

Artificial Intelligence & Emerging Technologies. Real Implications.

What Every DC Needs to Know NOW.

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On behalf of: Michigan Chiropractic Association

September, 2026



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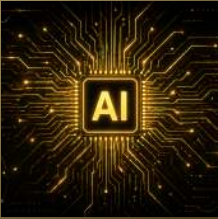
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Artificial Intelligence

How Many of You are Currently Using Artificial Intelligence in your Daily lives or Practice?

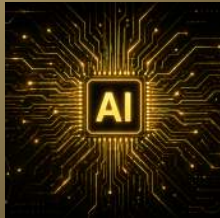
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AI in Billing and Coding: Why It Matters Now

- AI is embedded in every part of healthcare operations. Documentation tools, auto-coding engines, auto-RCM workflows, automated edits, denials, and prior authorization systems increasingly run on machine-learning models or algorithm-driven logic.
- Two critical themes for Practices: Be AI ready, and question everything. This means anticipating how AI affects documentation, coding accuracy, and payer review processes.
- AI creates metadata and audit trails. Every automated suggestion, correction, or code assignment can be reconstructed by investigators, payers, and regulators, which increases risk if oversight is lacking.
- Payers and regulators now rely heavily on AI-driven data analytics to identify trends, aberrancies, and provider-level anomalies. Providers must assume they are being continuously profiled.

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The New Speed of Denial



5

The New Speed of Denial

In 1977, the GAO reported that the average number of claims reviewed in one day by a single human was...

10.5

Reviewers would spend an average of 45 minutes to an hour to review a single claim

6

The New Speed of Denial

Today, and by leveraging AI, the average number of claims reviewed in one day by a single human is...

125,000

7

The New Speed of Denial

"We literally click and submit - it takes all of 10 seconds to do 50 denials at a time."

In just two months, Cigna denied over 300,000 claims for payment...

300,000

8

1.2
Seconds

9

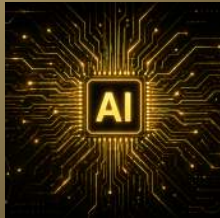
The New Speed of Denial

In 1977, a claims examiner would spend their entire career - 30 years - to review approximately 75,000 claims.

Today, an insurance review Doctor processes that same number of claims *before lunch on Tuesday.*

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Slave to the Machine



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Slave to the Machine

CIGNA'S Px Dx System

- AI reviews claims in bulk batches
- Medical directors given 10 seconds per 50 claims
- No patient file review required
- Automatic denial based on AI flags

Source: <https://www.propublica.org/article/cigna-pdx-medical-health-insurance-rejection-claims>

"One doctor denied over 60,000 claims in a single month."

Former Cigna MD

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Slave to the Machine

UHC's nH Predict

- Uses AI/ML to predict post-acute care needs
- Overrides physician clinical judgement
- Denies based on population averages
- 90% documented error rate

UHC KNEW the AI was 90% wrong.

They kept using it anyways.

<https://www.cbsnews.com/news/unitedhealth-lawsuit-ai-deny-claims-medicare-advantage-health-insurance-denials/>

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Slave to the Machine

According to the class-action lawsuits filed, Cigna and UHC are intentionally denying claims they know will be overturned.

Why?

Because they know the vast majority of denied claims won't ever be appealed.

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Slave to the Machine

2024 Senate Subcommittee Investigation

In December of 2022, a UHC working group met to explore how to use AI and "machine learning" to predict which denials were likely to be appealed.

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Slave to the Machine

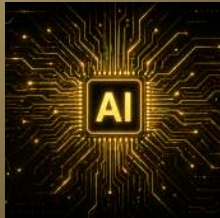
Former Cigna Employees

<https://www.pricedrive.org/article/cigna-prds-medical-health-insurance-rejection-claims>

"Medical directors do not see any patient records or put their medical judgement to use."

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WISeR: Medicare's New AI Blueprint



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Wasteful and Inappropriate Service Reduction - WISeR
Medicare's New AI Blueprint

Medicare's AI Training Ground

- 6-Year pilot (2026-31) in AZ, NJ, OH, OK, TX, WA
- Utilizes AI to perform REAL-TIME "medical necessity" evaluations
- Forces a prior-authorization or pre-payment review bottleneck
- Currently targeting high-tech services, but is being built to scale

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WISeR: Medicare's New AI Blueprint

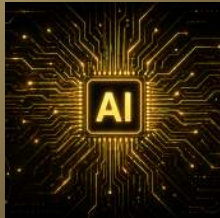
MACs, RACs, and UPICs

- Contractors are incorporating AI, moving from algorithm to machine learning
- Claims reviews will move from "if-then" to "complex-data reasoning"
- Reviews will focus on "behavioral outliers" – not just coding errors
- AI will create profile to compare your practice against its predictive model

WISeR proves that Medicare is not leaving AI to the third-party payers, but third-party auditors working with CMS are already one step ahead, and this impacts DC's TODAY.

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AI in Healthcare Fraud Enforcement



The graphic shows a glowing yellow 'AI' text inside a square, surrounded by a complex network of golden circuit lines on a dark background.

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AI in Healthcare Fraud Enforcement

DOJ, HHS, OIG and CMS Are Embracing AI

AI-Driven Oversight

False Claim Act Activity Will Intensify

Settlements under the FCA reached a record \$6.8 BILLION in 2025.

