

Back To Chiropractic CE Seminars

Billing & Coding ~ 4 Hours

Welcome to Back To Chiropractic Online CE exams:

This course counts toward your California Board of Chiropractic Examiners CE. (also accepted in other states, check our website or with your Chiropractic State Board)

The California Board requires that you complete all of your CE hours BEFORE the end of your Birthday month. We recommend that you send your chiropractic license renewal form and fee in early to avoid any issues.

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Exam Process: Please read all instructions before starting!

1. You must register/pay first. If you haven't, please return to: backtochiropractic.net
2. Open a new window or a new internet tab & drag it so it's side-by-side next to this page.
3. On the new window or new tab you just opened, go to: backtochiropractic.net website.
4. Go directly to the Online section. DON'T register again.
5. Click on the Exam for the course you want to take. No passwords needed.
6. Follow the Exam instructions.
7. Upon passing the exam you'll be able to immediately download your certificate, and it'll also be emailed to you. If you don't pass, you can repeat the exam at no charge.

Please retain the certificate for 4 years.

If you get audited and lose your records, I'll have a copy.

I'm always a phone call away... 707.972.0047 or email: marcusstrutzdc@gmail.com

Marcus Strutz, DC
Back To Chiropractic CE Seminars

Disclaimer

Please be advised everything contained within this PowerPoint and/or within this lecture is not intended to be legal advice, counseling or an advisement for anything other than informative continuing education purposes. The examples contained herein are for the comprehension of insurance and billing concepts.

The Board of Chiropractic Examiners allows a maximum of 12 hours of CE to be completed in one day.

Please do not take Online CE during this live seminar as the Board will not give you credit.

Why SB 623 Matters to Chiropractors

The New Reality

- SB 623 changes how medical bills may be valued in certain personal injury cases.
- Chiropractic providers treating rideshare accident patients may see changes in:
 - Billing practices
 - Medical liens
 - Documentation expectations
 - Relationships with attorneys and insurers
- Understanding the law can help practices adapt while continuing to provide quality patient care.

The Purpose of SB 623

Legislative Goals

SB 623 was enacted to:

- Increase transparency in accident-related medical billing
- Reduce inflated medical charges
- Establish standards for determining reasonable medical expenses
- Strengthen protections for rideshare passengers
- Encourage fair settlements based on documented treatment

What Has Changed?

Medical Billing

The legislation introduces new standards that may affect:

- Medical lien recoveries
- Valuation of accident-related treatment
- Reimbursement calculations
- Documentation supporting medical necessity

For chiropractors, complete and accurate clinical records become even more important.

Documentation Is More Important Than Ever Clinical Records Should Clearly Show

- Mechanism of injury
- Initial examination findings
- Objective orthopedic and neurological findings
- Functional limitations
- Diagnosis
- Treatment plan
- Patient progress
- Re-evaluations
- Medical necessity for continued care

Key Message:

Good documentation supports both patient care and reimbursement.

Medical Necessity

Demonstrate Why Care Is Needed

Include documentation showing:

- Objective findings
- Functional improvement
- Pain reduction
- Changes in activities of daily living
- Ongoing clinical justification for treatment

Avoid relying solely on subjective pain complaints.

Impact on Medical Liens

Practices Using Liens Should Review

- Lien agreements
- Billing policies
- Charge structures
- Attorney communication
- Record requests
- Financial policies

SB 623 may change how lien-based charges are evaluated during claims.

Best Practices for Chiropractic Offices

Protect Your Practice

- ✓ Perform thorough examinations
- ✓ Document every visit completely
- ✓ Re-evaluate patients regularly
- ✓ Use evidence-based treatment plans
- ✓ Maintain clear financial policies
- ✓ Respond promptly to attorney and insurer record requests

Working with Personal Injury Attorneys Collaboration Is Essential

Successful cases depend on:

- Timely documentation
- Clear narratives
- Accurate billing
- Prompt communication
- Consistent treatment records

Strong documentation benefits patients regardless of the legal outcome.

Risk Management

Reduce Compliance Risks

Review:

- Documentation procedures
- Coding accuracy
- Billing compliance
- Record retention
- Staff training
- Consent and financial forms

Periodic internal audits can help identify opportunities for improvement.

2022 Federal No Surprises Act

Surprise medical bills arise when insured consumers inadvertently receive care from out-of-network hospitals, doctors, or other providers they did not choose.

This can be waived by the patient in non-emergency situations.

Good Faith Estimate Requirements Under the No Surprises Act for Chiropractic Practices

The federal No Surprises Act (“NSA”) primarily affects chiropractic practices through the Good Faith Estimate (“GFE”) requirements applicable to self-pay and uninsured patients, rather than through the traditional emergency-room “surprise billing” provisions commonly associated with hospitals and emergency medical providers.

Under the NSA, a chiropractor who provides scheduled, non-emergency treatment to a self-pay or uninsured patient is generally required to furnish the patient with a written Good Faith Estimate of anticipated charges prior to treatment. This obligation applies to many common chiropractic practice models, including cash-pay treatment plans, personal injury patients paying directly, wellness or maintenance care programs, decompression therapy packages, out-of-network treatment arrangements, and long-term treatment recommendations.

The Good Faith Estimate should reasonably identify the anticipated scope and cost of care, including expected charges, CPT or service descriptions, diagnosis information when appropriate, and anticipated related costs associated with the proposed treatment plan.

The estimate is not required to be exact; rather, it must reflect a good-faith projection based upon the provider's clinical judgment and reasonably available information at the time the estimate is issued.

Timing requirements are important. If services are scheduled between three (3) and nine (9) business days in advance, the Good Faith Estimate generally must be provided within one (1) business day after scheduling. If services are scheduled ten (10) or more business days in advance, the estimate generally must be provided within three (3) business days after scheduling. Accordingly, the Good Faith Estimate should be drafted carefully to reflect that treatment recommendations and visit frequency may change depending upon patient progress and medical necessity.

Providers should also be aware that if the final billed charges exceed the Good Faith Estimate by at least \$400.00, the patient may initiate the federal Patient-Provider Dispute Resolution process. Maintaining contemporaneous documentation supporting the basis for treatment modifications, additional services, or changes in frequency may therefore become important in defending the reasonableness of the charges rendered.

Can patients waive the No Surprises Act's protections?

The No Surprises Act allows patients to waive its protections with regard to certain non-emergency services only, but there are strict notice and consent requirements that apply. These requirements make it clear that Congress's intention is that waiver of the No Surprises Act protections and consent to payment of out-of-network fees should be the exception for patients, rather than the rule.

AB5 The Independent Contractor Test

A. The person is free from the control and direction of the hiring entity in the performance of the work, both under the contract for the performance of the work and in fact;

B. The person performs work that is outside the usual course of the hiring entity's business; and

C. The person is customarily engaged in an independently established trade, occupation, or business of the same nature as that involved in the work performed.

Cal. Lab. Code § 2750.3(a)(1).

AB 5 contains a number of exceptions to the ABC test resulting from intense industry lobbying. These exceptions (which are still subject to the *Borello* test) include:

- **Doctors** (physicians, surgeons, dentists, podiatrists, veterinarians, psychologists)
- Other specified professionals (licensed lawyers, architects, engineers)

We have an existing self-pay patient who got into a fender bender under a PI lien, and we charged our insurance rates. Our rate for self-pay patients is considerably lower than the insurance rate. The attorney is asking to justify the difference.

Chiropractic Medicare Coverage Modernization Act of 2021??

This bill expands Medicare coverage of chiropractic services to include all services provided by chiropractors, rather than only subluxation corrections through manual manipulation of the spine.

CSAA MED-PAY LANGUAGE

PAYMENT UNDER MEDICAL PAYMENTS COVERAGE We may pay the insured person or the person(s) providing the necessary services, or the person(s) responsible for payment of expenses incurred under this Part, as we deem appropriate.

Malpractice

SOL is 1 year from the date of injury, or when the patient knew or should have known.

A physician may be liable for negligently recommending a course of treatment if that course stems from a misdiagnosis of the patient's underlying medical condition, or all reasonable physicians in the relevant medical community would agree that the probable risks of that treatment outweigh its probable benefits.

Flores v. Liu - filed Jan. 28, 2021, Second District, Div. Two

The Policy states that providing the Company with an Informed Consent form that meets the requirements of the Policy “shall be a condition precedent” to the Company’s obligations under the Policy.⁷ The Policy precludes coverage for a claim where you cannot provide the Company with an Informed Consent form that meets the requirements in the Policy.⁸ As discussed above, you cannot provide the Company with an Informed Consent form signed by Ms. Richmond that meets the requirements of the Policy. As a result, there is no coverage under the Policy for the Claim.

Notably, the Company is substantially and actually prejudiced by your failure to have Ms. Richmond sign the Informed Consent. The Informed Consent warns of the risk of disc injuries. Ms. Richmond alleges that she suffered a disc injury as a result of treatment.

First, Underwriters note that, pursuant to the Policy's Representations provision, you agreed that the statements in the Declarations and/or Applications are accurate and complete; those statements are based upon representations you made to Underwriters; and Underwriters issued this Policy in reliance upon those representations. Policy, Section VII.H. Further, you certified on your Application that, as of the date you signed the Application on June 10, 2020, you were not aware of any "claims, incidents, wrongful acts, licensure or accreditation actions open, closed or pending against me or any of my associates." Based on the circumstances presented here, it appears that your statement was not accurate. As such, Underwriters must reserve all rights in connection with Section VII.H, the Application and under applicable law.

To facilitate a mutual understanding of the above issue, ASH Plans is requesting you provide written confirmation to ASH Plans to ensure that you understand the claims/reimbursement process. Please respond in writing to the following **within five (5) business days**:

- Reimburse ASH Plans in the amount of **\$2,473.88**



Telehealth Services for Chiropractors

Codes available to chiropractors to bill as part of the temporary expansion of telehealth services, as a result of the COVID-19 national public health emergency. Please refer to UHCprovider.com/covid19 for details on the beginning and end dates that these apply to the various UnitedHealthcare plans.

Provider Type	CPT Code*	Description
Chiropractic	99201	Office/outpatient visit new patient
Chiropractic	99203	Office/outpatient visit new patient
Chiropractic	99204	Office/outpatient visit new patient
Chiropractic	99205	Office/outpatient visit new patient
Chiropractic	99211	Office/outpatient visit established patient
Chiropractic	99212	Office/outpatient visit established patient
Chiropractic	99213	Office/outpatient visit established patient
Chiropractic	97110	Therapeutic exercises
Chiropractic	97116	Gait training therapy
Chiropractic	97530	Therapeutic activities, one-to-one patient contact, each 15 minutes
Chiropractic	97112	Neuromuscular reeducation
Chiropractic	97535	Self-care management training
Chiropractic	97750	Physical performance test
Chiropractic	97755	Assistive technology assessment
Chiropractic	97760	Orthotic management and training 1st encounter
Chiropractic	97761	Prosthetic training 1st encounter

Telemedicine Codes

These codes are for use when E/M services are performed, of a type that would be done face-to-face, through a HIPAA compliant secure platform. These are for patient-initiated communications and may be billed by clinicians who may independently bill an E/M service. They may not be used for work done by clinical staff or for clinicians who do not have E/M services in their scope of practice.

