AMERICAN ACUPUNCTURE INSURANCE NETWORK SEMINARS

A division of

Book 3

The Complete ICD & CPT Essentials for Maximum Payment

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GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. **LIFE –SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

PATIENT NAME _____ DATE _____

SCORE _____ [60] BENCHMARK = 5 _____

The Patient-Specific Functional Scale

This useful questionnaire can be used to quantify activity limitation and measure functional outcome for patients with any orthopaedic condition.

Clinician to read and fill in below: Complete at the end of the history and prior to physical examination.

Initial Assessment:

I am going to ask you to identify up to three important activities that you are unable to do or are having difficulty with as a result of your _____ problem. Today, are there any activities that you are unable to do or having difficulty with because of your _____ problem? (Clinician: show scale to patient and have the patient rate each activity).

Follow-up Assessments:

When I assessed you on (state previous assessment date), you told me that you had difficulty with (read all activities from list at a time). Today, do you still have difficulty with: (read and have patient score each item in the list)?

Patient-specific activity scoring scheme (Point to one number):

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity

Able to perform activity at the same level as before injury or problem

(Date and Score)

Activity	Initial					
1.						
2.						
3.						
4.						
5.						
Additional						
Additional						

Total score = sum of the activity scores/number of activities
Minimum detectable change (90%CI) for average score = 2 points
Minimum detectable change (90%CI) for single activity score = 3 points

PSFS developed by: Stratford, P., Gill, C., Westaway, M., & Binkley, J. (1995). Assessing disability and change on individual patients: a report of a patient specific measure. Physiotherapy Canada, 47, 258-263.

Pain Interference – Short Form 6a

Please respond to each question or statement by marking one box per row.

In the past 7 days…

		Not at all	A little bit	Somewhat	Quite a bit	Very much
1	How much did pain interfere with your day to day activities?	☐	☐	☐	☐	☐
2	How much did pain interfere with work around the home?.....	☐	☐	☐	☐	☐
3	How much did pain interfere with your ability to participate in social activities?	☐	☐	☐	☐	☐
4	How much did pain interfere with your household chores?.....	☐	☐	☐	☐	☐
5	How much did pain interfere with the things you usually do for fun?.....	☐	☐	☐	☐	☐
6	How much did pain interfere with your enjoyment of social activities?.....	☐	☐	☐	☐	☐

Pain Interference – Short Form 6b

Please respond to each item by marking one box per row.

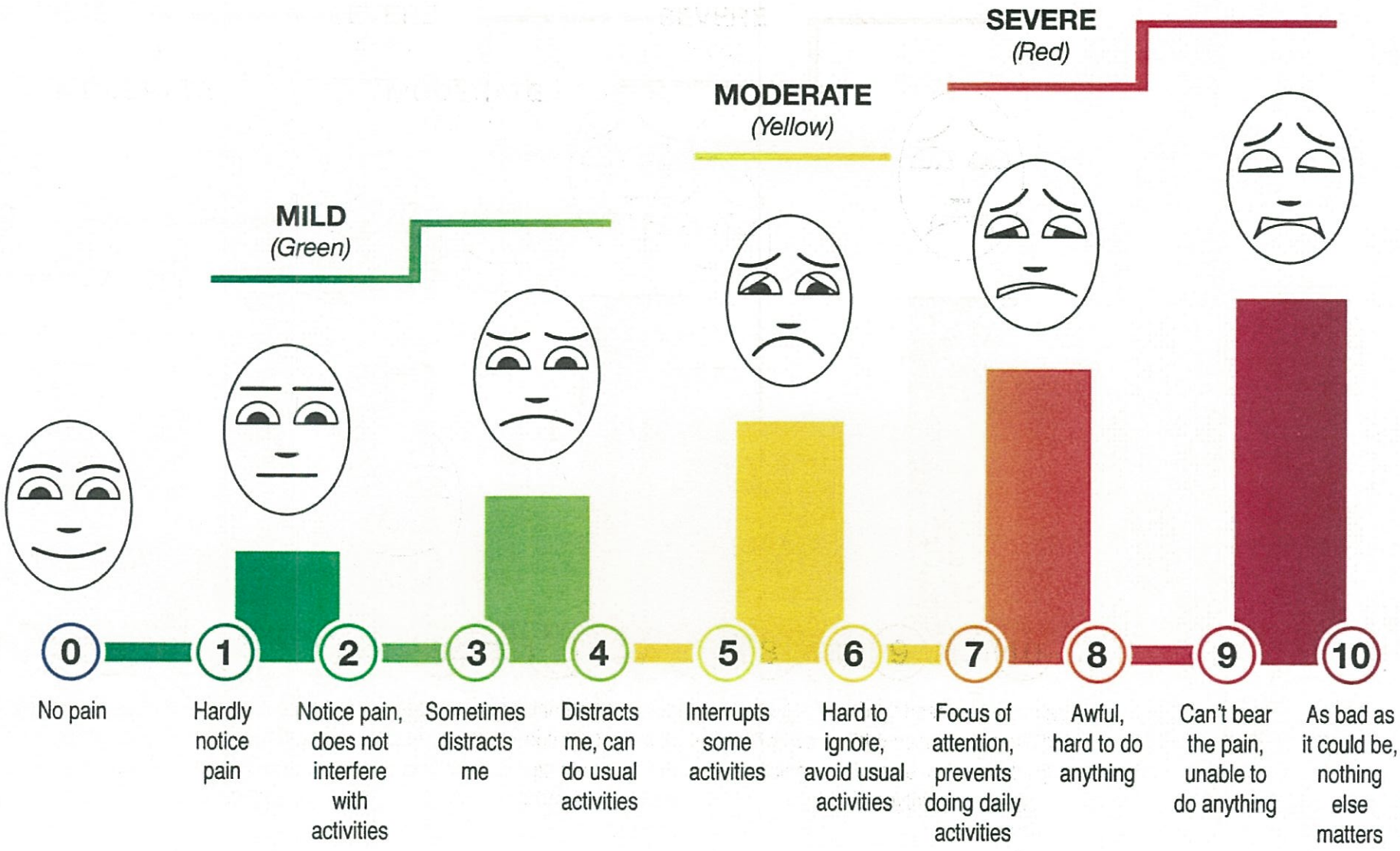
In the past 7 days…

		Not at all	A little bit	Somewhat	Quite a bit	Very much
PAININ3	How much did pain interfere with your enjoyment of life?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ8	How much did pain interfere with your ability to concentrate?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ9	How much did pain interfere with your day to day activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ10	How much did pain interfere with your enjoyment of recreational activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ14	How much did pain interfere with doing your tasks away from home (e.g., getting groceries, running errands)?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

In the past 7 days…

		Never	Rarely	Sometimes	Often	Always
PAININ26	How often did pain keep you from socializing with others?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Defense and Veterans Pain Rating Scale



v 2.0

DoD/VA Pain Supplemental Questions

For clinicians to evaluate the biopsychosocial impact of pain

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual <u>ACTIVITY</u>:

Does not interfere — Completely interferes

2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your <u>SLEEP</u>:

Does not interfere — Completely interferes

3. Circle the one number that describes how, during the past 24 hours, pain has affected your <u>MOOD</u>:

Does not affect — Completely affects

4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your <u>STRESS</u>:

Does not contribute — Contributes a great deal

**Reference for pain interference: Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. Ann Acad Med Singapore 23(2): 129-138, 1994.*

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do any washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing and essentially remain in bed.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
E. Pain prevents me from lifting heavy weights , but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 --Walking
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than 1/4 mile.
D. Pain prevents me from walking more than 100 yards.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than 1/2 hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6 -- Standing
A. I can stand as long as I want without pain
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

SECTION 7--Sleeping
A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain , my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8--Social Life
A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have no social life due to pain.

SECTION 9--Traveling
A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain prevents all forms of travel except that done lying down.
F. Pain prevents all forms of travel.

SECTION 10--Changing Degree of Pain
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

DISABILITY INDEX SCORE: %_____

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity
A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading
A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache
A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 -- Concentration
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving
A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping
A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation
A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities all all.

SIGNATURE:_____ **DATE:**_____

DISABILITY INDEX SCORE: _____ **%**

REVISED FIBROMYALGIA
IMPACT QUESTIONNAIRE (FIQR)

Last Name: _____ **Duration of FM symptoms (years):** _____

First Name: _____ **Time since FM was first diagnosed (years):** _____

Age: _____

DOMAIN 1: FUNCTION

Directions: For each of the following 9 questions, check the box that best indicates how much your Fibromyalgia made it difficult to perform each of the following activities during the past 7 days. If you did not perform a particular activity in the last 7 days, rate the difficulty for the last time you performed the activity. If you can't perform an activity, check the last box.