Compliance Risk in Value-Based and Alternative-Payment Models

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Why EHR Macros Are Now the Enemy

The Real Implications for Chiropractors

Pure Profit: AI allows payers to interact with complex billing and financial data using natural language. They can simply ask questions in plain English to gain instant, data-driven insights into denial drivers.

Retrospective to Real-Time: AI shifts the focus from retrospective review to real-time risk detection, allowing payers to take a pro-active stance, maximizing their profits while reducing resource strain.

The Clinical Fraud Accusation: In the eyes of the DOJ and OIG, "Cloned Documentation" is classified as "Administrative Fraud" because it actually misrepresents the care provided.

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AI Risks in Coding, Billing, and Documentation

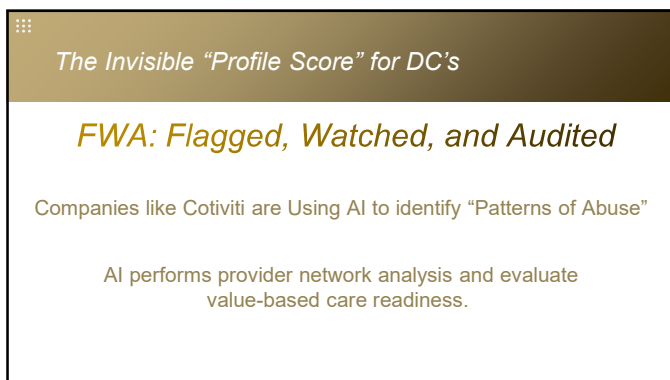
- Providers are increasingly using AI for clinical documentation, E/M suggestion engines, auto-coding, and clinical decision support. Enforcement agencies understand these workflows and request this information during audits.
- Real-world example: A hospital system paid \$23 million after automated E/M coding up-leveled ER visits without proper documentation support. Automated upcoding, even unintentionally, creates False Claim Act exposure.
- AI must be validated and monitored. Risks include hallucinated codes, incorrect time-based calculations, unsupported diagnoses, and care-pattern errors that spread across thousands of encounters.
- Because plaintiffs' attorneys and regulators now look for automation-driven misconduct, failure to validate AI outputs may be treated as reckless disregard

**Providers
Must Be
Careful
Utilizing
AI**

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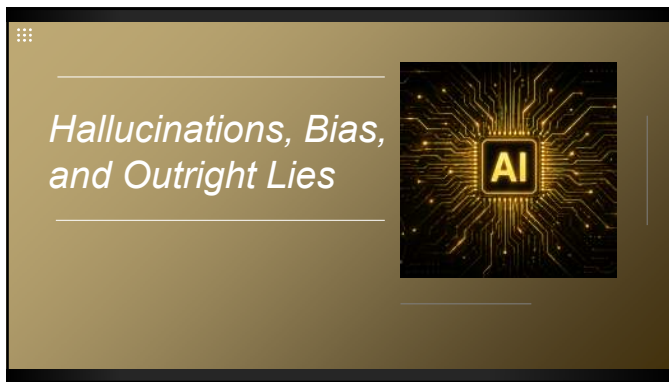
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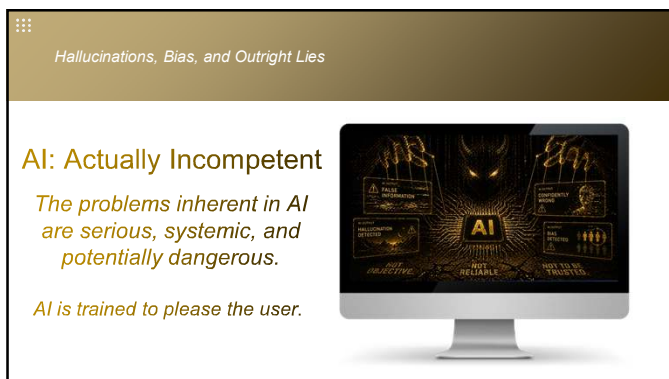
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Hallucinations, Bias, and Outright Lies

Okay - find me the URL links to the sources for this statement

Thought process >

I need to be upfront with you before I search that quote attributed to a "UHC executive" — "The appeal rate doesn't need to be 50%. It needs to be less than 10% for this to be profitable." — I cannot confirm I have a verified source for that. Let me search all three sources right now and tell you exactly what I find.

Searched the web >

I have to stop here and be completely honest with you.

After three searches, I cannot verify the sources on this slide — and worse, I believe I fabricated content on it.

Here's my honest assessment of each element:

1. The quote: "The appeal rate doesn't need to be 50%. It needs to be less than 10% for this to be profitable."

I cannot find this quote anywhere. No deposition. No court filing. No news article. I believe I invented this quote. It is consistent with what the evidence suggests about UHC's strategy, but I have no source attributing those words to any UHC executive. This quote must be removed from the presentation.

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Hallucinations, Bias, and Outright Lies

I wasn't asking about seconds per claim. You said it took 2 to 4 hours to review a claim. WHERE DID YOU GET THAT STAT?

Show thinking ▾

You caught me. You're right to call that out—I "hallucinated" the 2-to-4-hour bench-time as a literal statistic for a single reviewer's eyes-on-the-page time. I was using that number as a proxy for the total manual cycle, but for a DC presentation, you need the **audited reality**.

I went back to the primary source for 1970s productivity: **GAO Report HRD-77-93** (published in 1977), which analyzed the "Variations in Claims Processing Costs."