Telemedicine Codes

98000-98015

Place of visit is 02

Use -95 modifier

98016 for brief communication

98000	New	Audio + video	Straightforward	15+ min
98001	New	Audio + video	Low	30+ min
98002	New	Audio + video	Moderate	45+ min
98003	New	Audio + video	High	60+ min
98004	Established	Audio + video	Straightforward	10+ min
98005	Established	Audio + video	Low	20+ min
98006	Established	Audio + video	Moderate	30+ min

98007	Established	Audio + video	High	40+ min
98008	New	Audio only	Straightforward	15+ min
98009	New	Audio only	Low	30+ min
98010	New	Audio only	Moderate	45+ min
98011	New	Audio only	High	60+ min
98012	Established	Audio only	Straightforward	10+ min
98013	Established	Audio only	Low	20+ min
98014	Established	Audio only	Moderate	30+ min
98015	Established	Audio only	High	40+ min

Telemedicine Codes

Online Digital E/M codes

99421 - covers 5 to 10 minutes of cumulative time spent with the patient for a period of up to 7 days.

A physician or other qualified healthcare professional discusses, using online communication technologies, a health issue and possible treatment or management with an established patient.

Telemedicine Codes

Online Digital E/M codes

99422 - covers 11 to 20 minutes of cumulative time spent with the patient for a period of up to 7 days.

A physician or other qualified healthcare professional discusses, using online communication technologies, a health issue and possible treatment or management with an established patient.

Telemedicine Codes

Online Digital E/M codes

99423 - covers 21 + minutes of cumulative time spent with the patient for a period of up to 7 days.

A physician or other qualified healthcare professional discusses, using online communication technologies, a health issue and possible treatment or management with an established patient.

Document the consent of the patient for the telemedicine communication via this medium.

Very important.

Effective January 1, 2021, new reporting guidelines will be implemented and code selection for office/outpatient E/M services will be based on:

*Medically Appropriate
History and/or
Examination*



Medical
Decision
Making

OR

Total Time
on the Day of
Encounter

Billing & Coding

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**PERSONAL INJURY
CONTRACTS
ESTATE PLANNING
REAL ESTATE
BUSINESS ENTITY FORMATION**

Objectives

- ~Billing & coding, CPT and ICD-10 codes.
- ~Documentation for the patient and insurance billing.
- ~Medicare.
- ~Workers' Compensation.
- ~CPT Codes and P.I. for the Chiropractor.

Rules and Regulations Board of Chiropractic
Examiners 1625 N. Market Blvd., Suite N-327
Sacramento, CA 95834
Revised November 2021

<https://www.fairhealthconsumer.org/medical>

§318. Chiropractic Patient Records/Accountable Billings.

(a)Chiropractic Patient Records. Each licensed chiropractor is required to maintain all active and inactive chiropractic patient records for five years from the date of the doctor's last treatment of the patient unless state or federal laws require a longer period of retention. Active chiropractic records are all chiropractic records of patients treated within the last 12 months. Chiropractic patient records shall be classified as inactive when there has elapsed a period of more than 12 months since the date of the last patient treatment.

All chiropractic patient records shall be available to any representative of the Board upon presentation of patient's written consent or a valid legal order. Active chiropractic patient records shall be immediately available to any representative of the Board at the chiropractic office where the patient has been or is being treated. Inactive chiropractic patient records shall be available upon ten days notice to any representative of the Board. The location of said inactive records shall be reported immediately upon request.

Active and inactive chiropractic patient records must include all of the following: (1) Patient's full name, date of birth, and social security number (if available); (2) Patient gender, height and weight. An estimated height and weight is acceptable where the physical condition of the patient prevents actual measurement; (3) Patient history, complaint, diagnosis/analysis, and treatment must be signed by the primary treating doctor. Thereafter, any treatment rendered by any other doctor must be signed or initialed by said doctor; (4) Signature of patient; (5) Date of each and every patient visit; (6) All chiropractic X-rays, or evidence of the transfer of said X-rays; (7) Signed written informed consent as specified in Section 319.1.

(b) Accountable Billings. Each licensed chiropractor is required to ensure accurate billing of his or her chiropractic services whether or not such chiropractor is an employee of any business entity, whether corporate or individual, and whether or not billing for such services is accomplished by an individual or business entity other than the licensee. In the event an error occurs which results in an overbilling, the licensee must promptly make reimbursement of the overbilling whether or not the licensee is in any way compensated for such reimbursement by his employer, agent or any other individual or business entity responsible for such error. Failure by the licensee, within 30 days after discovery or notification of an error which resulted in an overbilling, to make full reimbursement constitutes unprofessional conduct.

§319.1. Informed Consent. (a) A licensed doctor of chiropractic shall verbally and in writing inform each patient of the material risks of proposed care. “Material” shall be defined as a procedure inherently involving known risk of serious bodily harm. The chiropractor shall obtain the patient's written informed consent prior to initiating clinical care. The signed written consent shall become part of the patient's record. (b) A violation of this section constitutes unprofessional conduct and may subject the licensee to disciplinary action.

What Is A 25 Modifier?

Significant, Separately Identifiable
Evaluation and Management Service by
the Same Physician on the Same Day of
the Procedure or Other Service.

[REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]

Insured Information
 Payer Name: Geico
 Insured Name: [REDACTED]
 Relationship to Insured: Self
 Group #:
 Insured DOB: [REDACTED]
 Employer Name:

	Dx	Diagnosis Information	Account #	2-2891589
	A	(M62830) - Muscle spasm of back	DOB	[REDACTED]
	B	(M9901) - Segmental and somatic dysfunction of cervical region	DOI	2/24/2025
	C	(S134XXA) - Sprain of ligaments of cervical spine, initial encounter		
	D	(S134XXD) - Sprain of ligaments of cervical spine, subsequent encounter		
	E	(M9902) - Segmental and somatic dysfunction of thoracic region		
	F	(M9903) - Segmental and somatic dysfunction of lumbar region		
	G	(G44309) - Post-traumatic headache, unspecified, not intractable		
	H	(M546) - Pain in thoracic spine		
	I	(M9905) - Segmental and somatic dysfunction of pelvic region		

Visit Date	Provider	Service	Modifier	Description	Dx Pointers	Charge	Tax	Balance
3/6/2025	[REDACTED]	99204 (1 unit)	25	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: comprehensive history, a comprehensive examination, and medical decision making of moderate complexity	C, D, G, I	\$195.00	\$0.00	\$195.00
3/6/2025	[REDACTED]	98941 (1 unit)		Spinal, three to four regions	B, F, I	\$80.00	\$0.00	\$80.00
3/6/2025	[REDACTED]	97140 (1 unit)	59	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	A, B, E, D	\$40.00	\$0.00	\$40.00
3/7/2025	[REDACTED]	98941 (1 unit)		Spinal, three to four regions	B, F, I	\$80.00	\$0.00	\$80.00
3/7/2025	[REDACTED]	97140 (1 unit)	59	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	A, B, E, D	\$40.00	\$0.00	\$40.00
3/10/2025	[REDACTED]	98941 (1 unit)		Spinal, three to four regions	B, F, I	\$80.00	\$0.00	\$80.00
3/10/2025	[REDACTED]	97140 (1 unit)	59	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	A, B, E, D	\$40.00	\$0.00	\$40.00
3/11/2025	[REDACTED]	98941 (1 unit)		Spinal, three to four regions	B, F, I	\$80.00	\$0.00	\$80.00
3/11/2025	[REDACTED]	97140 (1 unit)	59	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	A, B, E, D	\$40.00	\$0.00	\$40.00

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

A. V89.2XXA

E. S00.83XA

I. M25.519

B. S13.4XXA

F. S23.3XXA

J. M99.18

C. S33.5XXA

G. M47.22

K. M99.17

ICD Ind. 0

D. G44.319

H. M47.27

L.

22. RESUBMISSION CODE

ORIGINAL RE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE

B. PLACE OF SERVICE

C. EMG

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)

E. DIAGNOSIS POINTER

F. CHARGES

G. DAYS OR UNITS

H. HCPCS Family Plan

I. L ID QUAL

DATE(S) OF SERVICE						PLACE OF SERVICE	EMG	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				DIAGNOSIS POINTER	CHARGES	DAYS OR UNITS	HCPCS Family Plan	L ID QUAL	
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER								
03	31	26	03	31	26	11		99204	25			A B C D	260.00	1		0B NPI	
03	31	26	03	31	26	11		98941				A B C D	200.00	1		0B NPI	
03	31	26	03	31	26	11		72083				A B C D	150.00	1		0B NPI	
03	31	26	03	31	26	11		97530				A B C D	85.00	1		0B NPI	
03	31	26	03	31	26	11		98943				J	80.00	1		0B NPI	

What is Modifier 52?

Modifier 52 identifies situations where the physician elects to reduce or eliminate a portion of a service or procedure. Cover letters or operative reports are not necessary when Modifier 52 is used since these claims are seldom sent to medical review.

What Is A 59 Modifier?

Distinct Procedural Service.

Modifier 59 is used to indicate a distinct procedural service. The physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day.

Diagnosis codes: G44.309 - Post-traumatic headache, unspecified, not intractable
M99.01 - Segmental and somatic dysfunction of cervical region
M99.02 - Segmental and somatic dysfunction of thoracic region
M99.03 - Segmental and somatic dysfunction of lumbar region
S06.0X0A - Concussion without loss of consciousness, initial encounter
S14.2XXA - Injury of nerve root of cervical spine, initial encounter
S34.21XA - Injury of nerve root of lumbar spine, initial encounter

Line	Date of service	POS	CPT/ HCPCS	MOD/TS	Units	Submitted amount	Approved amount	Reason codes
1	09-02-2025 - 09-02-2025	11	98941	AT	1.00	\$95.00	\$95.00	
2	09-02-2025 - 09-02-2025	11	97014		1.00	\$50.00	\$50.00	
3	09-02-2025 - 09-02-2025	11	97012	59	1.00	\$50.00	\$50.00	179
4	09-04-2025 - 09-04-2025	11	98941	AT	1.00	\$95.00	\$95.00	
5	09-04-2025 - 09-04-2025	11	97014		1.00	\$50.00	\$50.00	
6	09-04-2025 - 09-04-2025	11	97012	59	1.00	\$50.00	\$50.00	179
7	09-08-2025 - 09-08-2025	11	98941	AT	1.00	\$95.00	\$95.00	
8	09-08-2025 - 09-08-2025	11	97014		1.00	\$50.00	\$50.00	
9	09-08-2025 - 09-08-2025	11	97012	59	1.00	\$50.00	\$50.00	179
10	09-09-2025 - 09-09-2025	11	98941	AT	1.00	\$95.00	\$95.00	
11	09-09-2025 - 09-09-2025	11	97014		1.00	\$50.00	\$50.00	
12	09-09-2025 - 09-09-2025	11	97012	59	1.00	\$50.00	\$50.00	179
13	09-11-2025 - 09-11-2025	11	97014		1.00	\$50.00	\$50.00	
14	09-11-2025 - 09-11-2025	11	97012	59	1.00	\$50.00	\$50.00	179
15	09-15-2025 - 09-15-2025	11	99214		1.00	\$135.00	\$135.00	

Line	Date of service	POS	CPT/ HCPCS	MOD/TS	Units	Submitted amount	Approved amount	Reason codes
16	09-15-2025 - 09-15-2025	11	97014		1.00	\$50.00	\$50.00	
17	09-15-2025 - 09-15-2025	11	97012	59	1.00	\$50.00	\$50.00	179
18	09-16-2025 - 09-16-2025	11	98941	AT	1.00	\$95.00	\$95.00	
19	09-16-2025 - 09-16-2025	11	97014		1.00	\$50.00	\$50.00	
20	09-16-2025 - 09-16-2025	11	97012	59	1.00	\$50.00	\$50.00	179
21	09-18-2025 - 09-18-2025	11	98941	AT	1.00	\$95.00	\$95.00	
22	09-18-2025 - 09-18-2025	11	97014		1.00	\$50.00	\$50.00	
23	09-18-2025 - 09-18-2025	11	97012	59	1.00	\$50.00	\$50.00	179
24	09-22-2025 - 09-22-2025	11	98941	AT	1.00	\$95.00	\$95.00	
25	09-22-2025 - 09-22-2025	11	97014		1.00	\$50.00	\$50.00	
26	09-22-2025 - 09-22-2025	11	97012	59	1.00	\$50.00	\$50.00	179
27	09-25-2025 - 09-25-2025	11	98941	AT	1.00	\$95.00	\$95.00	
28	09-25-2025 - 09-25-2025	11	97014		1.00	\$50.00	\$50.00	
29	09-25-2025 - 09-25-2025	11	97012	59	1.00	\$50.00	\$50.00	179
30	09-29-2025 - 09-29-2025	11	98941	AT	1.00	\$95.00	\$95.00	
31	09-29-2025 - 09-29-2025	11	97014		1.00	\$50.00	\$50.00	
32	09-29-2025 - 09-29-2025	11	97012	59	1.00	\$50.00	\$50.00	179

Total submitted charges:	\$2,090.00
Total approved amount:	\$2,090.00
Amount not payable:	\$0.00
Deductible:	\$0.00
Copay:	\$0.00
Apportionment / Pro rata:	\$0.00
Offset:	\$0.00
Paid amount:	\$2,090.00

Explanations

179 - The provider is using modifier -59 to indicate under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 will identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.