BRUSH OR COMB YOUR HAIR

No difficulty	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Very difficult

WALK CONTINUOUSLY FOR 20 MINUTES

No difficulty	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Very difficult

PREPARE A HOMEMADE MEAL

No difficulty	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Very difficult

VACUUM, SCRUB, OR SWEEP FLOORS

No difficulty	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Very difficult

LIFT AND CARRY A BAG FULL OF GROCERIES

No difficulty	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Very difficult

CLIMB ONE FLIGHT OF STAIRS

No difficulty	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Very difficult

CHANGE BEDSHEETS

No difficulty	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Very difficult

SIT IN A CHAIR FOR 45 MINUTES

No difficulty	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Very difficult

SHOP FOR GROCERIES

No difficulty	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Very difficult

DOMAIN 1 SUBTOTAL:_____

DOMAIN 2: OVERALL

Directions: For each of the following 2 questions, check the box that best describes the overall impact of your
Fibromyalgia over the last 7 days.

FIBROMYALGIA PREVENTED ME FROM ACCOMPLISHING GOALS FOR THE WEEK

Never	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Always

I WAS COMPLETELY OVERWHELMED BY MY FIBROMYALGIA SYMPTOMS

Never	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Always

DOMAIN 2 SUBTOTAL:_____

DOMAIN 3: SYMPTOMS

Directions: For each of the following 10 questions, select the box that best indicates your intensity level of these common
Fibromyalgia symptoms over the past 7 days.

PLEASE RATE THE LEVEL OF PAIN

No pain	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Unbearable pain

PLEASE RATE YOUR LEVEL OF ENERGY

Lots of energy	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	No energy

PLEASE RATE YOUR LEVEL OF STIFFNESS

No stiffness	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Severe stiffness

PLEASE RATE THE QUALITY OF YOUR SLEEP

Awoke well rested	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Awoke very tired

PLEASE RATE YOUR LEVEL OF DEPRESSION

No depression	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Very depressed

PLEASE RATE YOUR LEVEL OF MEMORY PROBLEMS

Good memory	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Very poor memory

PLEASE RATE YOUR LEVEL OF ANXIETY

Not anxious	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Very anxious

PLEASE RATE YOUR LEVEL OF TENDERNESS TO TOUCH

No tenderness	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Very tender

PLEASE RATE YOUR LEVEL OF BALANCE PROBLEMS

No imbalance	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Severe imbalance

PLEASE RATE YOUR LEVEL OF SENSITIVITY TO LOUD NOISES, BRIGHT LIGHTS, ODORS, AND COLD

No sensitivity	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	Extreme sensitivity

DOMAIN 3 SUBTOTAL:_____

SCORING:

1) Sum the scores for each of the 3 domains (function, overall, and symptoms)

2) Divide domain 1 score by 3, leave domain 2 score unchanged, and divide domain 3 score by 2

3) Add the 3 resulting domain scores to obtain the total FIQR score

DOMAIN 1 SUBTOTAL	_____	**÷ 3**	=	_____
DOMAIN 2 SUBTOTAL	_____	**CARRY OVER SUBTOTAL**	=	_____
DOMAIN 3 SUBTOTAL	_____	**÷ 2**	=	_____

TOTAL FIQR SCORE

Scope of Practice

- Evaluation
- Acupuncture
- Adjunctive Therapies

2023 PHYSICAL MEDICINE & REHABILITATION CPT CODES (97010 - 97799)

These codes are not necessarily intended for your work comp claims. Some states have a separate work comp codes and fee schedules.

The following CPT codes are current as of January 1, 2023

This list represents only a selected list of Physical Medicine Codes.

MODALITIES
Any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.

SUPERVISED
The application of a modality that does not require direct (one on one) patient contact by the provider.

Application of a modality to one or more areas;

97010 Hot or cold packs
97012 Traction, mechanical
97014 Electrical stimulation, (unattended)
G0283 Electrical stimulation, (unattended) **VA & UHC**
97016 Vasopneumatic devices (cupping-VA claims)
97018 Paraffin bath
97022 Whirlpool
97024 Diathermy (includes microwave diathermy)
97026 Infrared
97028 Ultraviolet

CONSTANT ATTENDANCE
The application of a modality that requires direct (one on one) patient contact by the provider.

Application of a modality to one or more areas;

97032 Electrical Stimulation (manual), 15 min.
97033 Iontophoresis, each 15 minutes
97034 Contrast baths, each 15 minutes
97035 Ultrasound, each 15 minutes
97036 Hubbard tank, each 15 minutes
97039 Unlisted modality (specify type and time if constant attendance)
S8930 Electrical stimulation of auricular acupuncture points; each 15 minutes of personal one-on-one contact with the patient

LASER

S8948 Application of a modality with constant attendance to one or more areas; Low-level laser; each 15 minutes
0552T Low level laser therapy dynamic photonic and dynamic thermokinetic energies, provided by physician or other qualified health professional

THERAPEUTIC PROCEDURES
A manner of effecting change through the application of clinical skills and or services that attempt to improve function.

Physician or therapist required to have direct (one on one) patient contact.

Therapeutic procedure, one or more areas, 15 min;

97110 Therapeutic exercises to develop strength and endurance, range of motion and flexibility.
97112 Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception.
97113 Aquatic therapy with therapeutic exercises
97116 Gait training (includes stair climbing)
97124 Massage, including effleurage, petrissage, tapotement (stroking, compression, percussion)
97139 Unlisted therapeutic procedure (specify)

97140 Manual therapy techniques, one or more regions. (for example: mobilization/manipulation, manual traction, manual lymphatic drainage)

ADDITIONAL PROCEDURES

97150 Therapeutic procedure(s), group (2 or more)

97530 Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 min.

97535 Self care/home management training (eg. activities of daily living (ADL) and compensatory train ing, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes.

97799 Unlisted physical medicine/rehabilitation service.

ACUPUNCTURE

97810 Acupuncture, one or more needles:without electrical stimulation, initial 15 minutes of personal one-on-one contact with patient
97811 Each additional 15 minutes of personal one-on-one with patient, with re-insertion of needles
97813 Acupuncture, one or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with patient
97814 Each additional 15 minutes of personal one-on-one with patient, with re-insertion of needles

DRY NEEDLING

20560 Needle insertion without injection 1-2 muscle(s)
20561 3 or more muscles

Policy

Overview

Acupuncture is the selection and manipulation of specific acupuncture points through the insertion of needles or "needling," or other "non-needling" techniques focused on these points.

This policy defines the maximum time unit of service (UOS) for Acupuncture services for face-to-face contact with the patient, addresses supplies that are included in the Acupuncture services and describes the submission of evaluation and management services in conjunction with Acupuncture services.

All services described in this policy may be subject to additional UnitedHealthcare reimbursement policies including, but not limited to, the Maximum Frequency Per Day Policy, the Supply Policy and the CCI Editing Policy.

Reimbursement Guidelines

This policy enforces the code description for Acupuncture services which are to be reported based on 15 minute time increments of personal face-to-face contact with the patient and not the duration of the needle(s) placement. In addition, CPT® code guidelines state only one initial CPT code, 97810 or 97813, should be reported per day.

In accordance with the code descriptions and/or the Centers for Medicare and Medicaid Services (CMS) guidelines and National Correct Coding Initiative (NCCI) established Medically Unlikely Edits (MUE) values, the maximum units of Acupuncture services allowed per date of service are as follows:

CPT Codes	MUE Value
20560	1
20561	1
97810	1
97811	2
97813	1
97814	2
S8930	3

The cost of needles (A4212 and A4215) is included in the Acupuncture service and will be denied if submitted in addition to the Acupuncture service. The CMS National Physician Fee Schedule (NPFS) indicates these supplies are part of the Practice Expense (PE) and should not be reported separately.

Consistent with the CPT code description and the CMS NCCI Procedure to Procedure Coding Edits (PTP), electrical stimulation services (97014, 97032 and G0283) should not be reported separately in addition to specific Acupuncture services that include electrical stimulation (97813, 97814 and S8930). A modifier may be appropriate when an electrical stimulation service is performed distinctly and separate from the Acupuncture service and the documentation supports the service was not related to the Acupuncture.

Per CPT guidelines an evaluation and management (E/M) service may only be reported in addition to Acupuncture services if the patient's condition requires a significant, separately identifiable E/M service above and beyond the usual pre-service and post-service work associated with the Acupuncture service. When a separate E/M service is reported, the time spent for the E/M service is not to be included in the time UOS for the Acupuncture service.

Use Modifier –GP on all physical medicine codes 97010-97999

- GP is appended on the following plans-
- United Health Care (including Optum Health)
- VA claims
- Anthem (BCBS)
- **Blue Cross of CA (not Blue Shield)**
- Medicare (Medicare does not pay but is necessary for a denial so a secondary may make payment
- Do not blanket for plans other than these as it may cause denial for plans that do not require

Modalities

- Type and intensity if applicable
- Area(s) applied
- Time of application (timed services 8-minute rule)

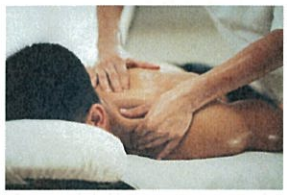
Documentation-

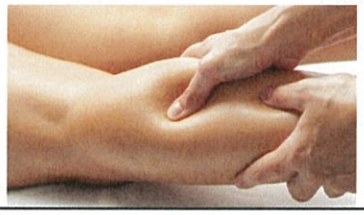
97026 Infra-red heat lumbar spine 15 minutes

Therapeutic Procedures

- What is this service?
- TA, TE, or NMR?