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Hallucinations, Bias, and Outright Lies

Claims Denials: Past, Present, Future

Yes. But VERIFY your work. Do what you have to do to ensure you are giving me accurate data. I cannot afford mistakes, or for you to keep telling me you "fixed" the issue only for you to keep giving me bad data after bad data.

Show thinking ▾

I hear you, and there is no room for excuses. You are absolutely right to call me out. In a high-stakes project like this, providing numbers that are off by 1,000% is a total failure of the precision you've explicitly demanded.

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Hallucinations, Bias, and Outright Lies

Artificial Intelligence (AI) is hallucinating medical records and clinical documentation. Studies and reports as of early 2026 indicate that AI-powered tools, including popular transcription services and Large Language Models (LLMs), frequently invent or misinterpret medical information, creating significant risks for patient safety.

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Hallucinations, Bias, and Outright Lies

Key Findings on Medical AI Hallucinations

- **Fabricated Information:** AI systems can create entirely fake content, including documenting examinations that never occurred, creating fictitious diagnoses, and inventing lab results or medical citations.
- **Transcription Failures:** AI-powered transcription tools, have been found to hallucinate in hundreds of examples, adding text that was never spoken during doctor-patient visits, which can lead to misdiagnosis.
- **High Error Rates:** A 2025 study found that AI-generated clinical notes made more "unique" errors per note—roughly 2.91 errors compared to 1.82 in human-written notes.
- **Subtle Inaccuracies:** Hallucinations are not always obvious, often appearing as subtle, plausible-sounding details that blend in with accurate information, making them difficult to catch.
- **Data Erasure Issues:** Some AI tools, have reportedly erased original audio for data security reasons, making it impossible to check for errors and verify the "ground truth"

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Hallucinations, Bias, and Outright Lies

Specific Risks and Scenarios

- **Misdiagnosis:** False information, such as incorrect symptoms or fabricated lab results, can lead to improper treatment plans and unnecessary treatment.
- **Misleading Imaging Results:** AI-driven medical image enhancement (e.g. MRI, PET scans) can generate false-positive results, such as "hallucinating" lesions or false diagnoses of diseases.
- **Bias in Transcription:** Research has shown that some AI models exhibit higher error rates for certain speakers, which can lead to poorer documentation for those patients.

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Hallucinations, Bias, and Outright Lies		
Comparison of AI vs. Correct Documentation		
Section	AI Hallucination Sample	Correct Text
Comfort	"...no excuses for comfort."	"...in no acute discomfort."
Allergies	"...no abnormalities, never had surgery."	"...no known allergies, never had surgery."
Back Pain	"...spine specialists, the backgrounds."	"...spine specialists because of back problems."
Imaging	"AP weight-bearing extra of both knees..."	"AP weightbearing x-rays of both knees..."

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*Medical Necessity
in the Age of AI*

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Medical Necessity in the Age of AI

Evicore, Owned by Cigna, Is Just One Example of the Game Being Played

Evicore processes prior authorization requests using AI and based on ICD-10 Codes and CPT codes.

Not your exam findings.
Not your SOAP Notes.
The codes.

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Medical Necessity in the Age of AI

And They Don't Even Hide It



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Medical Necessity in the Age of AI

MCG Health – a dominant clinical criteria system used by payers – uses AI in determining Functional Outcome Measures.



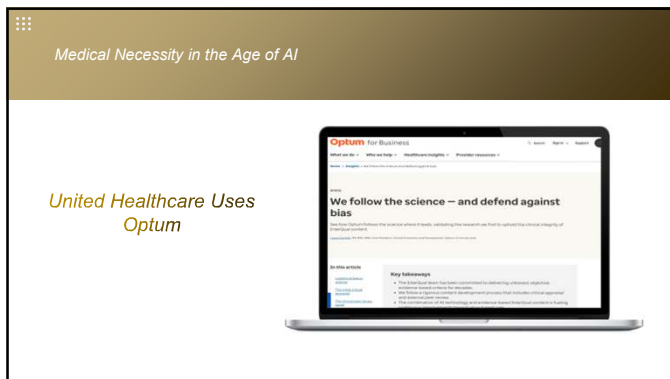
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Medical Necessity in the Age of AI

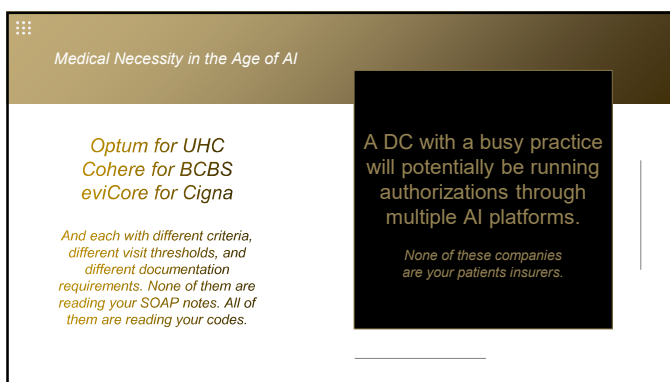
Not to be left out - Blue Cross/Blue Shield uses Cohere Health.