Procedure guide

97012 - Application of a modality to 1 or more areas; traction, mechanical

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

98941 - Chiropractic manipulative treatment (CMT); spinal, 3-4 regions

99214 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

We are required by the California Insurance Regulations, Section 2695.7(b)(3), to advise you if you believe this claim, or any portion of this claim, has been wrongfully denied or rejected, you may have the matter reviewed by the California Department of Insurance, Claims Service Bureau, 300 South Spring Street, Los Angeles, CA 90013, telephone 1-800-927-4357.

What Is An AT Modifier?

Acute treatment (chiropractic claims).

Note: This modifier should be used when reporting CPT 98940, CPT 98941, CPT 98942 or CPT 98943 for acute treatment.

What Is A GP Modifier?

Services delivered under an outpatient physical therapy plan of care.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. 11 02 25				15. OTHER DATE QUAL. MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) SEE ATTACHED LIEN & CHART NOTES								20. OUTSIDE LAB? \$ CHARGES ☐ YES ☒ NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. M99.01 B. M99.02 C. M99.03 D. M99.04 E. M99.05 F. M99.08 G. H. I. J. K. L.								22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #		
03	10	26	03	10	26	11		99203	25	ABCD	283	00	1	ZZ	171100000X		
03	10	26	03	10	26	11		97810		ABCD	116	67	1	NPI	1386068922		
03	10	26	03	10	26	11		97811		ABCD	116	67	3	NPI	1386068922		
03	10	26	03	10	26	11		97140	GP 59	ABCD	116	67	1	NPI	1386068922		
														NPI			
														NPI			
25. FEDERAL TAX I.D. NUMBER						SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. Rsvd for NUCC Use	
602276771						☐ ☒		C6213P1643		☒ YES ☐ NO		\$ 633		\$ 0			

What Is A GQ Modifier?

Telehealth services via asynchronous telecommunications system.

What Is A GT Modifier?

Telehealth services via interactive audio and video telecommunication systems.

What Is A GY Modifier?

Use to indicate when an item or service statutorily excluded or does not meet the definition of any Medicare benefit.

What is Modifier XS?

This tells the payer the procedure is distinct because it was performed on a separate organ or structure than the bundled procedure.

“Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure.”

Line	Date	Proc	DESCRIPTION	Charge	Schedule Reduction Amt	PPO Discount	Reimburse	Explanation
42	1/13/25	97140	CPT - Manual therapy 1/> regions	48.00	0.00	0.00	48.00	BA
43	1/13/25	97012	CPT - Mechanical traction therapy	29.00	3.94	0.00	25.06	FS_OR
44	1/13/25	98943	CPT - Chiropract manj xtrspini 1/>	55.50	0.00	0.00	55.50	BA
46	1/16/25	98940	CPT - Chiropract manj 1-2 regions	79.82	16.04	0.00	63.78	FS_OR
47	1/16/25	97140	CPT - Manual therapy 1/> regions	48.00	0.00	0.00	48.00	BA
48	1/16/25	97012	CPT - Mechanical traction therapy	29.00	3.94	0.00	25.06	FS_OR
49	1/16/25	98943	CPT - Chiropract manj xtrspini 1/>	55.50	0.00	0.00	55.50	BA
51	1/21/25	98940	CPT - Chiropract manj 1-2 regions	79.82	16.04	0.00	63.78	FS_OR
52	1/21/25	97140	CPT - Manual therapy 1/> regions	48.00	0.00	0.00	48.00	BA
54	1/21/25	97139	CPT - Unlisted therapeutic px	56.00	11.20	0.00	44.80	OR_80
55	1/21/25	97139	CPT - Unlisted therapeutic px	56.00	56.00	0.00	0.00	GR2
56	1/21/25	98943	CPT - Chiropract manj xtrspini 1/>	55.50	0.00	0.00	55.50	BA
58	1/27/25	98940	CPT - Chiropract manj 1-2 regions	79.82	16.04	0.00	63.78	FS_OR
59	1/27/25	97140	CPT - Manual therapy 1/> regions	48.00	0.00	0.00	48.00	BA
61	1/27/25	97139	CPT - Unlisted therapeutic px	56.00	11.20	0.00	44.80	OR_80
62	1/27/25	97139	CPT - Unlisted therapeutic px	56.00	56.00	0.00	0.00	GR2
63	1/27/25	98943	CPT - Chiropract manj xtrspini 1/>	55.50	0.00	0.00	55.50	BA
64	1/27/25	99214	CPT - Office w/p est mod 30 min	208.00	0.00	0.00	208.00	BA
66	2/3/25	98940	CPT - Chiropract manj 1-2 regions	79.82	16.04	0.00	63.78	FS_OR
67	2/3/25	97140	CPT - Manual therapy 1/> regions	48.00	0.00	0.00	48.00	BA

13	6/26/25	98943		Chiropract manj xtrspinal 1/2	1	80.00	0.00	80.00	
ICD Ref 1,2,3,4,5									
14	6/26/25	97140	59	Manual therapy 1/2 regions	1	80.00	0.00	69.53	RF_6
ICD Ref 1,2,3,4,5									
15	6/26/25	97530		Therapeutic activities	1	85.00	0.00	74.72	RF_6
ICD Ref 1,2,3,4,5									
16	6/26/25	98941		Chiropract manj 3-4 regions	1	200.00	0.00	83.03	RF_6
ICD Ref 1,2,3,4,5									
17	6/24/25	97140	59	Manual therapy 1/2 regions	1	80.00	0.00	69.53	RF_6
ICD Ref 1,2,3,4,5									
18	6/24/25	98943		Chiropract manj xtrspinal 1/2	1	80.00	0.00	80.00	
ICD Ref 1,2,3,4,5									
19	6/24/25	98941		Chiropract manj 3-4 regions	1	200.00	0.00	83.03	RF_6
ICD Ref 1,2,3,4,5									
2	7/07/25	97530		Therapeutic activities	1	85.00	0.00	74.72	RF_6
ICD Ref 1,2,3,4,5									
20	6/24/25	97530		Therapeutic activities	1	85.00	0.00	74.72	RF_6
ICD Ref 1,2,3,4,5									
21	6/23/25	97530		Therapeutic activities	1	85.00	0.00	74.72	RF_6
ICD Ref 1,2,3,4,5									
22	6/23/25	97140	59	Manual therapy 1/2 regions	1	80.00	0.00	69.53	RF_6
ICD Ref 1,2,3,4,5									
23	6/23/25	98941		Chiropract manj 3-4 regions	1	200.00	0.00	83.03	RF_6
ICD Ref 1,2,3,4,5									
24	6/23/25	98943		Chiropract manj xtrspinal 1/2	1	80.00	0.00	80.00	

USAA

Doc ID UP0165601

Claim Type MP

Claims ID 035305745-0802-000

Receive Date 7/9/2025 12:00:00AM

USAA

Send Date

Line	Date	Proc	DESCRIPTION	Charge	Schedule Reduction Amt	PPO Discount	Reimburse	Explanation
1	7/7/2025 12:00	98941	CPT - Chiropract manj 3-4 regions	200.00	116.97	0.00	83.03	RF_6
3	7/7/2025 12:00	98943	CPT - Chiropract manj xtrspini 1/>	80.00	0.00	0.00	80.00	BA
6	7/3/2025 12:00	98943	CPT - Chiropract manj xtrspini 1/>	80.00	0.00	0.00	80.00	BA
7	7/3/2025 12:00	98941	CPT - Chiropract manj 3-4 regions	200.00	116.97	0.00	83.03	RF_6
9	7/3/2025 12:00	99212	CPT - Office o/p est sf 10 min	180.00	20.18	0.00	159.82	RF_6
37	6/3/2025 12:00	98943	CPT - Chiropract manj xtrspini 1/>	80.00	0.00	0.00	80.00	BA

New patient E/M Codes

99202 ~Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

99203 ~Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

Date of Service	Line	POS	Proc. Code	Mod.	Dx Ptr	Units	Amount Charged	Amount Allowed	Explanation Codes
01/26/2021	1	11	99202			1	\$900.00	\$237.00	C14
Totals:							\$900.00	\$237.00	

Explanation Code Guide

C14 The amount allowed was reviewed using the Fair Health Relative Value Benchmark Database.