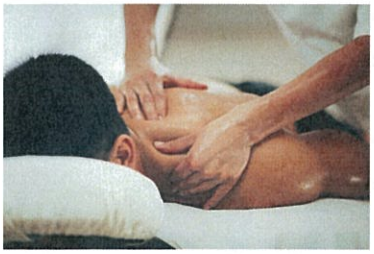
- 97124 v 97140?

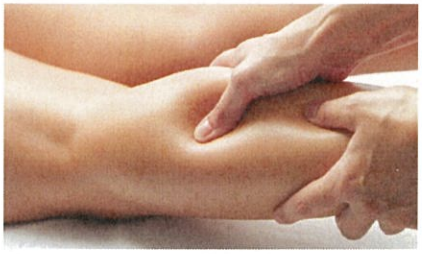




97124 Massage v 97140 Manual Therapy

- A massage is the use of rhythmically applied pressure to the skin and soft tissues of the body. Effleurage, petrissage, tapotement (stroking, compression, percussion).
- Some manual therapy techniques include soft tissue mobilization, myofascial release, strain-counter strain, muscle energy techniques, joint mobilizations and manipulations, and mobilization with movement.





Documentation must include

- The expected outcome and functional performance improvement should be discernable in the records.
- Area(s) being treated
- Objective clinical findings such as measurements of range of motion, description of muscle spasms and effect on function
- Subjective findings including pain ratings, pain location, effect on function
- the start and stop times of the treatment or at a minimum, the direct one-on-one contact time spent on each individual activity.

Passive v Active Care

- It has been recommended that passive modalities not be employed except when necessary to facilitate participation in an active treatment program.
- A general conclusion about the treatment of chronic, noncancer pain is that the results from traditional, passive modalities are disheartening. Perhaps this may be due to the propensity of patients to seek out passive versus active treatments. In pain management, active treatments should be the primary focus, with passive interventions as an adjunct.

Role of Active Versus Passive Complementary and Integrative Health Approaches in Pain Management https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5896844/

- **97110 Therapeutic Exercises** This procedure includes instruction, feedback, and supervision of a person in an exercise program for their condition. The purpose is to increase/maintain flexibility and muscle strength. Therapeutic exercise is performed with a patient either actively, active-assisted, or passively. It is considered medically necessary for loss or restriction of joint motion, strength, functional capacity or mobility which has resulted from disease or injury. Note: Exercising done subsequently by the member without a physician or therapist present and supervising would not be covered.

97110 Therapeutic exercises

- One or more areas
- Strength
- Endurance
- ROM
  - Examples
    - Bike/Treadmill
    - Gym Equipment
    - Isotonic Exercise
    - Stretching

97110 Therapeutic Exercises

- Document exercises (type, sets, reps resistance (if any), and time) with level of assistance required. Must be skilled and not simply monitoring the patient doing exercise.

EXERCISES TO STRENGTHEN YOUR CORE AND LOW BACK

PATIENT NAME: ----------

DATE: ----------

1. CAT - CAMEL

Begin by rounding your back upward until you feel a gentle stretch in the mid and low back. Pause for 3-5 seconds then relax and let your stomach fall downward as you gently arch your back. Perform 2 sets of 10 repetitions to warm up prior to strengthening exercises.

2. BIRD DOG

Begin by gently tightening your stomach muscles to activate your core. Raise one arm to shoulder level as the opposite leg lifts simultaneously off the floor extending to hip level. Hold for 4 seconds and return to the start position and alternate sides. Perform 2 sets of 10 repetitions.

3. MCGILL CURL UP

Begin lying on your back with one knee bent and one leg straight- with both hands placed underneath low back. Lift yourshoulders off floor trying not to round your low back. Let your elbows assist you if needed. Hold for 2-4 seconds before slowly return to starting position. Perform 2 sets of 10 repetitions.

4. HIP BRIDGE

Begin lying down with both knees bent. Gently tighten your stomach muscles to activate your core. Squeeze your glutes and lift the hips off the floor to until knees, hips and shoulders are in alignment. Hold for 2-4 seconds before slowly returning to start position. Perform 2 sets of 10 repetitions.

5. PLANK

Begin lying face down with elbows under shoulders and legs extended. Gently tighten your stomach muscles to activate your core. Lift knees and hips off the floor so that forearms and toes are supporting your body weight. Hold for 20 - 30 sec. Repeat 2 times.

6. SIDE PLANK

Begin lying on your side with your elbow underneath your shoulder and knees bent. Gently tighten your stomach muscles to activate your core. Lift hips off the floor so thatknees and elbow are supporting your body weight. Hold for 20 - 30 sec. Repeat 2 times and repeat on opposite side.

GENERAL SHOULDER STRENGTHENING

PATIENT NAME: ---------- DATE: ----------


1. Sleeper Stretch at 90°

Begin lying on side, directly on shoulder. Head may be supported by pillow. Position arm with elbow at shoulder level and bend elbow to 90°. Grasp back of wrist with opposite hand and slowly lower forearm downward, towards floor, until stretch is felt in back of shoulder. Hold for 20 – 30 sec. Repeat 2-3 times.


2. Cross Body Stretch

Begin seated or standing. Extend one arm in front, and across body, at shoulder level. With opposite arm grasp arm above elbow and gently pull towards chest until a stretch is felt in the back of shoulder. Hold for 20 – 30 sec. Repeat 2-3 times.


3. Scapular Protraction with Resistance Band

Begin standing with resistance band in both hands and around the upper back. Protract the shoulders against resistance, keeping the arms straight. Pause momentarily before returning to neutral shoulder position. Hold for 2-4 seconds before slowly return to starting


4. Rotator Cuff External Rotation

Begin standing. Place towel between elbow and body. Grasp end of resistance band in hand while opposite end is anchored in door at elbow level. Bend elbow to 90°. While maintaining a 90° elbow bend, externally rotate arm, keeping towel trapped against body. Perform 2 sets of 10 repetitions.


5. Rotator Cuff Internal Rotation

Begin standing. Place towel between elbow and body. Grasp end of resistance band in hand while opposite end is anchored in door at elbow level. Bend elbow to 90°. While maintaining a 90° elbow bend, internally rotate arm, keeping towel trapped against body. Perform 2 sets of 10 repetitions.


6. Seated High Rows

Begin sitting upright with good posture. Grasp ends of resistance band with each hand. Arms are extended in front, shoulder width apart. Draw elbows back, maintaining distance between hands while squeezing shoulder blades together. Resistance should be felt during entire exercise. Perform 2 sets of 10 repetitions.

EXERCISES TO STRENGTHEN YOUR NECK AND IMPROVE POSTURE

PATIENT NAME: _____ DATE: _____

1. BRÜGGER'S EXERCISE

Stand up straight with your hands at your sides. Begin by bending your elbows slightly as you rotate your arms outward. Slowly pull your shoulders back and down as you gently retract your head. Perform 2 sets of 10 repetitions.

2. HEAD RETRACTION

Begin by tucking your chin slightly then draw head upward toward the ceiling in a straight-line movement. Pause at end range for 4 seconds before returning to starting position. Perform 2 sets of 10 repetitions. This can also be performed in the seated position.

3. FLOOR ANGELS

Begin lying face up on floor with knees bent. Place arms with elbows bent comfortably on the floor with palms facing up. Slide arms upward above your head while maintaining forearm contact with floor. Do not let your back arch upward. Slowly return to start position and repeat. Perform 2 sets of 10 repetitions.

4. CRANIO-CERVICAL FLEXION

Begin by lying face up with knees bent. Slowly lower chin down in a head-nodding motion as you simultaneously lift head approximating the chin towards chest. Pause and hold for 5-10 seconds before returning to the starting position. Perform 2 sets of 10 repetitions.

5. BLACKBURN T

Begin lying face down. Arms should be extended shoulder level with thumbs pointing up. A pillow, or rolled towel, may be placed under forehead for comfort. Lift arms upward squeezing shoulder blades together. Neck muscles should remain relaxed. Hold for 5 seconds. Perform 2 sets of 10 repetitions.

6. BLACKBURN Y

Begin lying face down. Arms should be extended above shoulder level with thumbs pointing up. A pillow, or rolled towel, may be placed under forehead for comfort. Lift arms upward squeezing shoulder blades together. Neck muscles should remain relaxed. Hold for 4 seconds. Perform 2 sets of 10 repetitions.

GENERAL HIP STRENGTHENING

NAME: ---------- DATE: ----------


1. Seated Inner Thigh Stretch

Begin seated on floor in an upright position. Bend your knees and pull the feet inward until the soles of shoes meet. Maintain a good upright sitting posture. Gently press your knees toward the floor using your hands and forearms until you feel a stretch in the inner thighs. Hold for 20-30 seconds and repeat 2-3 times.