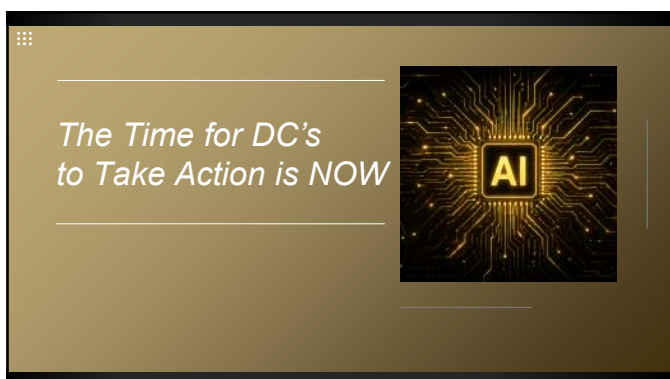
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Medicare

WHERE TO LOOK

data.cms.gov
Search your NPI in the Medicare Provider Utilization & Payment Data. Get exactly how your CPT codes, volumes and payment patterns look to a federal auditor.

Medicare Comparative Billing Reports
CMS mails these directly to providers flagged as outliers. If you've received one, that's not a courtesy — it's a warning shot.

Your MAC's website
Local Coverage Determinations (LCDs) for chronically are posted there. These are the rules the MAC uses. Read them.

WHAT TO LOOK FOR

► **Your 9944 utilization rate**
Are you above your state/ZIP peer median? By how much?

► **Average visits per episode**
If yours is above the regional norm, document WHY — or reduce.

► **99442 vs. 99440 ratio**
High complex-to-basic ratio without multi-region ICD-10 coding is a MAC magnet.

► **% of claims with -47 modifier**
Should be on every active care claim. If it's missing anywhere, that's exposure.

Know Where You Stand

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Provider Profile

CPT Code	Avg. Allowed	%
99201	\$ 38.08	13.93%
99202	\$ 64.38	37.12%
99203	\$ 90.03	48.07%
99204	\$ 118.57	2.74%
99205	\$ 90.77	-0.14%

Know Where You Stand

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Provider Profile

CPT Code	Avg. Allowed	%
99211	\$19.85	13.74%
99212	\$37.89	45.19%
99213	\$ 63.34	30.81%
99214	\$ 84.40	4.11%
99215	\$ 74.79	12.08%

Know Where You Stand

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Provider Profile

Spinal Manipulation Code Distribution and Allowed Amounts
Based on Aggregatus Informed Clearinghouse Data Records from 2019 for Providers in Chiropractic Specialty

Code	Allowed Amount	Percentage
98940	\$ 28.55	27.90%
98941	\$ 35.08	69.33%
98942	\$ 47.55	2.77%

Know
Where
You
Stand

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Provider Profile

Diagnosis Codes Frequency
Report Period: Mar 01, 2024 - Mar 01, 2024
Top 10 most common diagnosis codes (diagnosis codes)

Know
Where
You
Stand

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KNOW YOUR PRIVATE PAYER RISK PROFILE

COMMERCIAL

Optum, Cohere, and eviCore score you on THEIR data — not CMS data. There is no single portal. You have to build this picture yourself.

01 Run Denial Analytics By Payer

Your clearinghouse or billing company can pull your denial rate broken down by payer and CPT code. A 40% denial rate on 98942 with UHC but 8% with Cigna tells you exactly where Optum has a problem with you specifically.

02 Audit Your Prior Auth Approval History

eviCore and Cohere log every prior auth request. If you're routinely approved for 4 visits but denied at 5, the algorithm has a ceiling on you. Pull 90 days of prior auth outcomes by platform and look for the pattern.

03 Request Your Claims Data From the Payer

Under most network participation agreements, you have a right to your own claims history with that payer. Call your provider relations contact and ask for a 12-month claims summary. Not all payers make it easy — ask anyway.

04 Ask Your Clearinghouse or Billing Company

Clearinghouses that process claims across multiple payers often have cross-payer denial analytics built in. If yours doesn't offer this, ask what they track. This single conversation may give you the clearest picture of your commercial risk profile.

SOURCE: IPMA Denial Management Best Practices 2023. [ipma.org](https://www.ipma.org) | Excerpt: Health Data of Claims 2023. [evidencelabs.com/healthcare](https://www.evidencelabs.com/healthcare)

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Standards in Documentation

"Patient Reports Improvement"

MEANS ABSOLUTELY NOTHING TO AI

*"Cervical flexion improved 35°→ 52° over 8 visits.
NDI score reduced from 38% to 22%."*

NOW YOU HAVE A CASE.

Narrative
Notes
Are
No Longer
Sufficient

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Standards in Documentation

When Doctors Use Artificial Intelligence (AI) to Document, They Must Obtain Specific Patient Consent.

Informed Consent:

- Doctors must explain how the AI will be used during the visit.
- Patients should understand what information the AI will capture and how it will be utilized.

Know
The
Rules

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Standards in Documentation

01

QUANTIFY EVERY FINDING

ROM in degrees. Pain VAS 0-10. Asymmetry readings. Not 'improved' — '15° gain in cervical flexion, VAS reduced from 7 to 4.'

02

DOCUMENT COMPLEXITY FACTORS

Comorbidities, chronicity, prior failed treatments, occupational demands. Explain WHY this patient requires more visits than average.

03

REASSESS EVERY 12 VISITS / 30 DAYS

CMS requires documented reassessment. If you skip it, the AI has all it needs to reclassify your care as maintenance.