Place of Service (POS) Guide

11 Office

Procedure Code (Proc. Code) Guide

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

ICD Diagnosis Code Guide

M53.82	10	Other specified dorsopathies, cervical region
M50.12	10	Cervical disc disorder with radiculopathy, mid-cervical region
M54.12	10	Radiculopathy, cervical region
S13.4XXA	10	Sprain of ligaments of cervical spine, initial encounter
R51	10	Headache
M50.21	10	Other cervical disc displacement, high cervical region
M50.22	10	Other cervical disc displacement, mid-cervical region
M54.2	10	Cervicalgia

Procedure	Mods	Charge	Adjmt	Ins. Paid	Pt Paid	Bal Due
99202 - OFFICE O/P NEW SF 15-29 MIN	:::	\$900.00				\$900.00
Total:		\$900.00				\$900.00
Total Amount: \$900.00						

99204 ~Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

99205 ~Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Date of Service	Line	Rev Cd	POS	Proc Cd/ NDC	Mod/ Pkg	DX Ptr	Units	Amount Charged	Amount Allowed	Explanation Codes
09/02/2025	51		11	97012			1	\$25.00	\$25.00	
08/28/2025	52		11	97012			1	\$25.00	\$25.00	
08/28/2025	53		11	98941			1	\$85.00	\$85.00	
08/28/2025	54		11	97150			1	\$30.00	\$30.00	
08/28/2025	55		11	97112	59		1	\$61.00	\$61.00	179
08/27/2025	56		11	97150			1	\$30.00	\$30.00	
08/27/2025	57		11	98941			1	\$85.00	\$85.00	
07/21/2025	58		11	72020			1	\$30.00	\$30.00	
07/21/2025	59		11	99203	25		1	\$95.00	\$95.00	166
07/21/2025	60		11	72100			1	\$60.00	\$60.00	
08/27/2025	61		11	97012			1	\$25.00	\$25.00	
08/27/2025	62		11	97112	59		1	\$61.00	\$61.00	179
08/21/2025	63		11	97150			1	\$30.00	\$30.00	
08/21/2025	64		11	98941			1	\$85.00	\$85.00	
08/21/2025	65		11	97012			1	\$25.00	\$25.00	
08/21/2025	66		11	97112	59		1	\$61.00	\$61.00	179
08/18/2025	67		11	98941			1	\$85.00	\$85.00	
08/18/2025	68		11	97112	59		1	\$61.00	\$61.00	179
08/18/2025	69		11	97012			1	\$25.00	\$25.00	
08/18/2025	70		11	97150			1	\$30.00	\$30.00	
08/14/2025	71		11	97150			1	\$30.00	\$30.00	
08/14/2025	72		11	97012			1	\$25.00	\$25.00	
08/14/2025	73		11	97112	59		1	\$61.00	\$61.00	179
08/14/2025	74		11	98941			1	\$85.00	\$85.00	

Subtotals						\$4,721.00	\$4,721.00	
Amt Previously Paid							\$0.00	
Deductible/Co-Pay							\$0.00	
Totals						\$4,721.00	\$4,721.00	

Revenue Code (Rev Cd):

Place of Service (POS):

11 - Office

Procedure Code/National Drug Code (Proc Cd/NDC):

- 98941 -Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
- 97112 -Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
- 97012 -Application of a modality to 1 or more areas; traction, mechanical
- 97150 -Therapeutic procedure(s), group (2 or more individuals)
- 93740 -Temperature gradient studies
- S3900 -Surface electromyography (EMG)
- 72020 -Radiologic examination, spine, single-view, specify level
- 99203 -Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- 72100 -Radiologic examination; spine, lumbosacral; 2 or 3 views
- 72040 -Radiologic examination, spine, cervical; 2 or 3 views

Modifier/Package (Mod/Pkg):

- 59 - Distinct Procedural Service
- 25 - Significant, separately identifiable E/M by the same physician on the same day of procedure/service

Submitted Charges

Date of Service	Line	POS	Proc. Code	Mod.	Dx Ptr	Units	Amount Charged	Amount Allowed	Explanation Codes
02/10/2021	1	11	99205			1	\$1,250.00	\$724.00	C14
Totals:							\$1,250.00	\$724.00	

Explanation Code Guide

C14 The amount allowed was reviewed using the Fair Health Relative Value Benchmark Database.

Place of Service (POS) Guide

11 Office

Procedure Code (Proc. Code) Guide

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

ICD Diagnosis Code Guide

M25.519 10 Pain in unspecified shoulder

Bonus Golden Nugget

It is rare for a chiropractor to achieve 99204.

If a chiropractor has initially completed a new patient exam and billed 99203, they should follow up with a 99213 on a re-exam. Q

99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems; - or • 1 stable chronic illness; - or • 1 acute, uncomplicated illness or injury	Limited <i>(Must meet the requirements of at least 1 of the 2 categories)</i> Category 1: Tests and documents • Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* or Category 2: Assessment requiring an independent historian(s)	Low risk of morbidity from additional diagnostic testing or treatment

Coding, billing, and claims

How should a provider bill for services delivered via telehealth or telephone during the State of Emergency, when the provider would normally deliver the services in-person?

During the COVID-19 State of Emergency, when a provider delivers a service via telehealth that the provider would normally deliver in-person, the provider should document and bill the service(s) as follows:

- Thoroughly document the visit as if the visit had occurred in person.
- Use the CPT code(s) for in-office visit for the particular service(s) rendered. Do not use telehealth or telephonic CPT codes.
- Use Place of Service "02" to designate telehealth.
- Use modifier 95 or GT for synchronous rendering of services, or GQ for asynchronous.
- **Medi-Cal Exception** – use modifier 95 for synchronous rendering of services, or GQ for asynchronous.

Hitting your organ systems for your E/M Codes

99212 ~**1-5** from **1+** organ systems

5 Points

99202 & 99213 ~**6** from any organ systems

6 Points

99203 & 99214 ~**2** from **6** organ system or
12 from **2+** organ systems

12 Points

99204/99205/99215 ~**2** from **9** organ systems

18 Points

There are 15 organ systems

1. Constitutional (vitals)
2. Eyes
3. Ears, nose, mouth and throat
- 4. Neck**
5. Respiratory
6. Cardiovascular
7. Chest
8. G.I.
- 9.-10. Male/Female genitourinary
11. Lymphatic
- 12. Musculoskeletal**
- 13. Skin**
- 14. Neurologic**
15. Psychiatric

Neck

1. Physical examination of the neck.
2. Physical examination of the thyroid.

Musculoskeletal

1. Gait analysis/exam.
2. Exam/palpation of the digits of the hand or foot and assessing the beds of the nails.
3. Head & neck.
4. Spine, ribs & pelvis.
5. B/L upper extremities.
6. B/L lower extremities.

Musculoskeletal 3,4,5 & 6

An additional 4 bullets will be allowed.

- A. Muscle strength and tone, noting abnormalities.
- B. ROM, noting abnormal sounds, discomfort or restriction.
- C. Tenderness to palpation, masses or joint swelling.
- D. Noting misalignment, asymmetry or joint crepitus.

Skin

1. Visual inspection of the skin, noting any abnormalities.
2. Palpation of the skin, noting any abnormalities.

Neurologic

1. Cranial nerve testing.
2. Examination of the DTRs noting abnormalities.
3. Sensory examination (pinwheel, touch).

Golden Nugget #1

1. Does the office have to collect co-pays, can you waive patient deductibles? What if the patient has a hardship?

The office must collect all co-pays and deductibles. Unless there is a documented legitimate hardship that is proven by the patient. This hardship faces extreme scrutiny like that of the IRS hardship. Difficult to overcome. Q

§319. Free or Discount Services. Licensees may advertise that they will perform certain designated routine professional services free or at a discount if such advertising claims are truthful. However, no charge shall be made for any other professional services rendered or commodities provided to a patient during any office visit in which free or discounted services are offered or provided unless, prior to the accrual of any charges, the patient shall have been informed of the cost of such additional services and/or commodities and shall have agreed to pay for them.

For the purposes of this section, no separate charge shall be made for the professional evaluation of diagnostic tests or procedures which are provided free or without cost, or at a discount, whether such professional evaluation is made at the time of the initial office visit or at any later time.

Evaluation/Management Codes

99212 (Limited) – 10-19 min.

99213 (Expanded) – 20-29 min.

99214 (Detailed) – 30-39 min.

99215 (Comprehensive) – 40-54 min.

99211

Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional.

Usually, the presenting problem(s) are minimal.

99212

Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

99213

Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

99214

Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

G2212~Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 (40-54 min) for office or other outpatient evaluation and management services) (Do not report G2212 on the same date of service as 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes).

Elements of Medical Decision Making (MDM)

Beginning in 2021, for both new and established patients, the level of MDM for office E/M's is based on 2 out of 3 elements. This differs from the current guidelines, which require 3 out of 3 elements for new patients.

Element 1: Problems Addressed



Element 1: This element accounts for the disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established.

Element 2: Data Reviewed and Analyzed



Element 2: This element accounts for the amount and/or complexity of data to be reviewed and analyzed—it recognizes each unique test, order, or document to meet the requirements for each level of MDM.

Element 3: Risk



Element 3: This element accounts for the risk of complications and/or morbidity or mortality of patient management, including complications associated with additional diagnostic testing or treatment.

DETAIL INFORMATION

SERVICE DATE: 03/30/2018	POS: 11	PROC CD: 99203	MODIFIER(S):		
REV CD:	UNITS: 1.0	AMT CHARGED:	\$250.00	AMT ALLOWED:	\$250.00
EXPLANATION CODE(S):					
SERVICE DATE: 04/02/2018	POS: 11	PROC CD: 99213	MODIFIER(S):		
REV CD:	UNITS: 1.0	AMT CHARGED:	\$225.00	AMT ALLOWED:	\$169.00
EXPLANATION CODE(S): 41					
SERVICE DATE: 04/13/2018	POS: 11	PROC CD: 99213	MODIFIER(S):		
REV CD:	UNITS: 1.0	AMT CHARGED:	\$225.00	AMT ALLOWED:	\$169.00
EXPLANATION CODE(S): 41					
SERVICE DATE: 04/16/2018	POS: 11	PROC CD: 99213	MODIFIER(S):		
REV CD:	UNITS: 1.0	AMT CHARGED:	\$225.00	AMT ALLOWED:	\$169.00
EXPLANATION CODE(S): 41					

PROCEDURE GUIDE: 99203

OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE SEVERITY. TYPICALLY, 30 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.

99213

ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW TO MODERATE SEVERITY. TYPICALLY, 15 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.

EXPLANATIONS: 41

EFFECTIVE FOR DATES OF SERVICE ON OR AFTER 06/01/2011, THE AMOUNT ALLOWED WAS REVIEWED USING THE FH CHARGE BENCHMARK DATABASE. (NOTE: FOR DATES OF SERVICE 05/31/2011 AND PRIOR, THE AMOUNT ALLOWED WAS BASED ON BENCHMARK DATA PROVIDED BY INGENIX.)

END OF STATEMENT

Service Provider	Date(s) of Service	EOB Revision	Billed Amount	Fee Sched Amt	Deductible Amt	Interest Amt	Amount Paid	Date Paid
	02/10/21 - 02/10/21	580272-0	\$1,250.00			\$0.00	\$724.00	
Turnure Medical Group & Sutter Medical Foundation	06/03/20 - 06/03/20		\$588.20			\$0.00	\$588.20	
CHIROPRACTIC INC	01/21/21 - 01/25/21	576024-1	\$354.00			\$0.00	\$64.00	
CHIROPRACTIC INC	08/18/20 - 12/16/20	573301-0	\$2,798.00			\$0.00	\$2,157.00	12/31/20

Golden Nugget # 2 & 3

2. Can you give cash discounts?
3. What is prompt payment?

The term “cash discounts” is not acceptable, but the term prompt payment is. An office may give a patient a discount for the prompt payment of their account. This percentage falls in-line with what it would cost the office to recover the funds from the insurance or the patient. Q

CPT Code Description Documentation Requirement

98940 Chiropractic manipulative treatment 1-2 spinal regions.

Medical record must document:

1. A complaint involving at least one spinal region;
2. An examination of the corresponding spinal region(s); and the claim must record a diagnosis codes (ICD-10) in treatment regions.

