Billing & Coding

4 Hours

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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.

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.

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.

https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780

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)

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.

H.R.2654 - Chiropractic Medicare Coverage Modernization Act of 2021

117th Congress (2021-2022) | Get alerts

BILL Hide Overview

Sponsor: Rep. Higgins, Brian [D-NY-26] (Introduced 04/19/2021)

Committees: House - Energy and Commerce; Ways and Means

Latest Action: House - 04/20/2021 Referred to the Subcommittee on Health. (All Actions)

Tracker:

Introduced | Passed House | Passed Senate | To President | Became Law

More on This Bill

Constitutional Authority Statement

CBO Cost Estimates [0]

Subject — Policy Area:

Health

View subjects »

Give Feedback on This Bill

Contact Your Member

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**

UnitedHealthcare

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
Could be ending

99202-99215

Place of visit is 02

Use -95 modifier

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.

PPE Costs 99072

Supplies and Materials
Anything over the "usual" office supplies.

Medicare only pays PPE to MD's

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

LAW DOC TOP 10

1. Does the office have to collect co-pays, can you waive patient deductibles? What if the patient has a hardship?
2. Can the office give cash discounts?
3. What is prompt payment?
4. Must the office bill insurance companies weekly, bi-weekly monthly, or yearly?
5. Are there any Medicare shortcuts?
6. Does the office have to return over-payment or extra payments by an insurance company?
7. On pre-pay packages, what must the D.C. return in the event of cancellation? Do pre-pay packages expire?
8. Do you post your office fees on your website?
9. When will the single largest portion of baby boomers will become Medicare eligible?
10. Can the office bill separately for the ROF, or is it included in the exam?

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.

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.

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.

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.

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.“

New patient E/M Codes

99201 has been deleted

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

ACTIVITY	QTY	RATE	AMOUNT
Patient Name Services Rendered to [redacted] Diagnosis: M25.519 Shoulder Pain	1	0.00	0.00
99205-AJ 02/10/2021 99205 [redacted] MD Orthopedics NPI# [redacted] Initial Comprehensive Examination	1	1,250.00	1,250.00
[redacted] PLEASE REMIT PAYMENT TO : [redacted] CONSULTANTS	1	0.00	0.00
ADDRESS [redacted]	1	0.00	0.00

BALANCE DUE **$1,250.00**

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.

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
			(Must meet the requirements of at least 1 of the 2 categories)
			
			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

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 99354, 99355,99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes).

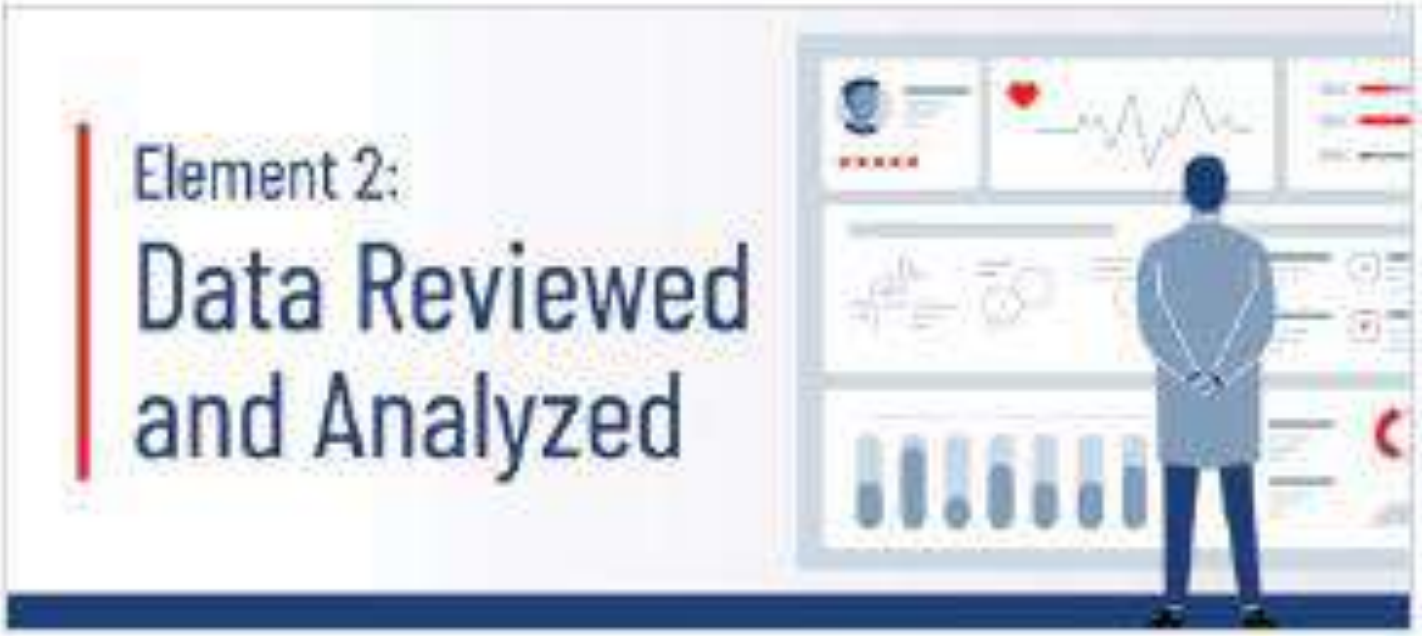
Elements of Medical Decision Making (MDM)