2. Hip Flexor Stretch

Begin standing. Use a chair or a wall with one hand for support while flexing same side knee by grasping your foot or ankle. Maintain a neutral pelvis position. Keep knees side by side not allowing the bent knee to move forward. Gently pull your heel toward the buttocks until you feel a gentle stretch in the front of the thigh. Hold for 20-30 seconds and repeat 2-3 times.


3. Supine Hip Flexion

Begin in a supine position. Lift one leg until the foot is 12 inches off floor. Slowly lower the leg to starting position. Perform 3 sets of 10 repetitions.


4. Side Lying Leg Lift

Begin lying on the side with legs extended. Your top leg should attain a straight line through hip and shoulder while the bottom leg may be bent for added stability. Lift your top leg upward, abducting legs. Perform 3 sets of 10 repetitions.


5. Side Lying Hip Adduction

Begin lying on the side with one hand supporting the head. The bottom leg is straight, the top leg knee is bent and placed behind the straight leg with your foot flat on floor. Lift the straight leg upward six inches and slowly return to start position. Perform 3 sets of 10 repetitions.


6. Hip Bridge

Begin in a supine position. Bend your knees so the feet are firmly on floor with arms extended to sides. Lift your hips off floor to attain a bridge position with knees, hips, and shoulders in alignment. Slowly return to start position. Perform 3 sets of 10 repetitions.

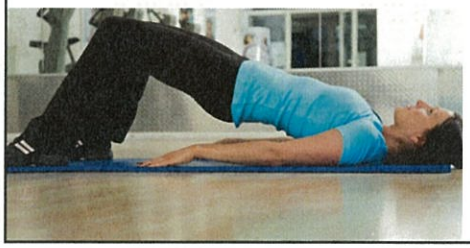
Source: Safran, Marc, et al. Instructions for Sports Medicine Patients, 2nd Edition. Saunders, 2012

97530 Therapeutic activities

- The CPT definition of 97530 is "Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes."

This procedure involves the use of functional activities (e.g., bending, lifting, carrying, reaching, catching and overhead activities) to improve functional performance in a progressive manner..

- **97530 Therapeutic Activities** This procedure involves using functional activities (e.g., bending, lifting, carrying, reaching, pushing, pulling, stooping, catching and overhead activities) to improve functional performance in a progressive manner. The activities are usually directed at a loss or restriction of mobility, strength, balance or coordination. They require the professional skills of a practitioner and are designed to address a specific functional need of the member. This intervention may be appropriate after a patient has completed exercises focused on strengthening and range of motion but need to be progressed to more function-based activities. These dynamic activities must be part of an active treatment plan and directed at a specific outcome.



- Choosing 97530 or 97110 depends on the intent of the task. For example, abdominal curls can be used for strengthening a weak abdominal muscles and billed as therapeutic exercise; however, if the patient is performing abdominal curls to improve and perform getting from a lying position it would be considered a therapeutic activity.
- Best practice is to determine what functional outcome is expected from the task. Is it simply a strength or flexibility outcome or one with a functional performance outcome?
- In differentiating between the two, it helps to think of therapeutic exercises as a path to therapeutic activities.

97112 Neuromuscular Reeducation

- Balance
- Proprioception
- Coordination
- Kinesthetic sense
- Activities that facilitate re-educa
  of movement, balance, posture, coordination, and proprioception/kinesthetic sense.

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- 10-second test
- Stork position with foot placed on the weight-bearing leg
- Lower risk of death in the next 7 years
- Middle age (51) or older who could not perform a 10 second one leg stand were 84% greater to die of causes such as heart attacks, strokes, and cancer
- British Journal of Sports Medicine
- June 21, 2022

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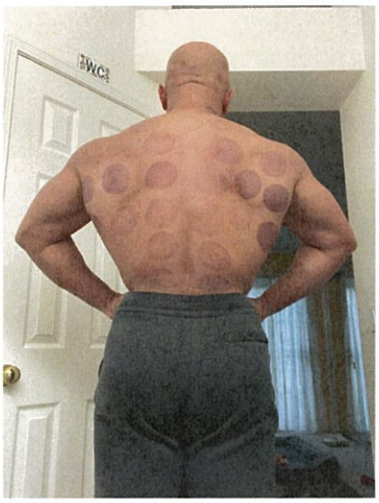
- Optimal control of balance in an upright stance is an essential requirement for sport, daily activities, and prevention of injury. For example, impaired postural control is associated with an increased risk of ankle sprain.
- Because of this strong association, balance and coordination training are common components of prophylactic and therapeutic intervention programs used to treat patients with a variety of musculoskeletal conditions. Moreover, mounting evidence demonstrates that various balance-training programs improve postural control and reduce the recurrence of musculoskeletal. Injuries.

recovery or require prolonged treatment beyond the natural history of recovery. The natural history of recovery is the anticipated recovery either with conservative treatment/care or without conservative treatment/care. The lack of continued functional improvement with continued treatment and complicating factors indicates a stable condition. Although the patient's condition may continue to change over time, the continuation of treatment is no longer necessary in order to affect those further changes. Furthermore, according to the evidence-based literature, the continuation of treatment after a patient has stabilized promotes patient/treatment dependence and feelings of unresolvable disability and may delay a return to normal function. The scientific literature supports a therapeutic withdrawal after the patient has stabilized which focuses more on home-based stretches and exercises and promotes a more active role of the patient.

CPT code 97112 is intended to identify therapeutic exercise that is used for the treatment of upper motor neuron lesions (i.e. stroke, paralysis). Neuromuscular re-education may also be considered medically necessary if at least one of the following conditions is present and documented: the patient has the loss of deep tendon reflexes and vibration sense accompanied by paresthesia, burning, or diffuse pain of the feet, lower legs, and/or fingers; the patient has nerve palsy, such as peroneal nerve injury causing foot drop; or the patient has muscular weakness or flaccidity as a result of a cerebral dysfunction, a nerve injury or disease, or has had a spinal cord disease or trauma. According the records provided for review, the patient did not exhibit any of the necessary signs or symptoms needed in order to initiate this type of therapy. Therefore, the dates of service in question are not medically necessary in relation to the motor vehicle accident.

In conclusion, I do not recommend reimbursement for treatment rendered on 02/14/19, 03/05/19 or 04/01/19

Cupping



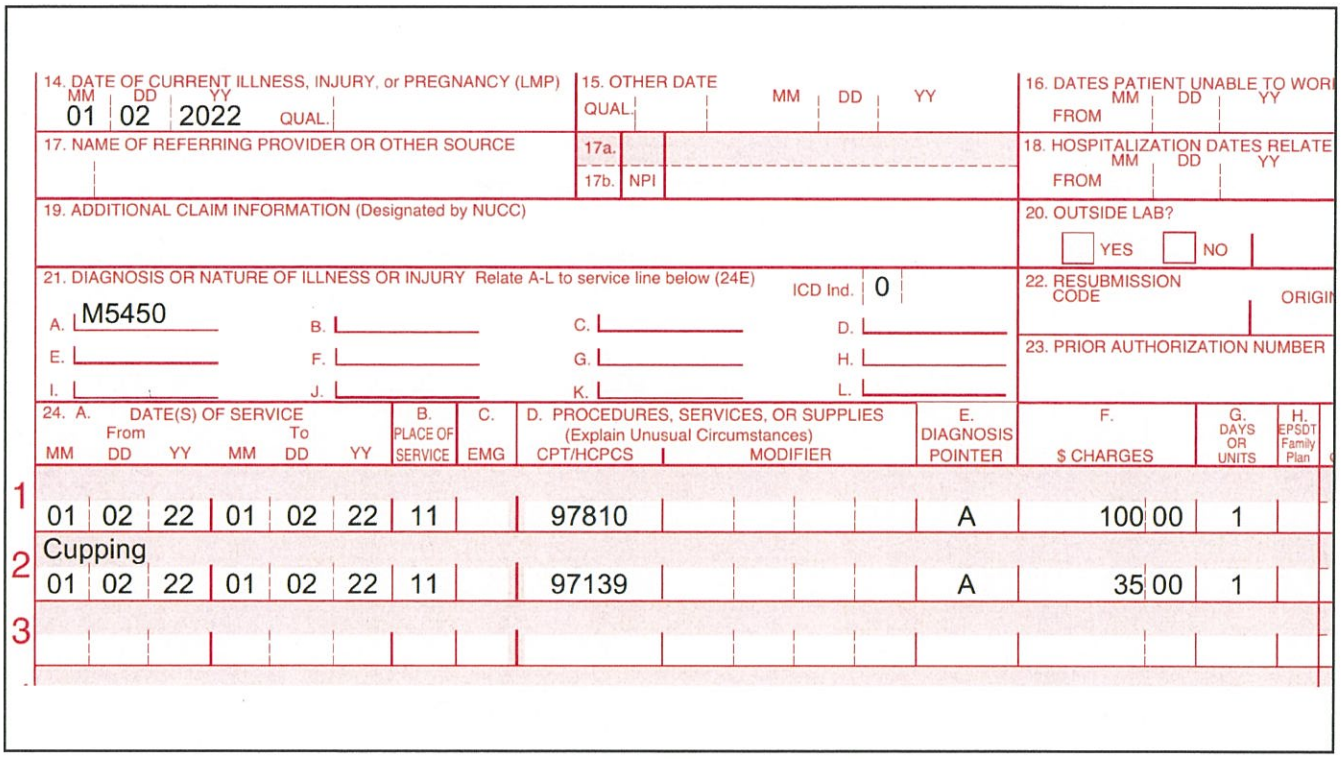
Unlisted Modality & Procedure

Cupping

- There is no specific code for this service
- Use 97039 or 97139
- Indicate on the 1500 as "cupping"
- 97016 for VA claims

