health benefit plan may or may not provide coverage for all of the health care services you are scheduled to receive or the providers providing those services. You may be responsible for the costs of the services that are not covered by your health benefit plan.

Your health benefit plan may or may not reimburse a provider for all services provided if the provider is not in your health benefit plan network. **You may be responsible for the costs of the services that are not covered by your health benefit plan.**

A nonparticipating provider must provide a good-faith estimate of the cost of the health care services to be provided. A good-faith estimate does not take into account unforeseen circumstances, which may affect the cost of the health care services provided.

You also have a right to request that the health care services be performed by a provider who participates with your health benefit plan network. You also may contact your carrier to arrange for those services to be provided at what may be a lower cost and to receive information on in-network providers who can perform the health care services that you need.

Estimated Services and Items	Date of Good Faith Estimate		
	Date of 1 st Appointment		
Description (in clear, understandable language)	Service Code (CPT, HCPCS)	Quantity	Expected Cost
Total Expected Charges			\$



Disclaimers:

Important Information About This Good Faith Estimate

This Good Faith Estimate reflects the items and services reasonably expected to be provided based on the information known at the time the estimate was prepared. Actual items, services, or charges may differ from this estimate.

Additional items or services may be recommended as part of your course of care that are not included in this Good Faith Estimate and may need to be scheduled or requested separately.

If the actual billed charges from a provider are at least \$400 more than the expected charges listed for that provider on your Good Faith Estimate, you may be eligible to initiate the federal Patient-Provider Dispute Resolution process. Information about this process is available through the Centers for Medicare & Medicaid Services (CMS). Initiating a dispute will not adversely affect the quality of health care services provided to you.

This Good Faith Estimate is not a contract and does not require you to obtain the items or services listed in this estimate from this provider.

I have received, read, and understand this disclosure.

Patient or Patient's Representative Signature

Date

Type or Print Name of Patient or Patient Representative

Date



A Good Faith Estimate does not replace:

- Insurance eligibility/benefit verification
- Required payer notices or authorizations
- A financial responsibility agreement
- Medicare ABN requirements
- Medicare Advantage organization determination requirements
- Medicaid billing restrictions
- Contractual requirements of participating providers
- Documentation of medical necessity
- Informed consent

COMPLIANT DISCOUNT PLANS

Healthcare Fee
Schedules &
Discount
Compliance

The Core Question

When can a healthcare practice charge less than its established fee schedule without creating compliance problems?

Four Common Pathways

1. Financial hardship
2. Prompt-pay / TOS
3. DMPO discounts
4. Medical / concierge agreements

The Second Layer

Even when a discount is generally permissible, payer participation agreements can impose stricter rules.



Start With the Fee Schedule

Healthcare providers establish their own fee schedules based on professional judgment and business needs.

Variation from that established fee schedule may be viewed as a dual-fee schedule unless it fits within a recognized exception.

The compliance question is not just “Can I offer a discount?” It is “What type of discount is this, and what rules apply?”

1. Identify the discount

Prompt pay, hardship, DMPO, or retainer?

2. Identify the patient

Self-pay, insured, Medicare/Medicaid?

3. Check the contract

Payer rules can be more restrictive.

Four Common Discount Structures

Each has a different rationale and compliance framework.

Prompt-Pay / TOS

A defined discount tied to immediate or timely payment and the collection costs the practice avoids.

Financial Hardship

A documented reduction based on the patient's inability to pay, not the timing of payment.

DMPO

A contractually defined discount for members of a discount medical plan organization.

Retainer / Concierge

A Michigan-specific structure involving fixed fees for access, amenities, or routine services.

Prompt-Pay / Time-of-Service Discounts

The discount should function as a collections tool, not a marketing incentive.

- Typically used for non-covered services.
 - Routine waiver or discounting of insured patient cost-sharing can create payer and fraud-and-abuse concerns.
- OIG Advisory Opinion 08-03 discussed discounts in the **5 – 15% range** where they reflected legitimate savings in collection costs.
- The discount should be fixed, defined in writing, and documented in the practice's compliance policy.
- It should not be negotiated case by case at the front desk.

****OIG:** The Office of Inspector General is an oversight division within government agencies designed to fight fraud, waste, abuse, and mismanagement.*

Prompt-Pay Guardrails

The “why” behind the discount matters.

Cost-justified

Tie the percentage to administrative and collection costs avoided by receiving payment promptly.

Not a marketing hook

Cannot be publicly advertised or used as an inducement to attract patients.

Contract check

Federal OIG guidance does not override private payer participation agreements.