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

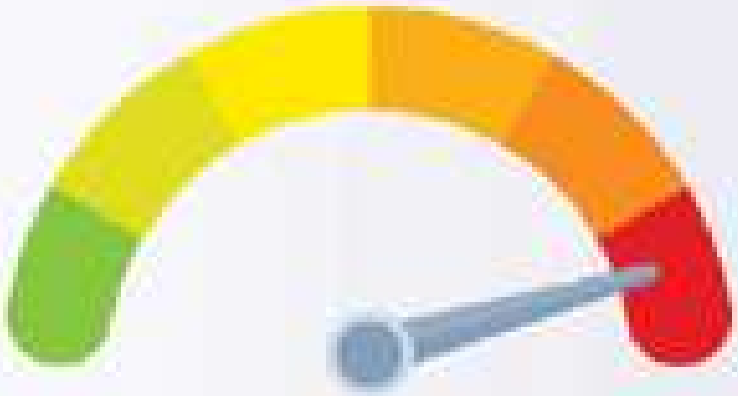
Element 1: This element accounts for the disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established.



Element 2: 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 OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN 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
[redacted]	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	
[redacted] CHIROPRACTIC INC	01/21/21 - 01/25/21	576024-1	$354.00			$0.00	$64.00	
[redacted] 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

Line	Date of Service	POS	CPT/ HCPCS	MOD/TS	Units	Submitted Amount	Approved Amount
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

Line	Date of Service	POS	CPT/ HCPCS	MOD/TS	Units	Submitted Amount	Approved Amount
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

CPT 99354/99355

Extended patient time with the E/M code. Used by the Doctor to explore other patient history, examination and/or counseling. This service is in the excess of time past the original E/M code. CPT 99354 is for the first hour, use code 99355 for each additional 30 min.

(Use 99355 in conjunction with 99354)

(Do not report 99355 in conjunction with

99202, 99203, 99204, 99205, 99211, 99212,

99213, 99214, 99215, 99415, 99416, 99417)

Example:

A new patient comes to your office due to neck pain. During the history and exam the doctor determines that the patient has numerous complicating factors. The doctor has exceeded the time allotted for the E/M code. In fact, the doctor spends an extra 60 min. with the patient getting more information and/or exam results. Your CPT codes would look like.

CPT 99202 (new patient), 99354 (extended time) and if you treat the patient 98940. Important, attach the 25 modifier to the E/M code if treatment is involved.

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 $30_{kg/m2}$ 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

HCPCS codes related to obesity screening, behavioral counseling or therapy:

- **G0446** – annual, face-to-face intensive behavioral counseling (IBT) for cardio-vascular disease (CVD), individual, 15 minutes
- **G0447** – face-to-face behavioral counseling for obesity, 15 minutes
- **G0473** – face-to-face behavioral counseling for obesity, group (2–10), 30 minutes.

The Healthcare Common Procedure Coding System (HCPCS, often pronounced by its acronym as "hick picks") is a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT).

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

Sample chart notes and billing for an office visit 99214 and preventive counseling 99401.

Visit note dated December 18, 2014 Complete. These are actual notes from a doctor. No spelling changes were made.

Chief Complaint/HPI
38 yo male with dyslipidemia, and elbow pain, review of systems he is doing well, studies are doing well, left elbow is stable, no myalgias
ROS Comment
Card: no cp or sob Pulm: no hemoptysis or cough GI: no diarrhea or Abdominal Pain GU: no urinary frequency or hesitancy Musculoskeltal : no muscle or joint pain Derm : no rashes or pruritus Allergy: no rhinitis or sinus congestion Psychiatric: no depression or insmonia Endocrine: no weight gain or loss Constitutional : no fever or chills Neuro: no numbness or tingling or vision changes or sx of diabetic neuropathy

Current Medication

atorvastatin 10 mg tablet, Tablet(s) PO TAKE 1 TABLET BY MOUTH AT BEDTIME, for a total of 90, start on April 22, 2014, end on September 16, 2015, TAKE 1 TABLET BY MOUTH AT BEDTIME.