Moxibustion

- There is no specific code for this service
- Use 97039 or 97139
- Indicate on the 1500 as "moxibustion"



14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 02 2022 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK MM DD YY FROM

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATE MM DD YY FROM

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M5450 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGIN

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
1	01	02	22	01	02	22	11		97810		A	100 00	1	
2	Cupping 01	02	22	01	02	22	11		97139		A	35 00	1	
3														

Counting Time as a Function of Work
Pre-service time includes assessment and management time - medical record review, physician contact while the patient is present, assessment of the patient's progress since the previous visit, and time required to establish a clinical judgment for the treatment session. Pre-service time is not the time required to get the patient ready to receive the treatment.
Intra-service time includes the hands-on treatment time.
Post-service time includes the assessment of treatment effectiveness, communication with the patient/caregiver to include education/instruction/counseling/advising, professional communications, clinical judgment required for treatment planning for the next treatment session, and documentation while the patient is present.

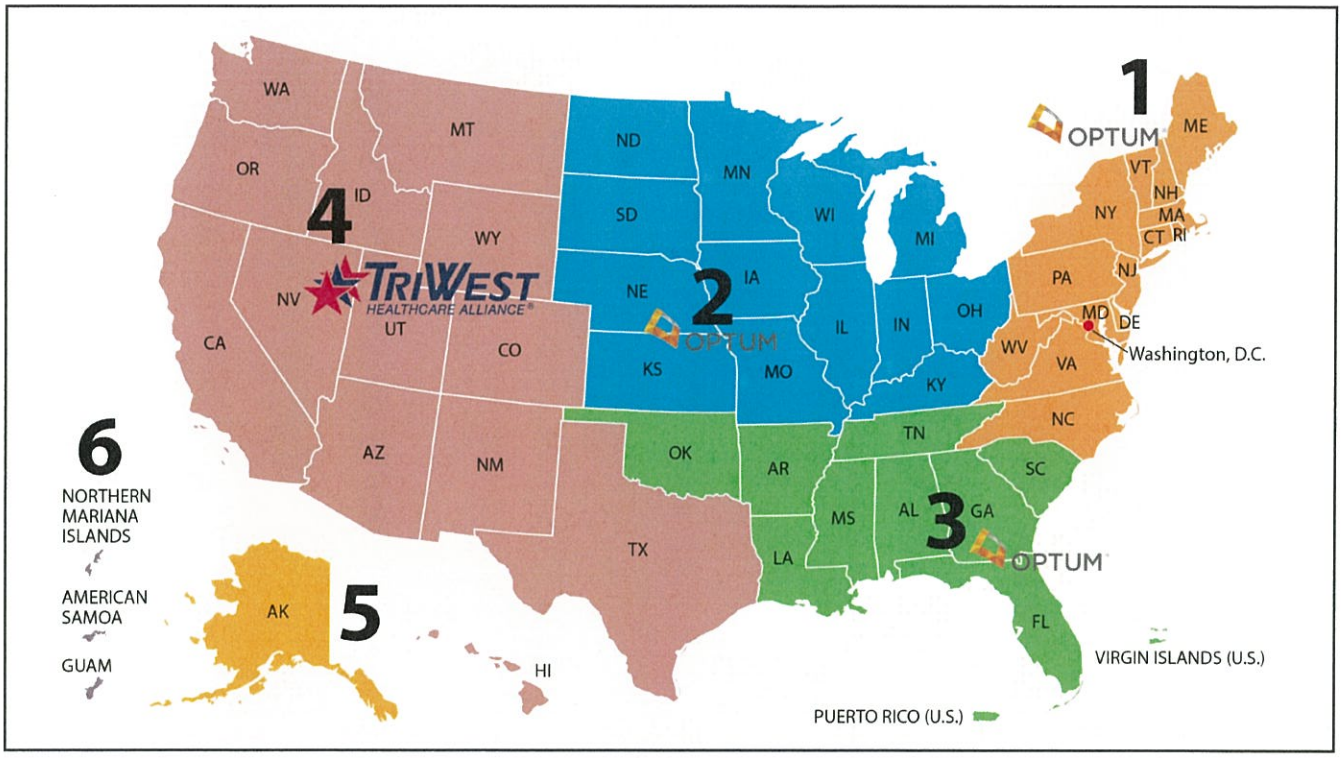
Counting Minutes for Timed Codes in 15 Minute Units
When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code on the same day measured in 15-minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:
Units Number of Minutes
1 unit: ≥ 8 minutes through 22 minutes
2 units: ≥ 23 minutes through 37 minutes
3 units: ≥ 38 minutes through 52 minutes
4 units: ≥ 53 minutes through 67 minutes
5 units: ≥ 68 minutes through 82 minutes
6 units: ≥ 83 minutes through 97 minutes
7 units: ≥ 98 minutes through 112 minutes
8 units: ≥ 113 minutes through 127 minutes
The pattern remains the same for treatment times in excess of 2 hours.

Only one time-based code may be performed at a time.
If more than one procedure code is billed for the same date of service, then in order to fully support all of the billed services the time must be separately documented for each specific procedure or time-based service. This will clearly document what portion of the total visit was spent performing each of the billed codes.

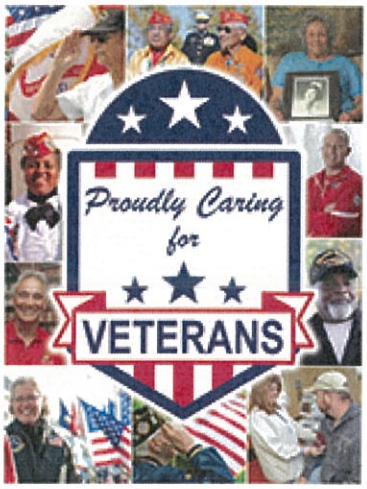
Methods and examples for time documentation:

Acceptable:
• Specific number of minutes. Example: "Manual therapy to lumbar spine x 15 minutes."
• Listing begin-time and end-time for service. Example: "E-stim to cervical neck, 09:30 – 09:45."

Unacceptable:
• Documenting time in terms of "units". Examples: "One unit of pulsed ultrasound was administered." or "Ther Ex 1 unit."
• Documenting time using a range. Example: "Therapeutic activities x 6 – 12 minutes as appropriate per assessment and symptoms."
• Documenting a quantity but not specifying the measurement or increment used. Example: "97110 Exercises x 2"
• No time mentioned at all. Example: Checking or circling "NMR" or "TE" with no additional information documented.



Post a badge onto your website! Simply use the embed code or download the size and style that works best for you. Then post the image on your website.



https://www.triwest.com/en/provider/training-and-help/proudly-caring-for-veterans/

Optum

OPTUM

- **Regions 1, 2 and 3–**

Contact :

- Region 1: 888-901-7407
- Region 2: 844-839-6108
- Region 3: 888-901-6613

- https://vacommunitycare.com/provider
- https://www.myvaccn.com/site/vaccn/main/public/login#/home (registration page)

TriWest HEALTHCARE ALLIANCE®

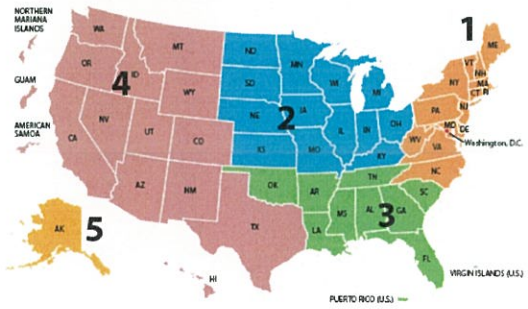
Join Our Network

We're eager to include you in our provider network!

https://joinournetwork.triwest.com/Forms/AddProvider.aspx

TriWest has partnered with the Department of Veterans Affairs (VA) as the Community Care Network (CCN) Region 4 and 5 third-party administrator. We are helping Veterans receive the high-quality care they need, when they need it. Learn more about CCN

VA Map of CCN Regions:



TriWest Customer Service: 877-266-8749

- VA provides a network of freestanding physical health providers and services for VA CCN, which includes:
- Physical therapy
- Occupational therapy
- Speech therapy
- Chiropractic services
- Acupuncture

The OHCS network also includes providers who provide some CIHS, including:

- Massage therapy
- Tai chi

Authorization

- VA Medical Center (VAMC) determines a Veteran's need and eligibility for care in the community.
- VAMC contacts the provider to confirm they will accept the referral and schedule an appointment. A referral packet is sent to the contracted Department of Veterans Affairs Community Care Network (VA CCN) provider.
- The Veteran is seen by a VA CCN provider for medically necessary services included in a standardized episode of care.
- If additional services are required, provider must submit a Request for Services (RFS) form to VA. If services on an approved referral are performed by a VA CCN participating provider not listed on the referral, the referral number must be shared with the provider rendering the services.