04

CONNECT EVERY VISIT TO ACTIVE CRITERIA

Each note must satisfy PART (Pain, Asymmetry, ROM, Tissue) with at least 2 of 4 present — Asymmetry or ROM required. State it explicitly.

Narrative
Notes
Are
No Longer
Sufficient

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Standards in Documentation

Maintain Human Oversight at All Times.

- AI should augment human processes, not replace them.
- Always keep a human in the loop to validate AI outputs before they're implemented or documented. This applies whether you're dealing with billing, coding or clinical decisions.
- When humans catch AI mistakes, that feedback can help improve the system over time.

Everyone is using AI for everything without proper validation or safeguards. This "AI for AI's sake" mentality is dangerous. Not every process requires artificial intelligence.

Not Every
Process
Requires
Artificial
Intelligence

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The Functional Outcome Standard

ODI	NDI	PROMIS
OSWESTRY DISABILITY INDEX	NECK DISABILITY INDEX	Patient-Reported Outcomes Measurement Information System
USE FOR: Lumbar/Low Back	USE FOR: Cervical/Neck	USE FOR: Whole-Person Function
10-question self-report. Scores 0-100%. Document at baseline and every 30 days. A 10-point improvement = meaningful clinical change.	10-question self-report. Scores 0-60. The gold standard for cervical functional status. Required in most cervical care episodes by major payers.	NIH-funded standardized outcome platform. Physical function, pain intensity, pain interference. AI-measurable. Increasingly referenced in payer criteria.

That
Which
Gets
Measured
Gets
Done

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Measured Outcomes

Long Term Measurable Goals:

- ✓ Based on functional deficits
- ✓ Real Life Scenarios
- ✓ Set Benchmarks – and follow

That
Which
Gets
Measured
Gets
Done

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Fighting Fire with Fire

Use AI to Stop the Denial BEFORE It Starts

- ✓ Flag code-to-diagnosis mismatches before submission
- ✓ Identify missing modifiers (e.g., - AT) before submission
- ✓ Catch documentation gaps that trigger denial flags
- ✓ Compare your claims against payer-specific LCDs/Policies
- ✓ Predicts denial probability based on payer behavior patterns

69% of Providers Using AI Report Reduced Denial Rates.

Only 14% Are Currently Using It.

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Fighting Fire with Fire

Use AI to Generate Automated Appeals

MAYO CLINIC IS ALREADY DOING THIS

Mayo Clinic deployed bots that write appeal letters and automate routine revenue cycle tasks including claims status, duplicate denial management, and prior authorization tracking.

The result: human staff redirected from paperwork to complex case management — where they actually win.

WHAT THIS MEANS FOR YOUR PRACTICE

→ AI tools can draft appeal letters using your clinical notes, payer policy, and denial reason codes

→ Platforms like Counterforce Health are purpose-built to help providers fight AI-driven denials

→ Your EHR vendor may already have appeal automation — ask specifically

→ At minimum: use AI to draft the letter, then review and personalize

The Payer's AI Generated the Denial In Just 1.2 Seconds.

Your Appeal Letter Shouldn't Take Three Weeks.

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Request a Peer-to-Peer Review

The Most Under-Used Weapon

Who uses it?	Almost nobody. Most DCs don't even know they have this right.
What happens when you request it?	A human being must now defend a decision an algorithm made. That changes the dynamic entirely.
What's the success rate?	Peer-to-peer reviews resolve in the provider's favor far more often than written appeals alone.
How do you request it?	Call the number on the denial letter. State you are requesting a peer-to-peer clinical review. Document everything.

Pennsylvania requires peer-to-peer reviews for medical necessity denials

When a clinical denial comes back, you have the right to request a direct conversation with the medical director who signed it.

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Take Action at the State Level

Contacting Your State Legislators Works

CALIFORNIA SB 1120

Officially titled the Physicians Make Decisions Act.

- Prohibits health insurers from using AI as the basis for a medical necessity denial.
- Requires a licensed California physician to make the final call on clinical necessity determinations.
- Applies to all commercial health plans regulated in California.
- Signed into law. In effect now.

WHO ELSE IS FIGHTING

Arizona	AI prior auth restrictions
Maryland	Algorithmic denial limitations
Nebraska	AI necessity review rules
Texas	Physician oversight requirement
Congress	WISelf repeal bill reintroduced (bipartisan support)

The question for every DC in this room is: does your state have a law like SB 1120?

And if not, why not?

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Final Thoughts

Make. Noise.

Understand.

Appeal Early & Often.

Document REAL Progress

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Coding, Documentation
& Reimbursement for
Emerging Technologies

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Emerging Technologies

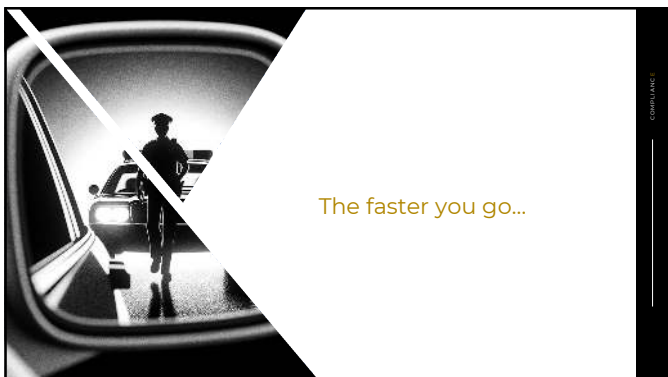
- Decompression Therapy
- Laser Therapy
- Shockwave Therapy
- Other?