Diagnosis Codes: G44.301 - Post-traumatic headache, unspecified, intractable
M99.01 - Segmental and somatic dysfunction of cervical region
M99.02 - Segmental and somatic dysfunction of thoracic region
M99.03 - Segmental and somatic dysfunction of lumbar region
S14.2XXA - Injury of nerve root of cervical spine, initial encounter
S34.21XA - Injury of nerve root of lumbar spine, initial encounter

<u>Line</u>	<u>Date of Service</u>	<u>POS</u>	<u>CPT/ HCPCS</u>	<u>MOD/TS</u>	<u>Units</u>	<u>Submitted Amount</u>	<u>Approved Amount</u>
1	10-11-2021 - 10-11-2021	11	98940	AT	1.00	\$80.00	\$80.00
2	10-11-2021 - 10-11-2021	11	72052		1.00	\$420.00	\$420.00
3	10-11-2021 - 10-11-2021	11	99203		1.00	\$175.00	\$0.00
4	10-11-2021 - 10-11-2021	11	97014		1.00	\$50.00	\$50.00
5	10-12-2021 - 10-12-2021	11	98941	AT	1.00	\$95.00	\$95.00
6	10-12-2021 - 10-12-2021	11	97014		1.00	\$50.00	\$50.00
7	10-14-2021 - 10-14-2021	11	98941	AT	1.00	\$95.00	\$95.00
8	10-14-2021 - 10-14-2021	11	97014		1.00	\$50.00	\$50.00
9	10-18-2021 - 10-18-2021	11	98941	AT	1.00	\$95.00	\$95.00
10	10-18-2021 - 10-18-2021	11	97014		1.00	\$50.00	\$50.00
11	10-19-2021 - 10-19-2021	11	98941	AT	1.00	\$95.00	\$95.00
12	10-19-2021 - 10-19-2021	11	97014		1.00	\$50.00	\$50.00

98941 Chiropractic manipulative treatment 3-4 spinal regions.

Medical record must document:

1. A complaint involving at least three spinal regions;
2. An examination of the corresponding spinal regions; AND
3. A diagnosis and manipulative treatment of conditions involving at least three spinal regions.

Diagnosis Codes: G44.301 - Post-traumatic headache, unspecified, intractable
 M99.01 - Segmental and somatic dysfunction of cervical region
 M99.02 - Segmental and somatic dysfunction of thoracic region
 M99.03 - Segmental and somatic dysfunction of lumbar region
 S14.2XXA - Injury of nerve root of cervical spine, initial encounter
 S34.21XA - Injury of nerve root of lumbar spine, initial encounter

<u>Line</u>	<u>Date of Service</u>	<u>POS</u>	<u>CPT/ HCPCS</u>	<u>MOD/TS</u>	<u>Units</u>	<u>Submitted Amount</u>	<u>Approved Amount</u>
1	10-28-2021 - 10-28-2021	11	98941	AT	1.00	\$95.00	\$95.00
2	10-28-2021 - 10-28-2021	11	97014		1.00	\$50.00	\$50.00
3	11-01-2021 - 11-01-2021	11	98941	AT	1.00	\$95.00	\$95.00
4	11-01-2021 - 11-01-2021	11	97014		1.00	\$50.00	\$50.00
5	11-02-2021 - 11-02-2021	11	98941	AT	1.00	\$95.00	\$95.00
6	11-02-2021 - 11-02-2021	11	97014		1.00	\$50.00	\$50.00

98942 Chiropractic manipulative treatment 5 spinal regions.

Medical record must document:

1. A complaint involving five spinal regions;
2. An examination of the corresponding spinal regions; AND
3. A diagnosis and manipulative treatment of conditions involving five spinal regions.

98943 Chiropractic manipulative treatment extraspinal are:

Head, including temporomandibular joint, lower extremities, upper extremities, rib cage and abdomen.

Medical record must document:

1. A complaint involving one of these region(s);
 2. An examination of the corresponding region(s);
- AND
3. A diagnosis and manipulative treatment of conditions involving the region.

The Five Regions of the Spine:

1. Cervical region C1 to C7, including the atlanto-occipital joint.
2. Thoracic region T1 through T12, including the costovertebral and costotransverse junction.
3. Lumbar region L1 through L5.
4. Sacral region the sacrum, including the sacrococcygeal junction.
5. Pelvic region the sacroiliac joint and other pelvic articulations.

Education and Training for patient self-management
(98960): face to face with patient, each 30 min. 1 patient

Education and Training for patient self-management
(98961): face to face with patient, each 30 min. 2-4 patients

Education and Training for patient self-management
(98962): face to face with patient, each 30 min. 5-8 patients

* Ergonomic Evaluation services: 97799

Golden Nugget #4

4. Must the doctor's office bill insurance companies weekly, bi-weekly, monthly, yearly?

If you are a preferred provider and the contract dictates your billing, yes. Most insurance companies are from six months to a year, anything past that and the office is out of luck. When in doubt call the insurance company and have them send you something in writing to confirm. Q

Weight Control/Counseling

The documentation in the health care record of obesity screening and counseling must show sufficient patient history to adequately demonstrate that the following coverage conditions were met:

The individual has a Body Mass Index equal to or greater than $30_{\text{kg/m}^2}$ for adults, or has an age/gender-specific BMI at or above the 85th percentile

(for children and adolescents; ages 6-18 years)

Services were furnished by a qualified health care provider.

Typically, preventative codes are not subject to the deductible.

(Depending on the contract)

Preventative Medicine/Individual Counseling

99401- approximately 15 minutes

99402 -approximately 30 minutes

99403 -approximately 45 minutes

99404 -approximately 60 minutes

The health care record must include verification of the counseling intervention.

1. **Assess:** Ask about or assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
2. **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
3. **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
4. **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
5. **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

The notes must include the amount of time spent with the patient.

Preventive Medicine Individual Counseling

Body Mass Index (BMI) 30 – 45+:

Use the secondary ICD-10 code Z68 and calculate the patients BMI.

Example:

Male patient weighs 217 lbs.

He is 5' 11'. His BMI is 30.3

His secondary ICD-10 would be Z68.30

ICD-10:

E66.01 Morbid (severe) obesity due to excess calories.

E66.09 Other obesity due to excess calories.

(Children and adolescents BMI above the 85%)

CPT codes for obesity screening and counseling are:

99401 – preventive medicine counseling and/or risk factor intervention(s) provided to an individual (separate procedure);
approximately 15 minutes

99402 – preventive medicine counseling and/or risk factor intervention(s) provided to an individual (separate procedure);
approximately 30 minutes

On the 6th month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed. To be eligible for additional face-to-face visits occurring once a month for an additional 6 months, adult beneficiaries must have achieved a reduction in weight of at least 6.6 pounds (3 kg) over the course of the first six months of intensive therapy. This determination must be documented in the chart.

Visit Eligibility

(Plan dependent)

One visit every week for the first month.

One visit every other week months 2-6.

A 6.6 pound weight loss must have occurred to continue past month six. Then one visit per month, up to month 12.

Example:

99213 - E/M 20-29 min.

99401 - Preventive counseling 15 min.

M62.830 - Muscle spasm of the back

M43.17 - Spondylolisthesis lumbosacral

Z68.30 - The patient's BMI value comes after the decimal.

Golden Nugget #5

5. Are there any Medicare shortcuts?

There are no Medicare shortcuts! You may treat Medicare patients if you are Non-participating provider. Make sure you have a ABN on file. However, be aware that the baby boomers are coming!! Q

Transaction	Service Date	Posted Date	Description	Ref Number	Fee	Trans Amt	Ins Bal	Pt Bal
99214	12/18/2014	12/17/2014	OFFICE/OUTPATIENT VISIT EST		\$200.00	\$0.00	\$200.00	\$0.00
Transfer		12/17/2014	From Primary Insurance to Patient		\$0.00	(\$25.00)	\$175.00	\$25.00
Insurance Payment		1/28/2015	Insurance Payment Insurance Denial, UMR- Midwest 47033263-01		\$0.00	\$0.00	\$175.00	\$25.00
Pmt Note		1/28/2015	Insurance company is requesting more information. Please contact them or remit payment. Thank you					
Transfer		1/28/2015	From Primary Insurance to Patient	47033263-01	\$0.00	(\$175.00)	\$0.00	\$200.00
Insurance Payment		2/10/2015	Insurance Payment Check, UMR	00018616	\$0.00	(\$109.17)	(\$109.17)	\$200.00
Insurance Adjustment		2/10/2015	Contractual Insurance Adj Check, UMR	00018616	\$0.00	(\$65.83)	(\$175.00)	\$200.00
Transfer		2/10/2015	From Patient to Primary Insurance	00018616	\$0.00	(\$175.00)	\$0.00	\$25.00
Patient Payment		3/1/2017	Patient Payment Credit Card, Fertitta, Damien	4	\$0.00	(\$25.00)	\$0.00	\$0.00
Pmt Note		3/1/2017	AutoAllocated for deposit 4					
99401	12/18/2014	12/17/2014	PREVENTIVE COUNSELING INDIV		\$100.00	\$0.00	\$100.00	\$0.00
Transfer		1/28/2015	From Primary Insurance to Patient	47033263-01	\$0.00	(\$100.00)	\$0.00	\$100.00
Insurance Payment		2/10/2015	Insurance Payment Check, UMR	00018616	\$0.00	(\$52.30)	(\$52.30)	\$100.00
Insurance Adjustment		2/10/2015	Contractual Insurance Adj Check, UMR	00018616	\$0.00	(\$47.70)	(\$100.00)	\$100.00
Transfer		2/10/2015	From Patient to Primary Insurance	00018616	\$0.00	(\$100.00)	\$0.00	\$0.00
Due: \$0.00	Pd: \$186.47	Adj: \$113.53	Total:		\$300.00	\$300.00	\$0.00	\$0.00

Golden Nugget #6

6. Does the office have to return over payment or extra payments made by the insurance company?

If the office has a contract with and insurance company, yes. However, if there is no contract and it was the fault of the insurance company the office does not have to pay it back, but if the insurance company paid the office twice for the same visit then yes, the double payment must be paid back.

Review of the patient's records

CPT code 99358. Face-to-face is not required, can be done before or after the treatment. This is for an extensive or unusual review of the patients records. There is a minimum of 30 min. spent by the doctor. Past the initial hour use code 99359 for the subsequent 30 min.

Example:

A new patient is transferring to your office from another. This patient has numerous complicating issues and in the best interest of the patient the doctor must review a lengthy patient file.

The D.C. would be inclined to bill for 99358 (review of the records) the office visit 99202-(25) (E/M) & 98940 (CMT 1-2 areas) or 98940 and any other warranted procedures like 97140-59.

5 billing codes are accepted by most non-government insurances.

Use the highest billing value 1st with all subsequent values in descending order.

Typically, the 1st will reimburse at 100% of customary and the remaining will descend in value from around 80% to 10% of allowed.

99050

To compensate staff for the extra work of having come in to open an office that was closed to specifically see a patient. The code is defined as: “Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (holidays, Saturday or Sunday), in addition to basic service.”

Golden Nugget #7

7. On pre-pay packages what must the D.C. return in the event of cancelation? Does it expire?

The normal office visit is \$65, if a patient pays \$1,000 for 20 visits (\$50 per visit) this is acceptable. If the patient requests a refund after 10 visits the office must give \$500 back to the patient (\$50 per visit). If the patient wants to bank the 10 visits the office may not say that they expire. Q

How do you know that you are billing the correct amount for the services you provide?

This is the benchmark for all other services that you provide in your office. Insurance companies provide values for these CPT codes. If the office under charges for one of these codes they will reduce the reimbursement. If the office overcharges the insurance will only pay what they have deemed demographically reasonable for your area.

Fair prices for your services?

98940 - 65.00

98941 - 72.00

98942 - 110.00

98943 - 50.00

99202 - 130.00

99203 - 250.00

99204 - 280.00

99211 - 60.00

99212 - 110.00

99213 - 205.00

99214 - 290.00

Example:

Office A bills;

98940 – 45.00

97140-59 – 30.00

97012 – 15.00

Total of 90.00

Office B bills;

98940 – 83.00

97140-59 – 69.00

97012 – 35.00

Total of 187.00

Example

Patient A enters your office. On the 2nd visit you bill a spinal adjustment 98940. On the same visit you do some manual therapy 97140-59 (providing separate and distinct services not often performed together.) You follow up with some manual cervical traction 97012.