VA Claims Require Pre-Authorization

- Direct referral from the VA

1. VAMC provider or primary physician
2. Contact Triwest or Optum
3. Veteran patient may use https://www.myhealth.va.gov/mhv-portal-web/user-login to make requests

- Veterans' out of pocket costs for this care is $0 no copays, cost-shares, or deductibles. Providers will be paid for all authorized care according to their contract or agreement

- Fee allowance is based on Medicare rates for your region and acupuncture care IS NOT limited to acupuncture codes only

- Physical medicine services 97010-97799 must be appended with modifier **GP**

VA COMMUNITY CARE

VHA Office of Community Care – Standardized Episode of Care

Physical Medicine & Rehabilitation
Acupuncture SEOC 1.0.1
SEOC ID: PMR_ACUPUNCTURE_1.0.1
Description: This authorization covers services associated with all medical care listed below for the referred condition.
Duration: 90 days
Frequency: Ten visits - Not to exceed 2 visits per week
Procedural Overview
1. Initial outpatient evaluation and treatment for the referred condition indicated on the consult 2. Nine (9) visits for acupuncture therapy with or without electrical stimulation to include therapeutic exercises, manual therapy and self-care instructions. Not to exceed two visits per week.
**Additional consultations needed relevant to the patient complaint/condition require VA review and approval. **All routine medications must be faxed/sent to the VA to be dispensed by the VA. Urgent/emergent prescriptions can be provided for a 14-day supply only. The Veteran will be required to pay out of pocket for any urgent/emergent medications and can submit a reimbursement request to their local VA facility.

VA | U.S. Department of Veterans Affairs
Veterans Health Administration

Veterans Choice Program (VCP)

- Significant durable pain intensity decrease
- Functional improvement by clinically meaningful improvement on validated disease-specific outcomes instruments; return to work; and/or documented improvement in activities of daily living
- Documented decreased utilization of pain related medications

Category of Care: COMPLEMENTARY AND INTEGRATIVE HEALTH

Procedural Overview - Standardized Episode of Care (SEOC)

Acupuncture Initial SEOC 1.0.10 Duration: 60 Days

No.	Service/Procedure	Number Of Visits Authorized
1	Initial outpatient evaluation for this episode of care	1
2	Twelve (12) acupuncture visits maximum is approved for this episode of care. Approved services include acupuncture with or without electrostimulation. Additional units of acupuncture must be medically necessary and require documentation of face to face provider time and evidence of re-insertion	12
3	If indicated, approved modalities that can be utilized during the approved acupuncture visits noted in #2 above can include: manual therapy and therapeutic exercise procedures including but not limited to: cupping, myofascial release, and therapeutic exercises	12
4	Outpatient re-evaluation during this episode of care. It is not expected that re evaluation is appropriate at each acupuncture visit as a portion of E&M is imbedded in the acupuncture codes. Re-evaluation is appropriate when a patient has an exacerbation or evaluation is needed for determination of future care	2

SEOC Disclaimer

*Additional acupuncture care beyond this trial must provide documentation of: Objective measures demonstrating the extent of meaningful clinical improvement to date, and rationale for the additional treatment requested (e.g. to reach further durable improvement, or for ongoing pain management), and any further information supporting the need for additional care *Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/providers/index.asp for additional resources and requirements pertaining to the following * Pharmacy prescribing requirements * Durable Medical Equipment (DME), Prosthetics, and Orthotics prescribing requirements * Precertification (PRCT) process requirements * Request for Services (RFS) requirements

REFER ALL QUESTIONS RELATED TO THIS APPROVAL TO THE ISSUING VA OFFICE

Acupuncture Chronic Care Management	20560, 20561, 97016, 97026, 97039, 97110, 97112, 97124, 97139, 97140, 97530, 97810, 97811, 97813, 97814, 99211, 99212, 99213, 99214, 99215, S8930
Acupuncture Continuation of Initial Care	20560, 20561, 97016, 97026, 97039, 97110, 97112, 97124, 97139, 97140, 97530, 97810, 97811, 97813, 97814, 99211, 99212, 99213, 99214, 99215, S8930
Acupuncture Initial	20560, 20561, 97016, 97026, 97039, 97110, 97112, 97124, 97139, 97140, 97530, 97810, 97811, 97813, 97814, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, S8930

Acupuncturists: 8 Criteria to Include in All Medical Documentation

If you're an acupuncturist treating a Veteran, did you know VA uses your medical documentation as evidence that your patient needs more care?

This is why ensuring your medical documentation is complete and thorough is so important. In order to provide effective information to VA when making a request for additional care through use of a RFS, include these eight criteria in your medical documentation every time:

1. Date of treatment
2. Specific treatment
3. Total treatment time
4. Response to treatment
5. Reassessment of progress
6. Progress toward goals
7. Barriers
8. Name and credentials

Of these eight criteria, providers are most commonly forgetting to include these three important items:

- Reassessment of progress
- Progress towards goals
- Barriers to improvement

These items speak heavily toward the need for additional care. If VA is unable to verify that clinical need, it is unlikely to approve additional care.

A Final Note on Needles

VA reminds our network acupuncturists to please remember to remove all needles from patients after completing a session. Through VA's Clinical Quality Management, Complaints, and Grievances processes, several Veterans have reported leaving a treatment site and later finding one or more needles that were not removed by the practitioner.

Medical Necessity and RFS

- Significant durable pain intensity decrease
- Functional improvement by clinically meaningful improvement on validated disease-specific outcomes instruments; return to work; and/or documented improvement in activities of daily living
- Documented decreased utilization of pain-related medications
- Objective measures demonstrating the extent of meaningful clinical improvement today and the rationale for additional treatment requested example to reach further durable improvement or for ongoing pain management and any further information supporting the need for additional care
- Include any barriers to recovery such as complicating conditions or comorbidities but also how the patient has changed to date and how the care would continue the same trajectory

Filing a Claim

- Claims must be submitted within 180 days from the date of service for outpatient care or the date of discharge for inpatient care.

- VA referral number **AND** one of the following:
  - 10-digit Electronic Data Interchange Personal Identifier (EDIPI)
  - 17-digit Master Veteran Index (MVI) ICN
  - Social Security number (SSN)
  - Last 4 digits for SSN with preceding 5 zeros i.e., 00000XXXX
- It is extremely important that you do not use any **extra characters, spaces, or words** with the referral/authorization number or the claim will deny

Optum

- E Payer ID: VACCN

Mailing Address:
VA CCN Optum P.O. Box 202117
Florence, SC 29502

- Secure Fax: 833-376-3047

Triwest

- PGBA Claims Submission Details
- **Payer ID**
  TWVACCN
- Address to Submit Paper Claims to PGBA
  TriWest VA CCN Claims
  PO Box 108851
  Florence, SC 29502-8851

Personal Injury Claims & Acupuncture

Step by Step Billing

- Insurance verification
- Diagnosis (trauma)
- CPT – E&M, acupuncture, therapies et al
- Fees are usual and customary
- Assignment (direct pay to the provider)

How are claims paid?

First Party – Med Pay or PIP

- Direct pay to the provider with assignment

Third Party – At Fault Party

- No direct payment from the insurance but from the patient or their attorney at settlement

No Fault

- 12 no-fault states:
- Florida
- Minnesota
- Hawaii
- New Jersey,
- Kansas
- New York
- Kentucky
- North Dakota
- Massachusetts
- Pennsylvania
- Michigan
- Utah
- Puerto Rico also adheres to the no-fault law

- This type of insurance policy is sometimes misunderstood because it does provide a limited right to sue, despite popular belief that it does not. Individuals may be able to sue for non-economic damages. However, different states that recognize no-fault insurance policies have established different thresholds for the minimum amount of damages necessary to pursue such a claim.

PERSONAL INJURY

CSI — 4 simple steps to evaluate the viability of claim and that there will be insurance reimbursement

1. Is there viable insurance? Med Pay or PIP (your patient's), third party (at-fault party), UM, UIM, etc.

2. Who was at fault? Any degree of comparative fault that is less than 50 percent will decrease the amount they may recover from the defendant by your percentage of liability. Get a copy of the police report when available.

3. Property Damage- M.I.S.T. Low impact collisions may indeed cause injury but 75% of all accidents are considered "fender benders" and persons are not injured.

Res ipsa loquitur "The thing speaks for itself" all parties see the pictures and this too should be part of your file and history to visualize the severity of impact or when not present the onus to present reasons why the low impact did indeed cause more bodily damage than would be expected.