OIG says that providing these discounts is permissible and low-risk under the Anti-Kickback Statute (AKS) only if they are not used as an advertisement to solicit business or induce patients to self-refer.

Financial Hardship Discounts

This is about documented inability to pay, not convenience.

- A formal written policy should define eligibility criteria, income thresholds or hardship standards, discount tiers, and the review cycle.
- Apply the policy uniformly to patients who request and qualify for assistance.
- For insured patients, use an individualized, good-faith determination rather than a blanket waiver of copays or coinsurance.
- Possible documentation includes proof of income, tax information, or a signed hardship attestation.

A Defensible Hardship Process

Consistency and documentation are central.

1

Written policy

Define objective criteria and discount tiers.

2

Patient request

Use a consistent application or attestation process.

3

Individual review

Determine whether the patient meets the policy.

4

Document

Retain supporting information and the eligibility decision.

5

Re-qualify

Reassess periodically, commonly annually.

DMPO Discounts

A Discount Medical Plan Organization is not insurance.

A DMPO contracts with a network of providers to offer members a defined discount off billed charges in exchange for a membership fee.

The DMPO does not pay the claim. The member pays the provider directly and receives the pre-arranged discount.

The provider's discount is established by contract with the DMPO rather than negotiated individually with each patient.

Providers should verify the organization's registration or licensing status where applicable and make sure their own advertising matches the DMPO's member disclosures.

DMPO + Insurance: Keep the Layers Separate

A discount plan should not be used to bypass payer rules.

When insurance covers the service

Apply standard insurance billing and contractual rules first.

Where the DMPO may fit

Use the DMPO discount only where the agreement intends it, such as self-pay, non-covered charges, or permitted remaining out-of-pocket amounts.

The source emphasizes that the DMPO arrangement is contractually defined for a specific member population.

That contractual structure is what distinguishes it from an informal, patient-by-patient dual-fee approach.

Example DMPO: ChiroHealthUSA

- ChiroHealthUSA operates as a Discount Medical Plan Organization (DMPO), not health insurance.
- The provider contracts with the network and agrees to extend the established network discounts to eligible ChiroHealthUSA members. This creates the contractual basis for charging members a discounted rate rather than simply creating an informal second fee schedule.
- The patient purchases a membership. ChiroHealthUSA currently lists the membership as \$49 per year for the patient and legal dependents.
- ChiroHealthUSA does not pay the provider or process a claim. The patient remains responsible for paying the provider at the applicable discounted rate.
- For patients who also have insurance or Medicare, ChiroHealthUSA states that the discount may be used for non-covered services or when benefits are exhausted, subject to the patient's health-plan restrictions. It is not a substitute for insurance.

Why does the DMPO matter?

The practice isn't simply deciding, "I'll charge cash patients less." The discounted fee exists because both the provider and patient participate in a defined discount-plan arrangement.

Michigan Medical Retainer Agreements

A Michigan statutory structure for prepaid, defined health care services

What is it?

A written contract between a health care provider and a patient.

The provider agrees to provide specified routine health care services for an agreed fee and period of time.

Why does it matter?

If the agreement meets [MCL 500.129](#), Michigan does not treat the arrangement as insurance or the business of insurance.

Chiropractic?

The statute applies to a “health care provider” authorized under Michigan's Public Health Code.

That definition is not limited to physicians.



What Could This Look Like in a Chiropractic Office?

Think: defined care + defined price + defined period

Example 1: Defined CMT Agreement

3-month agreement
Up to 12 chiropractic adjustments
Agreed fee: \$600

The agreement identifies the service, quantity, price, and time period.

Example 2: Mixed Services

3-month agreement
Up to 12 CMT visits
Up to 6 therapy visits
1 progress examination
Agreed fee: \$850

Services must be within lawful scope.

Example 3: Maintenance / Wellness

Monthly agreement
Up to 2 chiropractic adjustments per month
Agreed fee: \$100/month

The statute does not require an “unlimited concierge” model.

Note: Fees shown are for illustrative purposes only and are not intended to suggest or recommend what a provider should charge for any service or agreement. Providers are responsible for establishing their own fees.

Michigan Law Gives You a Checklist

To qualify as a Medical Retainer Agreement under MCL 500.129

- Must be in writing and signed by the provider and patient.
- Must allow either party to terminate the agreement with written notice.
- Must describe AND quantify the specific routine health care services included.
- Must state the fee and the period of time covered.
- Must prominently state: “THIS IS NOT HEALTH INSURANCE.”
- Must prohibit BOTH the provider and patient from billing an insurer or other third-party payer for the included services.
- Must state that the patient is responsible for services outside the agreement that are not otherwise covered by insurance.