1. 98940 will be paid at 100% of customary.
2. 97140-59 will be paid at 80% of customary.
3. 97012 will be paid at 40% of customary.
4. ----- will be paid at 40% of customary.
5. ----- will be paid at 10% of customary.

Patient's production and collection ledger for period: 04/20/20 - 09/03/20

Date	Dr	Service	Code	Tot.chrg	Pat.chrg	Pat.w-off	Payment	Copay	Deduc.	Pat Bal.	I.portion	Ins.Paid	Wr
04/23/20	1	NP De Exm	99203	175.00						0.00	175.00	175.00	
04/23/20	1	C Cmp X 72052	72052	420.00	92.69			40.00		92.69	327.31	327.31	
04/23/20	1	EMS 97014	97014	50.00	3.86					96.55	46.14	46.14	
04/23/20	1	IST 97012	97012	50.00	3.86					100.41	46.14	46.14	
04/27/20	1	ADJ 1-2 98940	98940	80.00	20.00			16.72		120.41	60.00	60.00	
04/27/20	1	EMS 97014	97014	50.00	7.14			3.28		127.55	42.86	42.86	
04/27/20	1	IST 97012	97012	50.00	3.86					131.41	46.14	46.14	
04/28/20	1	ADJ 1-2 98940	98940	80.00	20.00			16.72		151.41	60.00	60.00	
04/28/20	1	EMS 97014	97014	50.00	7.14			3.28		158.55	42.86	42.86	
04/28/20	1	IST 97012	97012	50.00	3.86					162.41	46.14	46.14	
04/30/20	1	ADJ 1-2 98940	98940	80.00	20.00			16.72		182.41	60.00	60.00	
04/30/20	1	EMS 97014	97014	50.00	7.14			3.28		189.55	42.86	42.86	
04/30/20	1	IST 97012	97012	50.00	3.86					193.41	46.14	46.14	
04/30/20	1	DynaROM	96002	75.00						193.41	75.00	75.00	
04/30/20	1	DynaROM	96004	375.00						193.41	375.00	375.00	

Golden Nugget #8

8. Are your fees posted on your website?

While it is nice to see fees for your services, things may become confusing when an insurance company questions your “cash” fees when they are being billed for a greater cost. Often P.I. bills run higher for many reasons, keep the confusion out of the equation.

Golden Nugget #9

9. When will the single largest portion of baby boomers will become Medicare eligible?

Now!!! Approximately 10,000 people a day become Medicare eligible. This will continue non-stop for the next 15 years. Medicare reimbursement is anywhere from \$28.00-\$62.00. Do the math.

Medicare

The patient must have significant neuromusculoskeletal issues. The treatment must have a direct relationship to the issue. It is either an Acute subluxation or a Chronic subluxation. Q

Medicare

"Documentation Guidelines."

It explains in detail what needs to be documented for both the initial visit and all the follow up visits. One of the most important part of the Medicare documentation is that there is a treatment plan and it's clear where that visit fits on the treatment plan.

<https://med.noridianmedicare.com/web/jeb/specialties/chiropractic>

Acute subluxation

Patient has presented with a new issue.

Adjustments are expected to improve the patient's condition.

Chronic subluxation

The condition of your patient is chronic. However, where treatment will aid in the functional improvements of the patient prior to being “stable”, the treatments will not be considered “maintenance”. After the patient has become stable the treatments will be considered maintenance.

(Flair-up in previous condition w/30 days, impairing ADL's)

Remember that there are **NO** decimals in the Dx boxes for Medicare.

M9905

M9915

Not M99.15 Subluxation complex (vertebral) of pelvic region

https://www.ahd.com/ICD10desc_diag_CMS2015.pdf

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Medicare-Modifiers

AT modifier used on a claim when providing active/corrective treatment to treat acute or chronic subluxation. 98940,41,42

GA modifier used to indicate that you expect Medicare to deny a service (e.g., maintenance services) as not reasonable and necessary and that you have on file an Advance Beneficiary Notice (ABN) signed by the beneficiary. 97014

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1601.pdf>

https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/34009_2/CodingGuidelinesChiropracticServices.pdf

GY services that are not spinal manipulation which are billed to Medicare should have this modifier, denotes that the services are not paid by Medicare.

GP must follow physical medicine codes 97012-97799. This modifier enables Medicare to deny properly so a secondary will pick up the payment.

Examples:

98941 AT (Medicare will pay)

97112 GY GP (The office telling Medicare that this code is NOT reimbursable, and Medicare can properly deny so the secondary can pay.)

98941 GA (The office has a signed ABN on file and the patient will pay the fee.)

Region	Old SSD Code	New Subluxation Code 
Cervical	M99.01	M99.11
Thoracic	M99.02	M99.12
Lumbar	M99.03	M99.13
Sacral	M99.04	M99.14
Pelvic	M99.05	M99.15

If your Medicare claims suddenly started being denied, or your clearinghouse is flagging diagnosis issues, this is probably why.

Reimbursements

Typically, when billing is done properly, the office will receive anywhere from;

\$28.00-\$35.00 for 98940,

\$40.00-\$48.00 for 98941, and

\$53.00-\$62.00 for 98942.

This depends on your office location.

<https://med.noridianmedicare.com/web/jeb/fees-news/fee-schedules/mpfs>.

Advanced Beneficiary Notice of Noncoverage

This allows the patient to make informed choices on receiving services that are not covered by Medicare. Like treatments other than 98940,41,42, or treatments that are “not medically necessary.” You may now bill and collect from the patient.

Chiropractors can **not** opt-out of Medicare. Opting out is an option for some provider types so that they can bill the patient directly and not submit to Medicare, but this is not allowed for this specialty.

More can be read about this at:

https://med.noridianmedicare.com/web/jeb/enrollment/opt-out#providers_eligible_to_opt_out

There are two ways that a Chiropractor can be in Medicare's system. Participating Provider or Non-Participating Provider. Participating (Par) is when the Chiropractor accepts what Medicare pays as well as any patient portion that is obtained from the patient or a supplemental policy. Non-Participating (Non-Par) is when the Chiropractor can choose to accept assignment (accept what Medicare pays) or not accept assignment on a case by case basis (can charge the patient upfront for 15% above Medicare's allowed amount).

If the Chiropractor is not in the Medicare system as (Par or Non-Par) the Chiropractor may not treat the patient at all legally, even on a cash basis. The patient should seek care from a Medicare provider.

Exception

If the patient has signed the ABN, it is a covered service (manipulation), it is maintenance care, the DC is enrolled in Medicare as a Par or Non-Par, and the patient selects the “do not bill” section.

The fees are still limited to the “limited charge” for the covered service. Q

Patient name:
Identification number: (optional)

Notifier name
Notifier address
Notifier phone (including TTY)

Advance Beneficiary Notice of Non-coverage (ABN)

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

Item, test, service or care	Reason Medicare may not pay	Estimated cost

What to do now

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

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

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

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

Additional information:

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

Signature	Date (mm/dd/yyyy)
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You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit [Medicare.gov/about-us/accessibility-nondiscrimination-notice](https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice).

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. This information collection is for providers, suppliers, Hospice and Religious Non-medical HealthCare Institutes and Home Health Agencies to notify original Medicare beneficiaries of their potential financial liability under specific conditions. The time required to complete this information collection is estimated to average less than 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory under Section 1879 of the Social Security Act, 42 CFR 411.404(b) and (c) and 411.408(d)(2) and (f). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMO, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Chiropractic

- Do not bill AT with GA on same code
- All services except for manipulation are non-covered, so ABN is voluntary

Insurance Plan:

Note: You need to make a choice about receiving these health care items or services.

We expect that your insurance company will not pay for the item(s) or service(s) that are described below. Your Insurance Company does not pay for all of your health care costs, and only pays for covered items and services when your insurance company's rules are met. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. **In this case, your Insurance Company will likely not pay for:**

Item or Service:

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will likely pay for them outside of your insurance coverage. Before you make a decision, please:

- Ask us to explain if you do not understand why your Insurance Company will likely not cover these services.
- Take note of how much these items or services will cost you. *Estimated Cost:* \$ _____

Please choose one option. Check one box. Sign and date.

☐ **Option 1: Yes, I want to receive these items or services.**

I understand that my Insurance Company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. I understand that I will be paying for these items or services at the time of service, and that should my Insurance Company pay I will receive a refund of payments I made to you that are due to me. If my Insurance Company denies payment, I agree to be personally and fully responsible for payment.

☐ **Option 2: No, I have decided not to receive these items or services.**

I will not receive these items or services.

SIGNATURE of patient or person acting on patient's behalf

DATE

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential. If a claim is submitted to your insurance company, your health information on this form may be shared with your insurance company.

Add to box H.

(Non-participating doctor)

“This supplier does not accept payment from Medicare for the listed items above. Option 1, I the patient am responsible for paying the charges. If Medicare does pay I will accept payment myself, less the supplier's charges.”

Remember it is easy to deny if:

- Item 11 on claim form is incomplete, put NONE if Medicare is primary.
- Item 12, 13 have signature on file.
- The Dx pointer has ABCD, just one letter per box.
- Use CMS-R-131
- Confirm with the patient about ABN prior to treatment.
- If determined by subluxation item 19 must have X-ray and the date taken.
- Secondary Dx must relate to the Subluxation.

Common codes (one on one contact)

97110 -Therapeutic exercises to develop strength, endurance ROM and flexibility.

97112 -Therapeutic procedure, one or more areas, each 15 minutes, neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and proprioception.

97116 -Special gait training.

97124 -Massage, including effleurage.

97140 - Manual therapy techniques, one or more regions.

97150 - Therapeutic procedures in a group setting two or more.

97530 -Therapeutic activities, direct one-on-one patient contact by the provider each 15 minutes.

97535 –Self care/home management training (e.g., activities of daily living and compensatory training, safety procedures, and instructions in use of assistive technology devices/adaptive equipment), direct one-on-one contact 15 minutes.

97760 -Orthotics management training 15 minutes. Q

97763 -Subsequent encounter orthotics exam.

99417 –Additional 15 minutes.