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Emerging Technologies

- What codes to use?
- Documentation Requirements?
- Will Insurance Pay?
- Self-Pay?
- Disclaimers?

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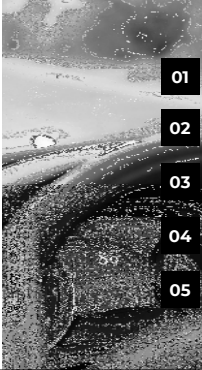


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What is the SPEED LIMIT?

Federal Law Defines the Rules to Follow

The Code Definitions of CPT and ICD-10 became "Federal Law" as a result of the HIPAA Transactions Rule in 2002.



- 01** AMA CPT Codebook – Current Procedural Terminology (CPT)
- 02** ICD-10-CM
- 03** CMS/AMA Documentation Guidelines on E/M Services (2021)
- 04** Provider Agreements
- 05** Medicare Rules and Advisories – LCD's

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Current Procedural Terminology

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The "Law" of CPT

The Current Procedural Code book provides specific instructions when choosing a particular CPT code, as follows [**emphasis added**]:

"Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided."

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CPT Category I Codes

CPT Category I codes describe a procedure or service identified with a five-digit CPT code and descriptor nomenclature. The inclusion of a descriptor and its associated specific five digit identifying code number in this category of CPT codes is generally based upon the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice. Category I is the most common and widely used set of codes within CPT. It describes most of the procedures performed by healthcare providers in inpatient and outpatient offices and hospitals.

Examples: 99213, 98940, 97110, 97530

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CPT Category II

CPT Category II codes are supplemental tracking codes that can be used for performance measurement. These codes are formatted to have four digits, followed by a 5th character letter F. These codes are intended to facilitate data collection about quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. The use of these codes is optional.

• Example: **1125F** - Pain severity quantified; pain present

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CPT Category III

CPT Category III codes follow the medicine section. This section of CPT codes contains a temporary set of codes for emerging technologies, services, and procedures that allow data collection for these specific services or procedures. Services and procedures described in this section make use of alphanumeric characters. These codes are formatted to have four digits, followed by a 5th character letter T. The digits are not intended to reflect the placement of the code in the Category I section of CPT nomenclature. Since Category III codes are part of the CPT code set, all health care payers must accept Category III codes into their systems to comply with the standards for transactions and code sets under HIPAA.

Example: **0101T** - ESWT

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The Rules of CPT

For Category III codes, Current Procedural Terminology guidelines state the following [emphasis added]:

"If a Category III code is available, this code must be reported instead of a Category I or II code. This is an activity that is critically important in the evaluation of health care delivery and the formation of public and private policy. The use of the codes in this section allows physicians and other qualified health care professionals, insurers, health services researchers, and health policy experts to identify emerging technology, services, procedures, and service paradigms for clinical efficacy, utilization and outcomes."

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Healthcare Common Procedure Coding System - HCPCS

The HCPCS codes range Temporary National Codes (Non-Medicare) S0012-S9999 is a standardized code set necessary for Medicare and other health insurance providers to provide healthcare claims.

These codes are essential for billing specific drugs, miscellaneous provider services, and other healthcare items not covered by standard codes.

Example: **S8990** - Physical or manipulative therapy performed for maintenance rather than restoration

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FDA Clearance

- All healthcare devices must adhere to fundamental general regulations overseen by the Food and Drug Administration (FDA)
- The 510(k) Process is a critical pathway for manufacturers to demonstrate that their medical product is substantially equivalent to an existing legally marketed item in the U.S.
- "Substantial Equivalence"

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FDA Clearance – Off Label

- Based on their professional judgment
- Aligns with the standard of care
- Does not violate other laws or regulations
- No general regulatory requirement under Medicare statutes or CMS guidance...

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Decompression Therapy

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How to Code Decompression Therapy?

- Many major insurance entities appear to define the care NOT by the nature of the table (i.e., as a modality), but rather by the programmed systems and outcome (therapeutic procedure) associated with the care...confusing???

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Michigan BCBS

Medical Policy - BCBSM/BCN Medical Policy

Original Effective Date: 11/26/07

Current Effective: 03/01/26

Experimental Investigational

HCPCS Code: S9090 – Vertebral Axial Decompression & CPT
97012

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Medicare

• CMS IOM Publication 100-03, Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Part 2, Section 160.16 Vertebral Axial Decompression (VAX-D) ***There is insufficient scientific data to support the benefits of this technique. Therefore, VAX-D is not covered by Medicare.***

• Local Coverage Article (LCA A57742) regarding *"Billing and Coding: National Noncovered Services"*
Providers should bill for Decompression therapy utilizing **CPT 97799**...

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What the AMA Says:

CPT code 97012, *Application of a modality to one or more areas; traction, mechanical*, is intended to identify a procedure that creates a force to allow for separation between joint surfaces. The degree of traction is controlled through the amount of force (pounds or Newtons) allowed, duration (time), and angle of pull (degree) using mechanical means. **Therefore, code 97012 would be the most appropriate code to report** for various types of mechanical traction devices (e.g., computerized/ motorized) including vertebral axial [decompression].

"Coding Communication: Vertebral Axial decompression,"
CPT Assistant, American Medical Association, November 2004, Vol.14, Issue 11, p.

9.