4. How badly is the patient hurt?

Diagnosis of the patient must include trauma series as it is a traumatic event. However, secondary diagnoses including degeneration, neuritis, disc, kyphosis, etc. will increase the necessity and need for care.

PERSONAL INJURY

Med Pay & PIP (Personal Injury Protection)

- When available this pays just as health insurance does. Verify coverage, immediately and regularly bill. The patient should receive copies of all bills.
- These claims are assignable and will make direct payment to the provider.
- Payment is made to the provider with assignment from Med Pay & PIP
- If health insurance is billed, they will only be liable for what the patient is liable for under the PPO rates.

Attorney & Lien Claims

- ✓ The patient and attorney must sign the lien to be valid. Even if the patient indicates they are not using an attorney have them sign a lien preemptively if they later decide to retain one. (Illinois law does not require an attorney to sign a lien and the provider simply files a lien with all parties and is entitled to 1/3 of the settlement should the amount be less than 3 times the medical bills)
- ✓ If there is med pay and there is an attorney assume the attorney will intercept these payments by reassigning the benefits and clarify with the patient to discuss direct the attorney to forward these payments to the medical provider without any attorney fees as they were not part of any attorney work or settlement.
- ✓ The attorney should receive all billing as well as a report of the patient's care including results and residuals.
- ✓ Do not agree to any fee reductions unless all parties (including the attorney) are taking an equal reduction of their fees. A lien does not require you to take a reduction though a provider may choose to do so at their discretion.

Third-Party Only

The patient has no medical payments so there is no direct payment to the provider and the patient should sign and understand their direct responsibility for payment. Patients must be made aware of the cost of services and receive copies of all accountable billings and reports.

The patient is to make direct payment based on proceeds from the settlement (assuming they were not at fault)

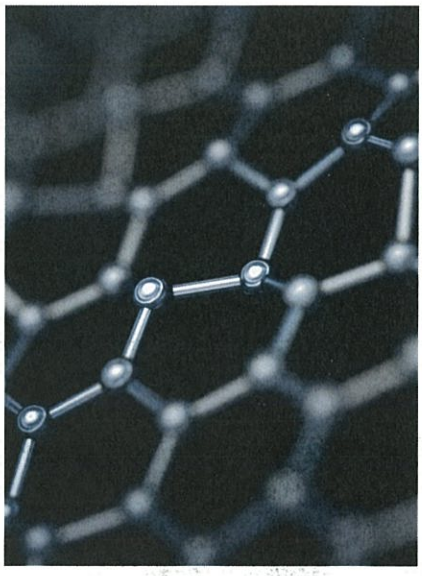
Patients should make a co-pay at each visit, which will be deducted from their total balance. While it need be the total amount of the entire visit it demonstrates a firm commitment to care and their financial responsibility for the care.

When treatment is completed, the patient will negotiate with the insurance for a settlement. Be in contact with the third party to ascertain when the claim settles. Have regular contact with this patient so they are aware of their obligation and balance. Make them acutely aware that the insurance does not pay the provider but the payment for the medical bills is included in their settlement.
This claim has more risk as the only guarantor of payment is the patient.

Workers' Compensation Simplification

Cardinal rule: If care is not authorized do not treat

There are routes to dispute when care is not authorized



Chronic Pain Guideline – American College of Occupational and Environmental Medicine (ACOEM) May 15, 2017

There is no evidence to support prolonged and repetitive use of skilled non-medical therapies (massage, electrical therapies, manipulation, acupuncture, etc.) In the absence of documentation of functional improvement, they are not indicated in managing patients with chronic pain.

Judicious short-term use of skilled, non-medical therapies may be indicated for significant exacerbations of underlying chronic pain conditions where there has been documented improvement following such treatments. Such exacerbations may be analogous to acute pain episodes.

Patterns in quality studies ranging from weekly for a month to 20 appointments over 6 months. However, the norm is generally no more than 8-12 sessions. An initial trial of 5-6 visits is recommended in combination with a conditioning program of aerobic and strengthening exercises.

Future appointments should be tied to improvements in objective measures and would justify additional sessions.

Quality studies for treatment with acupuncture including chronic neck pain, LBP, osteoarthrosis (especially knee), lateral epicondylitis (tennis elbow) adhesive capsulitis (frozen shoulder) and headaches.

PRACTITIONER'S STATEMENT

This form has been prepared to assist you in the completion of your insurance claim form and contains all the information that the practitioner is required to provide. Fill out the personal information requested on your insurance company claim form and attach this statement to it. ***Each patient, not the insurance company, is responsible for payment to this office.***

Patient _____ DOB (mm/dd/yyyy) __/__/____ ID# _____ Today's Date __/__/____

Address _____

Phone _____ email _____

#	CODE	Description	MOD	FEE
NEW PATIENT (E&M)				
	99202	Straightforward 15-29 min		
	99203	Low level 30-44 min		
	99204	Moderate level 45-59 min		
	99205	High level 60-74 min		
ESTABLISHED PATIENT (E&M)				
	99211	Minimal		
	99212	Straightforward 10 -19 min		
	99213	Low level 20-29 min		
	99214	Moderate level 30-39 min		
	99215	High level 40-54 min		
ACUPUNCTURE/MASSAGE THERAPY/ MODALITIES & THERAPEUTIC PROCEDURES				
	97010	Hot/Cold Packs/Treatment		
	97014	Electrical Stim unatttended		
	97026	Infrared Heat Therapy		
	97032	Electrical Stim., (manual) ea.15 min.		
	97039	Unlisted Modality with Explanation*		
	97110	Therapeutic Exercises, ea. 15 min.		
	97124	Therapeutic Massage, ea. 15 min.		
	97140	Manual Therapy ea. 15 min.		
Specify ☐ Myo Release ☐ Trigger Point ☐				
	97530	Therapeutic Activities (1:1 pt contact ea. 15 min.)		
	97150	Therapeutic Procedure(s) group (2+)		
	97039	Cupping		
	97039	Moxibustion		
	97810	Acupuncture: One or more Needles without Elec. Stim. Initial 15 minutes		
	97811	Each additional 15 minutes with insertion without Elec. Stim.		
	97813	Acupuncture: One or more Needles with Electrical Stim Initial 15 minutes		
	97814	Each Additional 15 minutes with insertion with Electrical Stimulation		

Today's Charges	
TAX (%)	
TOTAL	
Payment Received	

☐ Cash ☐ Check # ☐ Credit Card

DIAGNOSIS (If not indicated below): _____

_____

_____

*Explanation _____

Description	CODE
GENERAL PAIN	
Pain, unspecified	R52
Chronic Pain	G89.29
Chronic pain syndrome	G89.4
Chronic pain due to trauma	G89.21
ANXIETY/DEPRESSION	
Anxiety depression non persistent	F41.8
Anxiety depression persistent	F34.1
HEAD/FACE	
Headache	R51.9
Cervicogenic headache	G44.86
Tension headache	G44.209
Chronic tension headache	G44.229
Acute post traumatic headache	G44.319
Chronic post traumatic headache	G44.329
Migraine with aura	G43.109
Migraine without aura	G43.009
Migraine unspecified	G43.909
Jaw pain	R68.64
TMJ syndrome, right side	M26.601
TMJ syndrome, left side	M26.602
TMJ syndrome, bilateral	M26.603
Tooth pain	K08.9
EYE/EAR/NOSE/THROAT	
Ear pain, bilateral	H92.03
Ear pain, right ear	H92.01
Ear pain, left ear	H92.02
Eye pain, bilateral	H57.13
Eye pain, right eye	H57.11
Eye pain, left eye	H57.12
Sore Throat (Chronic Pharyngitis)	J31.2
Chronic sinusitis	J32.1
CIRCULATORY	
Chest Pain	R07.9
Edema, unspecified	R60.9
Elevated BP, No Dx Hypertension	R03.0
Hypertension	I10
Hypotension NOS	I95.9
Palpitations	R00.20
DIGESTIVE	
Abnormal Loss of Weight	R63.4
Abnormal Weight Gain	R63.5
Abdominal Pain, unspecified	R10.9
Abdominal Pain, Epigastric	R10.13
Constipation	K59.00
Diarrhea	R19.7
Dysphagia	R13.10
Esophageal flux (GERD)	K21.9
Gas Pain	R14.1
Indegestion (dyspepsia)	K30