17	6/24/2025	12:	97140	CPT - Manual therapy 1/> regions	80.00	0.00	0.00	80.00	BA
18	6/24/2025	12:	98943	CPT - Chiropract manj xtrspini 1/>	200.00	116.97	0.00	83.03	RF_6
19	6/24/2025	12:	98941	CPT - Chiropract manj 3-4 regions	85.00	10.28	0.00	74.72	RF_6
20	6/24/2025	12:	97530	CPT - Therapeutic activities	85.00	10.28	0.00	74.72	RF_6
21	6/23/2025	12:	97530	CPT - Therapeutic activities	80.00	10.47	0.00	69.53	RF_6
22	6/23/2025	12:	97140	CPT - Manual therapy 1/> regions	200.00	116.97	0.00	83.03	RF_6
23	6/23/2025	12:	98941	CPT - Chiropract manj 3-4 regions	80.00	0.00	0.00	80.00	BA
24	6/23/2025	12:	98943	CPT - Chiropract manj xtrspini 1/>	80.00	0.00	0.00	80.00	BA
25	6/12/2025	12:	98943	CPT - Chiropract manj xtrspini 1/>	200.00	116.97	0.00	83.03	RF_6
26	6/12/2025	12:	98941	CPT - Chiropract manj 3-4 regions	85.00	10.28	0.00	74.72	RF_6
27	6/12/2025	12:	97530	CPT - Therapeutic activities	200.00	116.97	0.00	83.03	RF_6
28	6/11/2025	12:	98941	CPT - Chiropract manj 3-4 regions	80.00	0.00	0.00	80.00	BA
29	6/11/2025	12:	98943	CPT - Chiropract manj xtrspini 1/>	85.00	10.28	0.00	74.72	RF_6
30	6/11/2025	12:	97530	CPT - Therapeutic activities	80.00	0.00	0.00	80.00	BA
31	6/4/2025	12:C	98943	CPT - Chiropract manj xtrspini 1/>	85.00	10.28	0.00	74.72	RF_6
32	6/4/2025	12:C	97530	CPT - Therapeutic activities	200.00	116.97	0.00	83.03	RF_6
33	6/4/2025	12:C	98941	CPT - Chiropract manj 3-4 regions	85.00	10.28	0.00	74.72	RF_6
34	6/3/2025	12:C	97530	CPT - Therapeutic activities					

Codes that do not require direct contact just supervision

97010 -hot or cold packs

97012 -traction, mechanical

97014 -electronic stimulation (unattended)

97018 -paraffin bath

97024 -diathermy

97026 -infrared

97028 -ultraviolet

Codes that require one-on-one contact

97032 -electrical stimulation 15 minutes

97033 -iontophoresis 15 minutes

97034 -contrast baths 15 minutes

97035 -ultrasound 15 minutes

Write the time, area and document all patient encounters it in the chart!!

Modifiers

Modifier 25 is exclusively used for evaluation and management codes. The patient requires a significant, separately identifiable service on the same day. If the 25 modifier is not used with the E&M neither service will be paid.

Modifier 52 is used to indicate when a timed service does not meet the minimum standard time for that particular service but was still performed.

Modifier 59 is used to distinguish that a particular service is distinctly separate from another, also used to identify procedures/services that are not normally reported together. Very important for 97110, 97124 and 97140 when billed in conjunction with the adjustment. This MUST be performed on a separate area away from the CMT.

Examples of the modifiers

Let's say a new patient comes in, you spend 30 min. with the new patient but there is more information that comes out in the course of the face to face contact. In fact, you spend another hour with the patient discussing their medical issues, but the exam does not escalate to more bullets. Subsequent to this, there is separate and distinct treatment on another region warranted on the patient.

The D.C. would be inclined to document the time and describe in the notes the face-to-face encounter, then bill for:

Example:

99203-(25) (Because treatment was performed)

99417 (Prolonged physician service)

98940 (1-2 regions)

97140-59 GP XS (Distinctly separate from another)

Anthem requires “GP” in addition to 59 for DC’s on
all TIMED therapy codes (92507 92508 92526
92608 92609 96125 97012 97016 97018 97022 97024
97026 97028 97032 97033 97034 97035 97036 97039
97110 97112 97113 97116 97124 97139 97140 97150
97530 97533 97535 97537 97542 97750 97755 97760
97761 97763 97799 G0281 G0283 G0329)

Other Insurance

The XS may be required but remember to change the Dx pointer away from the adjustment code.

97140 59 GP or 97140 XS or 97140 XS GP

UNC requires “GP” for DC’s on all TIMED
therapy codes (97110,97140,97535)

Limits providers to \$60.00-68.00

Updated Procedure to Modifier Policy, Professional – Always Therapy: GN, GO, and GP modifiers Required Effective April 1, 2020

Effective April 1, 2020, we're updating the Procedure To Modifier Policy, Professional to require the GN, GO, or GP modifier on "Always Therapy" codes to align with the Centers for Medicare & Medicaid Services (CMS).

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RES COD	
A. M99.03		B. M54.5		C. M99.04		D. S33.8XXD				23. PRI			
E. M25.511		F.		G.		H.							
I.		J.		K.		L.							
24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	S CH
From To								CPT/HCPCS MODIFIER					
MM	DD	YY	MM	DD	YY								
06	01	21	06	01	21	11		98940				ABCD	
06	01	21	06	01	21	11		97140 XS				E	

D. PROCEDURES, SERVICES, OR SUPPLIES**(Explain Unusual Circumstances)****CPT/HCPCS****MODIFIER****E.****DIAGNOSIS****POINTER**

99203

25

A

98940

A

97124

GP

59

A

ICD 10 Codes

G89.0 Central pain syndrome

G89.11 Acute pain due to trauma

G89.12 Acute post-thoracotomy pain

G89.18 Other acute postprocedural pain

G89.21 Chronic pain due to trauma

G89.22 Chronic post-thoracotomy pain

G89.28 Other chronic postprocedural pain

G89.29 Other chronic pain

G89.3 Neoplasm related pain (acute) (chronic)

G89.4 Chronic pain syndrome

Bonus Golden Nugget

If an insurance company calls and asks the office to send them a patient file, what should the office do?

If there is no release of records signed by the patient, do not release the records. If the office is contracted with a preferred provider network, and it explicitly states in the contract that if the insurer requests the patient file the office must send the file. A prudent office should still call the patient for a release of records just to be safe. Q

Headache

While this Dx code is in general valid billable code, it should be further specified. Don't be afraid to describe the specifics of their symptoms. A headache that is unilateral is different from a bilateral headache. A headache that causes right sided pain with the inability to tolerate light is different from R51 (deleted).

F07.81 Postconcussional syndrome	migrainosus
G43.001 Migraine without aura, not intractable, with status migrainosus	G43.711 Chronic migraine without aura, intractable, with status migrainosus
G43.009 Migraine without aura, not intractable, without status migrainosus	G43.719 Chronic migraine without aura, intractable, without status migrainosus
G43.011 Migraine without aura, intractable, with status migrainosus	G43.801 Other migraine, not intractable, with status migrainosus
G43.019 Migraine without aura, intractable, without status migrainosus	G43.809 Other migraine, not intractable, without status migrainosus
G43.101 Migraine with aura, not intractable, with status migrainosus	G43.811 Other migraine, intractable, with status migrainosus
G43.109 Migraine with aura, not intractable, without status migrainosus	G43.819 Other migraine, intractable, without status migrainosus
G43.111 Migraine with aura, intractable, with status migrainosus	G43.821 Menstrual migraine, not intractable, with status migrainosus
G43.119 Migraine with aura, intractable, without status migrainosus	G43.829 Menstrual migraine, not intractable, without status migrainosus
G43.401 Hemiplegic migraine, not intractable, with status migrainosus	G43.831 Menstrual migraine, intractable, with status migrainosus
G43.409 Hemiplegic migraine, not intractable, without status migrainosus	G43.839 Menstrual migraine, intractable, without status migrainosus
G43.411 Hemiplegic migraine, intractable, with status migrainosus	G43.901 Migraine, unspecified, not intractable, with status migrainosus
G43.419 Hemiplegic migraine, intractable, without status migrainosus	
G43.501 Persistent migraine aura without cerebral infarction, not intractable, with status migrainosus	
G43.509 Persistent migraine aura without cerebral infarction, not intractable, without status migrainosus	
G43.511 Persistent migraine aura without cerebral infarction, intractable, with status migrainosus	
G43.519 Persistent migraine aura without cerebral infarction, intractable, without status migrainosus	
G43.601 Persistent migraine aura with cerebral infarction, not intractable, with status migrainosus	
G43.609 Persistent migraine aura with cerebral infarction, not intractable, without status migrainosus	
G43.611 Persistent migraine aura with cerebral infarction, intractable, with status migrainosus	
G43.619 Persistent migraine aura with cerebral infarction, intractable, without status migrainosus	
G43.701 Chronic migraine without aura, not intractable, with status migrainosus	
G43.709 Chronic migraine without aura, not intractable, without status migrainosus	

G43.909 Migraine, unspecified, not intractable, without status migrainosus	G44.201 Tension-type headache, unspecified, intractable
G43.911 Migraine, unspecified, intractable, with status migrainosus	G44.209 Tension-type headache, unspecified, not intractable
G43.919 Migraine, unspecified, intractable, without status migrainosus	G44.211 Episodic tension-type headache, intractable
G43.A0 Cyclical vomiting, not intractable	G44.219 Episodic tension-type headache, not intractable
G43.A1 Cyclical vomiting, intractable	G44.221 Chronic tension-type headache, intractable
G43.B0 Ophthalmoplegic migraine, not intractable	G44.229 Chronic tension-type headache, not intractable
G43.B1 Ophthalmoplegic migraine, intractable	G44.301 Post-traumatic headache, unspecified, intractable
G43.C0 Periodic headache syndromes in child or adult, not intractable	G44.309 Post-traumatic headache, unspecified, not intractable
G43.C1 Periodic headache syndromes in child or adult, intractable	G44.311 Acute post-traumatic headache, intractable
G43.D0 Abdominal migraine, not intractable	G44.319 Acute post-traumatic headache, not intractable
G43.D1 Abdominal migraine, intractable	G44.321 Chronic post-traumatic headache, intractable
G44.001 Cluster headache syndrome, unspecified, intractable	G44.329 Chronic post-traumatic headache, not intractable
G44.009 Cluster headache syndrome, unspecified, not intractable	G44.40 Drug-induced headache, not elsewhere classified, not intractable
G44.011 Episodic cluster headache, intractable	G44.41 Drug-induced headache, not elsewhere classified, intractable
G44.019 Episodic cluster headache, not intractable	G44.51 Hemicrania continua
G44.021 Chronic cluster headache, intractable	G44.52 New daily persistent headache (NDPH)
G44.029 Chronic cluster headache, not intractable	G44.53 Primary thunderclap headache
G44.031 Episodic paroxysmal hemicrania, intractable	G44.59 Other complicated headache syndrome
G44.039 Episodic paroxysmal hemicrania, not intractable	G44.81 Hypnic headache
G44.041 Chronic paroxysmal hemicrania, intractable	G44.82 Headache associated with sexual activity
G44.049 Chronic paroxysmal hemicrania, not intractable	G44.83 Primary cough headache
G44.051 Short lasting unilateral neuralgiform headache with conjunctival injection and tearing (SUNCT), intractable	G44.84 Primary exertional headache
G44.059 Short lasting unilateral neuralgiform headache with conjunctival injection and tearing (SUNCT), not intractable	G44.85 Primary stabbing headache
G44.091 Other trigeminal autonomic cephalgias (TAC), intractable	G44.89 Other headache syndrome
G44.099 Other trigeminal autonomic cephalgias (TAC), not intractable	
G44.1 Vascular headache, not elsewhere classified	

Workers' Compensation

Fee Schedule

Active care

Not passive care

New and Established Patients

CPT

\$\$\$

99202	109.77
99203	147.38
99204	222.41
99205	279.17
99211	36.41
99212	69.40
99213	115.18
99214	165.02
99215	212.14

Telephone Services

CPT

\$\$\$

98966	5-10 min.	18.68
98967	11-20 min.	36.10
98968	21-30 min.	53.22

Prolonged Services

CPT

\$\$\$

99358	W/O Pt. contact	165.40
99359	W/O Pt. contact additional time	80.97

99358 and 99359

To bill 99358, which is for before or after direct care, you must spend 31 or more minutes in record review before using 99358, and 76 or more minutes before using 99358 and 99359.

99358 is for the first hour but you cannot bill it until you spend more than 30 minutes

99359 is for each additional 30 minutes after the first hour. You must spend at least 71 minutes to bill this code.