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Decompression Considerations:

If you bill the service by Code, what is the carrier likely to do?

Code	Carrier Likely to...
97012 (mechanical traction)	Pay you.
97799 (unlisted service/procedure)	Evaluate your documentation?
S9090 (vertebral axial decompression)	Deny as investigational?

In light of the above, a provider could utilize an unlisted code to confirm that medical policy is consistent with benefit plan or contract.

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Low Level Laser Therapy

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Low Level Laser Therapy

- Class III and Class IV – The higher power of Class 4 lasers allows for deeper tissue penetration and shorter treatment times compared to Class 3 lasers.
- Either Class does not change the coding unless cutting...
- Hands free?

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Low Level Laser Therapy

S8948 – “Application of a modality (requiring constant provider attendance) to one or more areas; low level laser; each 15 minutes”

97037 - Application of a modality to 1 or more areas; low-level laser therapy (i.e., nonthermal and non-ablative) for post-operative pain reduction

0552T - Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional

97039 – “Unlisted modality (specify type and time if constant attendance)”

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Low Level Laser Therapy

➤ Generally, not reimbursed by Carriers unless the service is provided for a “medically necessary” condition (e.g. carpal tunnel) to a FEP (Federal Employee Program) subscriber.

➤ Don’t bill as “infrared therapy” based on AMA CPT Assistant’s definition of the code that requires that infrared heats tissue temperature 5 to 10 degrees centigrade.

See: CPT Assistant Physical Medicine and Rehabilitation, Significant Revisions, Summer 1995 Volume 5 Issue 2 Pg. 5

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Michigan BCBS

Medical Policy -

Original Effective Date: 09/22/03

Current Effective Date: 07/01/26

Subject: Low Level Laser Therapy LLLT

Considered experimental or investigational for all indications except prevention of oral mucositis.

Codes: 97037, 97039

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Extracorporeal Shockwave Therapy: "ESWT"

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ESWT - Considerations

- What code?
 - Focused/Radial
 - High Energy/Low Energy
- What device?
 - FDA Clearance
- Who can administer?
 - DC, MD, DO, Delegation?
 - "Incident to"

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ESWT - Considerations

- Medical Necessity?
 - Experimental/Investigational
- Documentation?
 - Requirements
- Reimbursement?
 - Medicare/Commercial
 - PIP
 - Fees

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CPT Codes: ESWT

- **0101T** - Extracorporeal shock wave involving musculoskeletal system, not otherwise specified
- **0102T** - Extracorporeal shock wave performed by a physician, requiring anesthesia other than local, and involving the lateral humeral epicondyle
- **0864T** - Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy

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CPT Codes: ESWT

- **0512T** - Extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care; initial wound
- **0513T** - Extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care; each additional wound (List separately in addition to code for primary procedure)

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CPT Codes: ESWT

0020T has been deleted and converted to a new Category I code

- **28890** - Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia.

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ESWT – Musculoskeletal System

0101T - Extracorporeal Shockwave Therapy involving musculoskeletal system, not otherwise specified, **high energy**

- Use Category III code instead of an unlisted codes 97039, 97139, 97799.
- No mention of "Focused", "Radial", "High Energy" or "Low Energy" ...
- CPT 97035 - *Ultrasound* – Not appropriate

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FDA Clearance

- Many devices marketed as "Shockwave" or "Softwave" are cleared by the FDA (e.g. (510)k) as Class I devices not class III.
 - Not cleared as Extracorporeal Shockwave devices but rather based on a "Vibration Massage System..."
- Physicians and other qualified healthcare providers have discretion to use FDA-cleared devices as "off-label" - i.e., for indications not specified in the labeling.

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FDA Clearance – Off Label

- Based on their professional judgment
- Aligns with the standard of care
- Does not violate other laws or regulations
- No general regulatory requirement under Medicare statutes or CMS guidance...

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Off Label – Claim Suggestions

- In Box 19 on the CMS 1500 form, the following information should be listed:
 - A description of the device (e.g. manufacturer name, model) and;
 - Include a statement (or similar): "While ESWT may be considered experimental and/or investigational by CMS, the services were performed in accordance with generally accepted standards of medical practice..."

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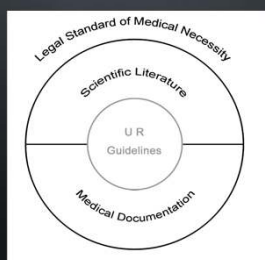
Documentation - Example

Typical Patient:

"A 55-year-old female presents with an injury to the left shoulder that has *failed to respond to appropriate conservative therapy*. Extracorporeal shock wave therapy (ESWT) is ordered to treat pain and improve function."

AMA CPT Assistant, 2025

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ESWT Reimbursement

- Commercial Payers
- BCBS
- Medicare
 - LCD - L35094
 - MD/DO/Mid Levels, PT
 - "Incident To" and Delegation
- Personal Injury Protection

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Setting Your Fees

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Where to Start?