The Biggest Rule: You Cannot Bill Those Services to Insurance

The agreement creates a separate payment arrangement for the services it covers

Included in the Agreement

The provider cannot bill an insurer or other third-party payer for those services.

The patient also agrees not to submit those services to a third-party payer.

Not Included in the Agreement

Services outside the agreement are handled separately and may be billed normally when otherwise appropriate.

Practical point

Do not mix and match after the fact. The agreement should make it clear which services are included before care is provided.

What If the Patient Has Insurance?

MCL 500.129 is only one layer of the analysis

Cash / Self-Pay Patient

Cleanest application.

The patient enters a defined prepaid arrangement and neither party bills a third-party payer for the included services.

Commercial Insurance

More complicated.

If the provider participates with the patient's plan, check the payer contract before placing otherwise covered services outside the insurance arrangement.

Special Payer Rules

Do not assume the Michigan retainer statute overrides Medicare, Medicare Advantage, Medicaid, auto no-fault, workers' compensation, or other program-specific billing rules.

What If the Patient Doesn't Use All the Visits?

The statute requires termination rights, but it does not provide a refund formula

Early Termination

Either party must be allowed to terminate with written notice.

The agreement should explain how prepaid funds are handled if the patient terminates before the end of the term.

Agreement Expires

Example: the patient purchased access to up to 12 visits over 3 months but used only 8.

MCL 500.129 does not expressly say whether unused services must be refunded at normal expiration.

Office Policy

Define the refund / unused-service methodology in the written agreement and apply it consistently.

Avoid deciding refunds case by case.

Medical Retainer Agreement: Office Implementation

This should be a formal program, not a front-desk discount

- Use a written agreement built around the requirements of MCL 500.129.
- Clearly define which services are included, how many, and for what period.
- Define termination, unused services, and refund methodology before collecting prepayment.
- Keep the arrangement separate from insurance billing for the included services.
- Screen for payer-specific restrictions before offering the arrangement to insured patients.
- Train staff so the program is offered and administered consistently.
- The MAC has a retainer agreement template available for members on our website.

The Payer Contract Is a Second Rulebook

A generally permissible discount can still violate a network agreement.

Contracted rates may define the allowed amount and may also affect how the payer views usual and customary charges.

In-network providers are generally restricted from routinely waiving copays, coinsurance, or deductibles.

Some payer agreements may require notice of prompt-pay, hardship, or concierge programs.

Payer rules can be stricter than federal guidance. The practice must satisfy both layers.

Where Is Fee Flexibility Greatest?

Network status changes the analysis.

IN-NETWORK

Contract terms govern the transaction.

Patient cost-sharing and allowed amounts are generally controlled by the participation agreement.

Discount programs need to be checked against payer-specific restrictions.

SELF-PAY / OUT-OF-NETWORK

There is generally more fee flexibility because no network contract governs the transaction.

State consumer-protection, pricing-transparency, and other applicable laws still matter.

Don't Forget the Value of Your Services!

- A discount may be legally permissible, but that does not mean it should become the default way you price your care.
- Frequent or significant discounting can unintentionally communicate that your regular fee does not reflect the true value of the service.
- Patients may begin to view the discounted price as the “real” price and the regular fee as inflated.
- Consider the value of your time, expertise, clinical decision-making, documentation, staff, overhead, and the care being provided when establishing fees.
- A compliant discount program should have a specific purpose, not simply be used because a patient asks for a lower price.

There is a difference between making care financially accessible and undervaluing the care you provide.

Before You Implement Any Discount Program

Build the compliance structure before offering the discount.

Written Policy

Define the program, eligibility, percentage, and workflow.

Documentation

Record why the discount applies and retain supporting materials.

Consistency

Apply the same criteria to similarly situated patients.

Payer Review

Check participation agreements and payer manuals.

Staff Training

Make sure the front desk and billing team know what they can and cannot offer.

Periodic Review

Revisit the policy as contracts, laws, and guidance change.

Key Takeaways

The discount itself is only one part of the compliance analysis.

Start with one established fee schedule.

Use a recognized, defined discount structure rather than informal price negotiation.

Document the reason, rules, and application of the discount.

Do not assume federal guidance overrides a payer contract.

Be especially cautious when the discount affects insured patient cost-sharing.

Bottom line:

A compliant program is intentional, written, consistent, documented, and checked against payer-specific requirements.