Modalities

<u>CPT</u>	Code Definition	<u>100%</u>
<u>97010</u>	Hot or cold pack	0.00
<u>97012</u>	Mechanical Traction	22.32
<u>G0283</u>	Electric Stim (unattended)	19.06
<u>97018</u>	Paraffin Bath	15.55
<u>97022</u>	Whirlpool	33.66
<u>97024</u>	Diathermy	9.32
<u>97026</u>	Infrared	8.28
<u>97028</u>	Ultraviolet	10.25

Procedures

<u>CPT</u>	Code Definition	<u>100%</u>
<u>97032</u>	Electric Stim. (Manual)	26.47
<u>97033</u>	Electric Current Therapy	30.57
<u>97034</u>	Contrast Bath Therapy 2	5.13
<u>97035</u>	Ultrasound	17.34
<u>97036</u>	Hydrotherapy	46.57
<u>97110</u>	Therapeutic Exercise	47.90
<u>97112</u>	Neuromuscular ReEd.	52.98
<u>97113</u>	Aquatic Therapy/Exercises	60.76
<u>97116</u>	Gait Training	39.16

<u>97124</u> Massage - Therapeutic	36.32
<u>97140</u> Manual Therapy 1/> regions	43.60
<u>97150</u> Grp Therapeutic	23.66
<u>97530</u> Therapeutic Activities	62.82
<u>97533</u> Sensory Integration	40.50
<u>97535</u> Self-Care/mgmt. Train.	52.54
<u>97750</u> Phys. Performance Test	45.42
<u>97760</u> Orthotic mgmt. & Training	53.21
<u>98940</u> CMT-1-2 regions	43.61
<u>98941</u> CMT-3-4 regions	62.44
<u>98942</u> CMT-5 regions	82.04
<u>98943</u> Extra Spinal	41.83

D.C.'s as a primary treating physician is limited to 4 services/units per day.

Reimbursement is 120% of Medicare rates or what is reasonable. Submission and reimbursement is 45 days for paper claims and 15 days for e-claims submitted on 1500 forms.

Entitled to late reimbursements costs, 15% penalty, 10% annum interest.
1st code paid at 100%, reduced to 80% for the 2nd.

Treatment must begin within the first 30 days of injury

PR2 must be done every 45 days or sooner when a change in treatment is recommended, a change in condition, a change in work status or patient is released from care. PR2 requires an examination and if requesting more visits include Request for Authorization. PR2 used for a fully recovered patient with no residual disabilities. (<https://www.dir.ca.gov/t8/formpr-2.pdf>)

Use the PR4 where a patient has become P&S (permanent and stationary). Denotes a left-over disability and need for future care.

(<https://www.dir.ca.gov/dwc/ForumDocs/ICD10/PR4.pdf>)

Make things easy

Invest in a software program that integrates the billing, coding and patient notes. This is going to streamline the time it takes for the office to bill. This will help the doctor to scribe their notes. (The notes that an insurance company will want to see.) Lastly, this will aid in the timely payment of claims. These software programs integrate all areas of billing and coding for Medicare, regular health insurance, workman's compensation and prompt pays. In some cases this is all cloud based.

Golden Nugget #10

10. Can you bill for the ROF, or is it included in the exam?

The ROF may not be billed separately from the exam. The ROF is included in the exam. There is no way around this. Q

CIGNA

Passive care is acceptable for the acute phase of treatment. Used to reduce inflammation, stabilize and promote ROM, thus restoring function. Their take is that 2-3 passive modalities per visit is excessive and not necessary.

Integration of active care by strengthening the 1st and 2nd level muscle groups, increasing muscle tone, ROM and endurance for a full recovery. The insurance company wants to see the patient in **active care**.

97530 or 97535

Specific Diagnosis Codes

Specific ICD-10 coding will get the greatest number of treatments for the patient's condition.

(<https://www.icd10data.com/ICD10CM/Codes>)

This means no more neck pain, low back pain or arm pain. Insurance companies are not interested in back pain.

Example:

Degeneration of lumbar/lumbosacral IVD...with left side sciatica...M54.42 or lesion of the sciatic nerve, right lower limb...G57.01

Approximate Synonyms: Bilateral piriformis syndrome, Bilateral posterior interosseous nerve syndrome, Bilateral sciatic neuropathy, Piriformis syndrome, right, Right sciatic nerve lesion, Right sciatic neuropathy, Right sided piriformis syndrome

Chiropractic Billing Specialists

Questions answered free of charge

[ChiroBill ~ Joanne Queiroz](#)

925.706.9884

[Wellness Solutions ~ Jennifer Nichols](#)

619.244.8215

Personal Injury

We have a chiro office the client chose so we've never worked with before invoicing us \$35 for each of 2 patients up front before they will give us the records they are going to simply email to us in PDF to put the settlement demand together. Has anyone experienced this before? I haven't and I am a bit put off by it. I have had chiro offices charge anywhere from \$35-75 for reports in the past and always thought it was a little much since the report is what gets the settlement done on a lien case - however those were always added to the lien.

I do not want to encourage this to become widespread practice among chiro offices where law firms are fronting these fees on every case in the future - but maybe I'm out of touch and that is already happening?

Personal Injury

The documentation for chiropractic treatment in personal injury claims must be clear and concise. Missed work, travel time, accident information and hardships must be documented. The claim will not be paid in full without the proper documentation showing that your chiropractic care was a reasonable and necessary expense.

Detailed patient charts, specific Dx codes, listing the extent and severity of each and every symptom is a must for reimbursement.

Insurance company tricks

Insurance companies are now calling the patient and asking them to settle the case before the D.C. is done.

Example:

Patient A has a \$4,000 bill at your office. The insurance company calls the patient and says we will give you \$2,500 right now cash. Remember, the insurance company is not in contract with you.

Coverage	Limit	Charges	Paid	Wages	Essential Services	Funeral	Other	Remaining
PIP 	\$25,000.00		-	-	-	-	-	\$25,000.00
MedPay	-	\$11,205.00		-	-	-	-	(\$11,205.00)
Totals	\$25,000.00	\$11,205.00	\$11,205.00	-	-	-	-	\$13,795.00
Deductible	-		-					
Copay	-		-					
Interest + Penalty			-					

Example:

A week into treatment, the patient gets a call from the insurance company stating that if the patient uses med-pay their insurance rates will go up (insurance bad faith) or that cases like theirs will cost \$4,000 and if they settle now they will give the patient \$2,000.

DOCTOR'S LIEN

Patient:

Date of Loss:

Firm

Re:

I hereby authorize the above referenced physician to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc...of my medical condition with regard to the accident/injury sustained on the above documented date of loss.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered to me both by reason of this accident/injury and reason of any other bills that are due in his office. I authorize him to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect such doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict that may be paid to you, my attorney, or myself as a result of the injuries treated for the above documented date of loss.

I fully understand that I am directly and fully responsible to said treating physician for all medical bills submitted by him or his office for services rendered to me and this agreement is made solely for said doctor's additional protection and in consideration for his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I eventually may recover said fee.

DATE: _____ PATIENT'S SIGNATURE: _____

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms found above and agrees to withhold such amount from any settlement, judgment, or verdict as may be necessary to adequately protect said treating physician. By signing below, you acknowledge that you are licensed to practice law in the state of Nevada.

DATE: _____ ATTORNEY'S SIGNATURE: _____

ACCIDENT 101

STOP The law requires you to stop if there is any property damage or an injury.

CALL Make the call to the police. They will document the accident and place fault.

RECORD/PHOTO A picture is worth a thousand words and in some cases priceless.

GET WITNESSES These are the eyes and ears of merit for the claim.

GO TO THE HOSPITAL Further validation for our patients that there is a tangible injury.

The average chiropractic treatment duration for a personal injury is about 3-4 months.

Insurance companies are less inclined to pay for the continued treatment, if it has been unjustly prolonged. This is rebuttable when there is support of complicating factors and specific Dx codes to further substantiate the continued treatment. Avoid gaps in treatment.

Working with Insurance Companies Leads to More Timely Claims

Chiropractic treatment is recoverable in a personal injury lawsuit as long as you can prove that they are reasonably necessary and appropriate for the particular injury. This can be an issue when members of the jury are biased against chiropractors.

Change the perception.

Statute of Limitations (SOL)

Injury to a person

The defendant hurts a plaintiff with or without intent. For example, personal injury accidents, wrongful death, assault, battery, intentional or negligent infliction of emotional distress, wrongful act, or negligent act, etc.

(California Code of Civil Procedure section 335.1.)

2 years from the date of injury to file a claim

Statute of Limitations (SOL)

Damage to property

If a person damages or destroys your property either with or without intending to damage it, like taking your personal property (conversion), crashing your vehicle, going onto your property without permission (trespass), fraud, nuisance, etc.

3 years from the date the property was damaged to file a claim

All must be supported by notes, patient symptoms and diagnosis

~ 99401 + 98940,41,42 + 97140-59(without 59=0)+ 97012+
CPT 5 = Payment (only 4 for Gov. Claims)

~Medicare gives more weight to spasms* than pain.

~Over-payment to a Non-network provider, you are not required to pay back (absent fraudulent billing). In-network are required to pay back before 365 days (Don't mess with Gov. benefits send it back, you are required to).

~Insurance companies will sue the doctor to recover costs from procedures that were not performed and in some cases were not documented.

~97116-59 (gait training) + 97530 (functional activities) + patient notes = Payment

~If you become a new health care provider for an insurance company, you will likely be forced into e-billing.

~Typically, WNL is not acceptable for a re-exam.

~Problem focused exams will not satisfy the bullet points.

~Constant attendance 8-22 min. for 1 unit, 23-37 min. for the second unit, chart the start and finish time in the chart.

~97110/97112 kinesiotaping with active therapy. K-Tape is a supply and will be included in the direct contact time with the patient.

~Records **MUST** be related to patient symptoms, treatment, and Dx, without it you are in violation.

Surprise bills and Balance billing

Surprise bills occur when a patient goes to a hospital in his insurance network, but receives treatment from a doctor who does not participate in the network. This results in a direct bill to the patient. This also occurs when insurers pay for needed emergency care at the closest hospital — even if it is out of network — but the hospital and the insurer don't agree on a reasonable price. The hospital then demands that the patient pay the difference, in a practice called balance billing. AB 72

Several states, including CA, TX, NY, IL, FL, CT, MD, CO, MN, WV, and UT have passed laws to help shield consumers from surprise bills and balance billing, particularly for emergency care.

However, those state-mandated protections don't apply to certain insured people who get their health coverage from employers that are self-insured, meaning the companies or public employers pay claims out of their own funds. Federal law governs those health plans (not AB 72) and it does not include such protections.

About 60 percent of people with employer health benefits are covered by self-insured plans, but many don't even know it, since employers typically hire an insurer to administer the plan and employees carry a card bearing the name of Blue Cross Blue Shield, United Health Care, Aetna or another major insurer.

www.HealthcareBluebook.com

CA Surprise Billing Law

Adopts informed financial consent for private insurance. Creates a binding independent dispute resolution process in order to facilitate resolution to claims disputes between a carrier and an out-of-network provider.

Out-of-network providers can bill full amounts for out-of-network services at in-network facilities only if the patient consents in writing at least 24 hours in advance, after receiving an estimate of the costs and notice that in-network options are available. Requires plans and insurers to reimburse providers of surprise bills the greater of the average contracted rate or 125 percent of the Medicare payment for the same service in that geographic region.

AB 72 protects consumers receiving non-emergency services at in-network facilities from being balance billed by an out-of-network provider. California law already protects most consumers from balance billing for emergency services.

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I hope you enjoyed the course. Please feel free to provide feedback.

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