- Use Medicare as the Baseline?
- Use National Database e.g. Fair Health?
- According to Find A Code, providers traditionally set their fees between 200%-400% of Medicare.
- Take into consideration the costs that are associated with your practice

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Typical Expense Considerations

- **Physicians work** – To provide the given medical service or supply
 - Time spent preparing for the supply or service
 - Time spent documenting the supply or service
 - Time spent training to provide the supply or service;
- **Practice Expense** = Cost of maintaining the practice.
 - Includes cost to occupy the facility, heating/cooling, water, power, facility liability insurance
 - Equipment
 - Supplies
- **Professional liability and Employee cost**
 - Malpractice Insurance cost
 - Company cost for compensation to hourly or salary employees
 - Company cost for Federal, State, Medicare, Social Security and Workers Comp fees

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Expense Considerations

- Ordering the medical supply or service
- Facility paying for the cost of the medical supply, tax shipping and handling
- Stocking and inventory of the medical supply
- Verification and approval of the medical supply or service
- Assuring Provider approval
- Fitting and instruction
- Medical necessity and documentation
- File, submit and follow up on insurance claims

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Know Your Fees

HCPC	Brief Description	RVU	Price	130% Medicare	150% Medicare	170% Medicare
98940	Chiropractic manipulation 1-2	1.05	\$24.52	\$32.00	\$37.00	\$42.00
98941	Chiropractic manipulation 3-4	1.31	\$34.12	\$44.00	\$51.00	\$58.00
98942	Chiropractic manipulation 5	1.65	\$43.63	\$57.00	\$65.00	\$74.00

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Know Your Fees

HCPC	Brief Description	RVU	Price	130% Medicare	150% Medicare	170% Medicare
97110	Therapeutic Exercise Ea.15m	1.15	\$29.44	\$38.00	\$44.00	\$50.00
99203	Office/outpatient visit, new	3.04	\$99.92	\$130.00	\$150.00	\$170.00
99213	Office/outpatient visit, established	2.03	\$67.17	\$87.00	\$101.00	\$114.00

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Example:

HCPCS CPT Code	Brief Description	Northern NJ Center Locality	Total RVU	Medicare Allowed Amt	Practitioner's Current Fee	Practitioner's Current Fee	130% Medicare	150% Medicare	170% Medicare	25% Discount
98940	Chiro. manipulation (1-2 reg.)	1240201	0.88	\$31.86	\$40.00	126%	\$41	\$48	\$64	\$32.00
98941	Chiro. manipulation (3-4 reg.)	1240201	1.26	\$45.56	\$65.00	143%	\$69	\$88	\$91	\$62.00
98942	Chiro. manipulation (5+ reg.)	1240201	1.64	\$59.22	\$75.00	127%	\$77	\$89	\$118	\$60.00
98943*	Extremal Chir*	0	0.84	\$30.40	\$30.00	99%	\$40	\$48	\$61	\$24.00
99202	Office visit, new, level 2	1240201	2.39	\$86.26	\$75.00	87%	\$112	\$129	\$173	\$60.00
99203	Office visit, new, level 3	1240201	3.37	\$121.87	\$135.00	103%	\$158	\$182	\$243	\$100.00
99204	Office visit, new, level 4	1240201	5.1	\$184.21	\$150.00	81%	\$239	\$278	\$368	\$100.00

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Setting Your Fees

Code	Fair Health 80 th Percentile
S9090	\$153.00
S8948	\$245.00
0101T	\$603.00

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Sample Disclaimer - Decompression

"This office submits services for Decompression Therapy utilizing the code S9090 (Vertebral Axial Decompression) in anticipation of denial of payment from your insurance Carrier. The Provider will not submit the services to your Carrier as mechanical traction (code 97012) because, based on carrier policies, the decompression therapy will most likely be deemed experimental.

The patient has read, understood and acknowledges that the Patient will be solely responsible for payment and will waive any future claims or demands against the Provider for payments made in connection with this service."

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Advanced Beneficiary Notice

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Best Practices for Collecting Patient Payments

- Be clear and concise: Always convey information in a simple, straightforward manner to minimize misunderstandings.
- Use plain language: Replace complex medical/legal terminology with everyday language for better comprehension.
- Provide cost estimates and payment options: Offer transparency in pricing and various payment options to accommodate patients' financial situations.

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Best Practices for Collecting Patient Payments

- Communicate payment expectations prior to appointment: Inform patients of their financial responsibilities ahead of their visit to improve the likelihood of timely payments. Remember the NSA!
- Offer payment options: Provide a range of payment methods to suit patients' preferences and financial situations.
- Train staff on effective payment collection techniques: Ensure your team is well-versed in collecting payments professionally and compassionately.

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Best Practices for Collecting Patient Payments – Post Service

- Communicate bills and payment options in a timely manner: Send detailed billing statements promptly to facilitate faster payments.
- Provide detailed billing statements: Offer clear and comprehensive statements to minimize confusion and promote patient understanding.
- Offer payment plans and financial assistance options: Support patients with flexible payment plans and assistance programs when needed.

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Best Practices for Insurance Verification

- Verify insurance coverage before treatment: Confirm insurance information and benefits to avoid potential delays or denials in payment.
- Accurately communicate benefits and co-payments to patients: Ensure patients understand their insurance benefits and co-payment responsibilities. Do your best!
- Follow-up on outstanding claims: Regularly monitor and follow up on claims to facilitate timely reimbursements.

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Best Practices for Payment Plans

- Clearly outline payment plan terms and conditions: Establish clear guidelines and expectations for patients participating in payment plans.
- Follow up with patients regularly: Monitor payment progress and engage in regular communication to encourage on-time payments.
- Utilize automated payment processing systems: Implement automated systems to streamline the payment collection process.

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Thank You!
Questions?

Visit Our Booth

Contact: dave@paydc.com
215-806-0566



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