Allergies

No known drug allergies

No known food allergies

Active Diagnoses

ACHILLES TENDINITIS

Encounter for general adult medical examination without abnormal findings

Encounter for screening for malignant neoplasm of prostate

Mass on back

OT MALAISE/FATIGUE
Other bursitis of elbow, unspecified elbow
Pure hyperglyceridemia
SCREEN MALIG NEOP-COLON
SCREENING LIPOID DISORD
Special screening, testicular cancer

Medical History
*Denies any medical problems Status: Active
Surgical History knee surgery Notes: Dr. Recorded Date: October 29, 2009
shoulder surgery Notes: Dr. Recorded Date: October 29, 2009

Family History
Relationship: Father Recorded Date: October 29, 2009
Notes: one month ago, 60 years old from motorcycle accident, had stent at age of 51, no prostate
Relationship: Mother Recorded Date: October 29, 2009
Notes: 63 healthy no colon can ocer dm or htn

Social History
Marital status Married 7. 8 two boys
Alcohol history Never drinks alcohol
Has the patient used cocaine? No
Additional comments

Physical Exam

Collected 12/18/2014 08:45 AM By: MD

Weight 217 lbs

Height 5' 11"

BMI 30.265

Temp

RR

HR 79 bpm

BP 134/82 mmHg

BP 2

Head Circ

SpO2 98 %

Waist

Constitutional
*general appearance overall: well nourished, NAD, conversant, pleasant, well developed and in no acute distress development: well developed and appears stated age stature/Body Habitus: normal body habitus hygiene/Attention to Grooming: good hygiene
Eyes
* general eyes overall: anicteric sclera, moist conjunctiva, no lid lag
Ears/Nose/Throat
*ENT
overall: NC/AT and normal hearing

Neck
*thyroid overall: normal size, normal consistency, nontender and no masses, lesions or adenopathy
* inspection of neck overall: no carotid bruits
major salivary glands: nontender and soft
Respiratory
* auscultation overall: breath sounds clear bilaterally
* respiratory effort/rhythm overall: no retractions, normal rhythm and normal rate

Cardiovascular

* auscultation of heart overall: regular rate, normal heart sounds, no murmurs and regular rhythm
* inspection of carotid pulses overall: strong, bilaterally equal, no bruits
* extremities overall: no clubbing, no edema, warm to the touch, capillary refill normal and no cyanosis

Musculoskeletal

* digits and nails overall: no clubbing and digits benign
*gait and station overall: normal gait and normal station

Integument

* inspection of skin overall: no rash, lesions and normal temperature, tone, texture, and turgor
* palpation overall: no induration, no tenderness

Neurologic

* cranial nerves overall: cranial nerves 1-12 intact

Psychiatric

*orientation/consciousness overall: oriented to person, place and time level of consciousness: alert
* mood and affect overall: normal mood and affect
* appearance overall: well-groomed, good eye contact

Diagnoses

PURE HYPERGLYCERIDEMIA (on lipitor, tolerating it well, lipids reviewed and they were excellent, liver ok, ldld 78, small ldlp 269)

Tennis elbow (recurred , tried Diclofenac and it works, MRI reviewed, complete tear of common extensor tendon at humeral head, we communicated via text and patient had a conversation with Dr., he will not have surgery, this is unchanged as of 10/23)

SPECIAL SCREENING, PROSTATE CANCER (no fam hx of prostate ca, no bph sx, will order in Jan of 2015. Discussed for prevention of prostate cancer)

Services Performed

OFFICE/OUTPATIENT VISIT EST
PREVENTIVE COUNSELING INDIV

Services Ordered

NMR LipoProfile
CBC With Differential/Platelet
Prostate-Specific Ag, Serum
Plan
A return visit is indicated in 3 months. 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
99201 - 75.00
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;	Office B bills;
98940 – 45.00	98940 – 65.00
97140-59 – 30.00	97140-59 – 55.00
97012 – 15.00	97012 – 35.00
Total of 90.00	Total of 155.00

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. 97410

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 94012-97799. 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.)