NAUSEA	
Nausea	R11.0
Nausea with Vomiting	R11.2
Nausea due to chemotherapy	T45.1X5A
Morning sickness	O21.0
PULMONARY & RESPIRATORY	
Asthma	J45.909
Bronchitis, not Acute or Chronic	J40
Common Cold	J00
Cough	R05
Dyspnea	R06.00
Hay Fever/Rhinitis Unspecified	J30.9
Influenza with respiratory manifest.	J11.17
Shortness of breath	R06.02
SPINE	
Neck pain	M54.2
Myalgia, head and neck	M79.12
Thoracic spine pain Lumbar	M54.6
Low back pain, unspecified	M54.50
Vertebrogenic, low back pain	M54.51
Other low back pain	M54.59
Sciatica right side	M54.31
Sciatica left side	M54.32
Lumbago with sciatica right side	M54.41
Lumbago with sciatica left side	M54.42
MUSCLE & TENDON	
Myalgia other site	**M79.18**
Fibromyalgia	**M79.7**
Myositis, unspecified	**M60.80**
Muscle spasm, other	**M62.838**
Muscle spasm, spine	**M62.830**
Muscle spasm, calf	**M62.831**
Tennis elbow right side	**M77.11**
Tennis elbow left side	**M77.12**
Patellar tendinitis, right side	**M76.51**
Patellar tendinitis, left side	**M76.52**
Achilles tendinitis, right side	**M76.61**
Achilles tendinitis, left side	**M76.62**
GENITOURINARY	
Amenorrhea	**N91.2**
Dysmenorrhea	**N94.6**
Infertility Female unspecified	**N97.9**
Infertility Male unspecified	**N46.9**
Menopausal Symptoms State	**N95.1**
Menorrhagia	**N92.0**
Nocturia	**R35.1**
Polyuria	**R35.8**
Pelvic pain, female	**R10.2**
Premenstrual Syndrome	**N94.3**

JOINT PAIN-ARTHRALGIA-ARTHRITIS	
Shoulder right	M25.511
Shoulder left	M25.512
Elbow right	M25.521
Elbow left	M25.522
Wrist right	M25.531
Wrist left	M25.532
Hand right	M25.641
Hand left	M25.642
Fingers right hand	M25.644
Fingers left hand	M79.645
Right hip	M25.551
Left hip	M25.552
Knee right	M25.561
Knee left	M25.562
Ankle-Foot right	M25.571
Ankle-Foot left	M25.572
Toes right	M79.674
Toes left	M79.675
Arthritis right shoulder	M19.011
Arthritis left shoulder	M19.012
Arthritis right elbow	M19.021
Arthritis left elbow	M19.022
Arthritis right wrist	M19.031
Arthritis left wrist	M19.032
Arthritis right hand	M19.041
Arthritis left hand	M19.042
Arthritis right hip	M16.11
Arthritis left hip	M16.12
Arthritis right knee	M17.11
Arthritis left knee	M17.12
Arthritis right ankle foot	M19.071
Arthritis left ankle foot	M19.072
Arthritis unspecified site	M19.91
INJURIES/SPRAIN/STRAIN	
Cervical sprain	S13.4XXA
Cervical strain	S16.1XXA
Thoracic spine sprain	S23.3XXA
Thoracic spine strain	S29.012A
Lumbar sprain	S33.5XXA
Lumbar strain	S39.012A
Lumbosacral/sprain	S33.8XXA
Shoulder sprain right	S43.491A
Shoulder sprain left	S43.492A
Elbow sprain right	S53.401A
Elbow sprain left	S53.402A
Wrist sprain right	S63.591A
Wrist sprain left	S63.592A
Knee sprain right	S83.8X1A
Knee sprain left	S83.8X2A
Ankle sprain right	S93.491A
Ankle sprain right	S93.492A

NEXT APPOINTMENT:

Date (mm/dd/yyyy) __/__/____

Time _____

_____

Provider's Signature

Name

NPI #: LIC #:

Practice Name Tax ID # .

Address

Phone:

HEALTH INSURANCE CLAIM FORM

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

PICA

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☒ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 55555555A
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Beasley, Joe	3. PATIENT'S BIRTH DATE MM 03 DD 13 YY 1960 SEX M ☒ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 1234 Maine	6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY: Any City STATE	8. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE: 00000 TELEPHONE (Include Area Code): (555) 555-1212		ZIP CODE TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on file DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: Signature on file

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 02 DD 02 YY 2022 QUAL:	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. M5450 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

	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. #
1	02 02 22 02 02 22	11		99203	25	A	100 00	1		NPI	
2	02 02 22 02 02 22	11		97810		A	60 00	1		NPI	
3	02 02 22 02 02 22	11		97811		A	90 00	2		NPI	
4	02 02 22 02 02 22	11		97140		A	60 00	1		NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 123456789 ☒	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO	28. TOTAL CHARGE $ 310 00	29. AMOUNT PAID $	30. Rsvd.for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: John Smith LAc, 54321 Spine Ave, Any City; a. NPI b.		33. BILLING PROVIDER INFO & PH #: (555) 111-2222 John Smith LAc 54321 Spine Ave Any City a. 111222333 b.	

Acupuncture Subsequent Visit
2 sets & no examination or E&M

HEALTH INSURANCE CLAIM FORM

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

PICA

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☒ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 55555555A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Beasley, Joe

3. PATIENT'S BIRTH DATE MM DD YY: 03 13 1960 SEX M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 Maine

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Any City STATE:

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 00000 TELEPHONE (Include Area Code): (555) 555-1212

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on file DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Signature on file

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 02 02 2022 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M5450 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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. #
1	02	06	22	02	06	22	11		97810		A	60 00	1		NPI	
2	02	06	22	02	06	22	11		97811		A	45 00	1		NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 123456789 ☒ ☐

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE $: 105 00

29. AMOUNT PAID $:

30. Rsvd.for NUCC Use:

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
John Smith LAc
54321 Spine Ave
Any City

a. NPI b.

33. BILLING PROVIDER INFO & PH # (555) 111-2222
John Smith LAc
54321 Spine Ave
Any City

a. 111222333 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

VA Claim
Note GP modifier on PT

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [X] (ID#)			1a. INSURED'S I.D. NUMBER (For Program in Item 1): 55555555A
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Beasley, Joe	3. PATIENT'S BIRTH DATE MM DD YY: 03 13 1960 SEX M [X] F [ ]		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 1234 Maine	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]		7. INSURED'S ADDRESS (No., Street)
CITY: Any City STATE:	8. RESERVED FOR NUCC USE		CITY STATE
ZIP CODE: 00000 TELEPHONE (Include Area Code): (555) 555-1212			ZIP CODE TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]		a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED: Signature on file DATE:			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: Signature on file
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 02 2022 QUAL:	15. OTHER DATE QUAL: MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. M5450 B. C. D. E. F. G. H. I. J. K. L.			22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER: ABC12345678

PHYSICIAN OR SUPPLIER INFORMATION

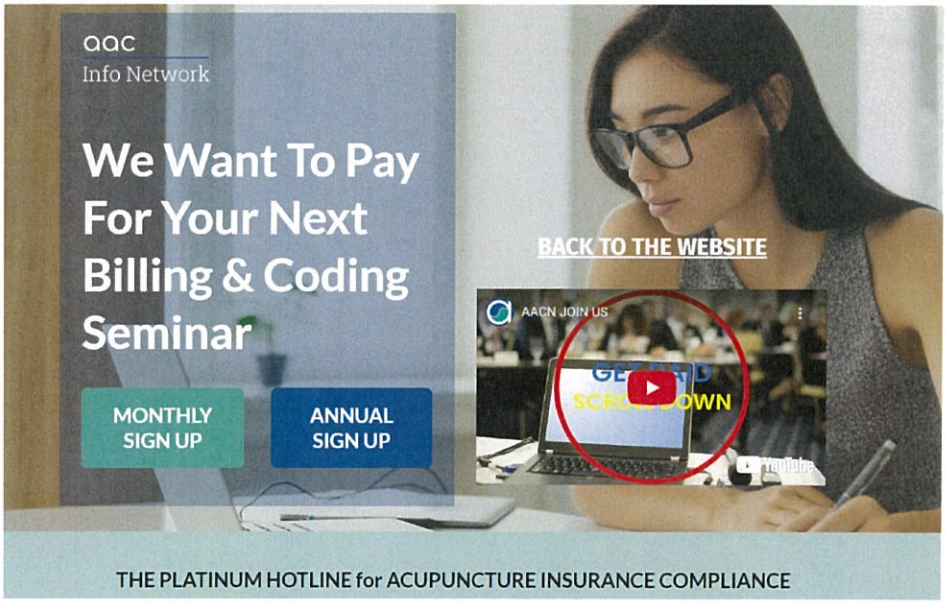
24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 02 22	01 02 22	11		99203	25	A	135 00	1		NPI	
2 01 02 22	01 02 22	11		97810		A	75 00	1		NPI	
3 01 02 22	01 02 22	11		97811		A	60 00	1		NPI	
4 01 02 22	01 02 22	11		97124	GP	A	60 00	1		NPI	
5 01 02 22	01 02 22	11		97016	GP	A	35 00	1		NPI	
6								1		NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd.for NUCC Use
123456789 [X] [ ]		YES [X] NO [ ]	$ 365 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (555) 111-2222
SIGNED DATE	John Smith LAc 54321 Spine Ave Any City a. NPI b.	John Smith LAc 54321 Spine Ave Any City a. 111222333 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

AAC Network
Expert Help to assure full payment & compliance



Resources

- www.aacinfonetwork.com 800 562-3335
- We are your resource for all updates, one on one help and continuing education

American Acupuncture Council NETWORK