Area of Spine	Names of Vertebrae	Number of Vertebrae	Short Form or Other Name	Subluxation ICD-10 code
Neck	Occiput Cervical Atlas Axis	7	Occ, CO C1-C7 C1 C2	M99.00 M99.01
Back	Dorsal or Thoracic Costovertebral Costotransverse	12	D1-D12 T1-T12 R1-R12 R1-R12	M99.02
Low Back	Lumbar	5	L1-L5	M99.03
Pelvis	Ilii, R and L (I, Si)		I, Si	M99.05
Sacral	Sacrum, Coccyx		S, SC	M99.04

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

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

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

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

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

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

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

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

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

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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.

99354 -Prolonged face to face doctor contact 1st hour.

99355 -For 30 min. spent with the patient past the 1 hour

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)

99354 (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 97762 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.

A.	M99.03	B.	M54.5	C.	M99.04	D.	S33.8XXD
E.	M25.511	F.		G.		H.	
I.		J.		K.		L.	

22. RES COD

23. PRIO

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	$ CH
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
G43.001 Migraine without aura, not intractable, with status migrainosus
G43.009 Migraine without aura, not intractable, without status migrainosus
G43.011 Migraine without aura, intractable, with status migrainosus
G43.019 Migraine without aura, intractable, without status migrainosus
G43.101 Migraine with aura, not intractable, with status migrainosus
G43.109 Migraine with aura, not intractable, without status migrainosus
G43.111 Migraine with aura, intractable, with status migrainosus
G43.119 Migraine with aura, intractable, without status migrainosus
G43.401 Hemiplegic migraine, not intractable, with status migrainosus
G43.409 Hemiplegic migraine, not intractable, without status migrainosus
G43.411 Hemiplegic migraine, 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
G43.711 Chronic migraine without aura, intractable, with status migrainosus
G43.719 Chronic migraine without aura, intractable, without status migrainosus
G43.801 Other migraine, not intractable, with status migrainosus
G43.809 Other migraine, not intractable, without status migrainosus
G43.811 Other migraine, intractable, with status migrainosus
G43.819 Other migraine, intractable, without status migrainosus
G43.821 Menstrual migraine, not intractable, with status migrainosus
G43.829 Menstrual migraine, not intractable, without status migrainosus
G43.831 Menstrual migraine, intractable, with status migrainosus
G43.839 Menstrual migraine, intractable, without status migrainosus
G43.901 Migraine, unspecified, not intractable, with status migrainosus

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

Workers' Compensation

Fee Schedule

Active care

Not passive care

New and Established Patients

CPT	$$$
~~99201~~	~~60.69~~
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		$$$
99354	First hour	190.90
99355	Additional 30 min	145.09
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

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

Procedures

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

97124 Massage - Therapeutic	36.32
97140 Manual Therapy l/> regions	43.60
97150 Grp Therapeutic	23.66
97530 Therapeutic Activities	62.82
97533 Sensory Integration	40.50
97535 Self-Care/mgmt. Train.	52.54
97750 Phys. Performance Test	45.42
97760 Orthotic mgmt. & Training	53.21
98940 CMT-1-2 regions	43.61
98941 CMT-3-4 regions	62.44
98942 CMT-5 regions	82.04
98943 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…M51.36/M51.37 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.

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 balanced billed by an out-of-network provider. California law already protects most consumers from balance billing for emergency services.

Q

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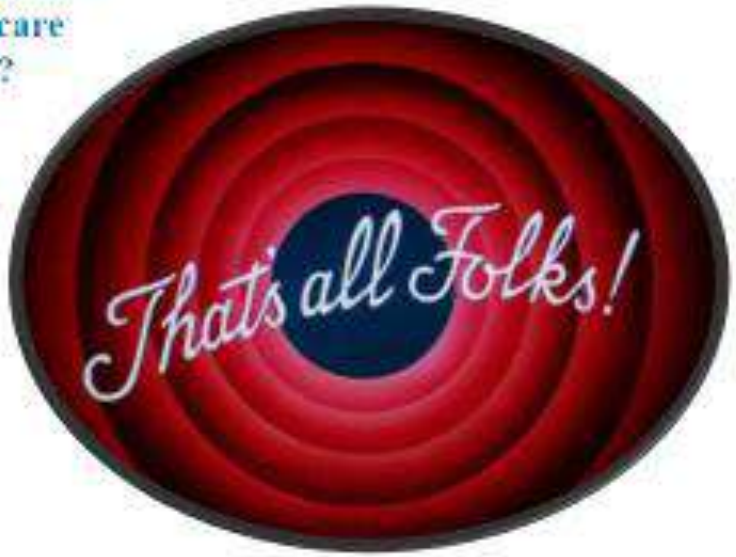

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