2023-2024
The Complete ICD & CPT Essentials
For Maximum Reimbursement

Book 3

"it is critical to stay abreast of changes in CPT and ICD10 and payer billing guidelines related to coding…maintaining current knowledge is imperative for the long-term survival and safety of a practice."

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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.

- **Time-Based Codes**
  - For any time-based procedure codes, the duration of the service must clearly be documented in the medical record. If the duration of the time-based service is not clearly and properly documented in the medical record, then the service is not supported due to incomplete documentation; the procedure code will be denied as not documented.
  - If more than one procedure code is billed for the same date of service, 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.
    - Unacceptable documentation of time-based codes:
    - Documenting time in terms of "units"
    - Documenting time using a range
    - Documenting a quantity but not specifying the measurement or increment used
    - No time mentioned at all

UnitedHealthcare

Cigna

Physical therapy, occupational therapy, and chiropractic claims for greater than four units (60 minutes) of timed service

The portion of a physical therapy (PT), occupational therapy (OT), or chiropractic claim that is greater than four units (60 minutes) of timed, short-term rehabilitation services per patient, per day, per provider will be denied as being not medically necessary.

We will update the Omnibus Codes (0504) medical coverage policy to reflect this change. This update is effective for dates of service on or after October 15, 2022.

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-

97012 Cervical spine distraction with harness intermittent 30 pounds of force for 15 minutes. Supine with roll support.

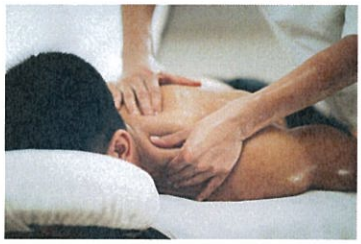
97026 Infra-red heat lumbar spine 15 minutes

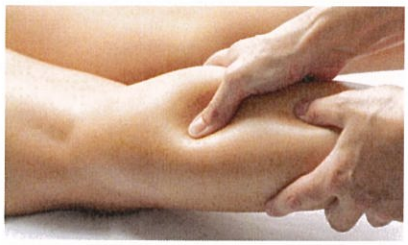
97014 E stim bilateral trapezius 4 pads to patient tolerance 50hz 15 minutes

97035 Ultrasound left patellar tendon 8 minutes 0.5 intensity

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.





APTA – Manual Therapy- 97140

- *Manual therapy techniques* are skilled hand movements and skilled passive movements of joints and soft tissue and are intended to improve tissue extensibility; increase range of motion; induce relaxation; mobilize or manipulate soft tissue and joints; modulate pain; and reduce soft tissue swelling, inflammation, or restriction. Techniques may include manual lymphatic drainage, manual traction, massage, mobilization/manipulation, and passive range of motion.
- 97124 relaxation versus 97140 muscle rehabilitation

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.

Are you stuck on the 4M's of care?

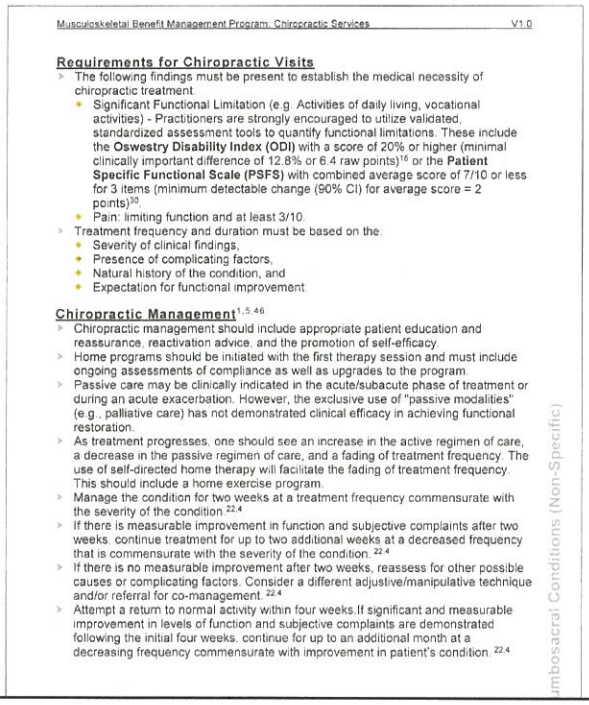
- Manipulation
- Mobilizations,
- Muscle release
- Modalities.
- These interventions fall under the category of **passive care**. While these techniques can be useful in providing relief of symptoms, they don't often solve the problem.

The provider should attempt to integrate some form of active care as early as possible. Continued use of passive care modalities may lead to patient dependency and should be avoided.

The utilization of passive modalities is not considered medically necessary once the acute phase of care is over

Passive modalities are most effective during the acute phase of treatment, since they are typically directed at reducing pain, inflammation, and swelling.

CIGNA Policy CPG 278



Musculoskeletal Benefit Management Program: Chiropractic Services V1.0

Requirements for Chiropractic Visits

- The following findings must be present to establish the medical necessity of chiropractic treatment:
  - Significant Functional Limitation (e.g. Activities of daily living, vocational activities) - Practitioners are strongly encouraged to utilize validated, standardized assessment tools to quantify functional limitations. These include the **Oswestry Disability Index (ODI)** with a score of 20% or higher (minimal clinically important difference of 12.8% or 6.4 raw points)[16] or the **Patient Specific Functional Scale (PSFS)** with combined average score of 7/10 or less for 3 items (minimum detectable change (90% CI) for average score = 2 points)[30].
  - Pain: limiting function and at least 3/10.
- Treatment frequency and duration must be based on the:
  - Severity of clinical findings,
  - Presence of complicating factors,
  - Natural history of the condition, and
  - Expectation for functional improvement.

Chiropractic Management[1,5,46]

- Chiropractic management should include appropriate patient education and reassurance, reactivation advice, and the promotion of self-efficacy.
- Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program.
- Passive care may be clinically indicated in the acute/subacute phase of treatment or during an acute exacerbation. However, the exclusive use of "passive modalities" (e.g., palliative care) has not demonstrated clinical efficacy in achieving functional restoration.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency. The use of self-directed home therapy will facilitate the fading of treatment frequency. This should include a home exercise program.
- Manage the condition for two weeks at a treatment frequency commensurate with the severity of the condition.[22,4]
- If there is measurable improvement in function and subjective complaints after two weeks, continue treatment for up to two additional weeks at a decreased frequency that is commensurate with the severity of the condition.[22,4]
- If there is no measurable improvement after two weeks, reassess for other possible causes or complicating factors. Consider a different adjustive/manipulative technique and/or referral for co-management.[22,4]
- Attempt a return to normal activity within four weeks.If significant and measurable improvement in levels of function and subjective complaints are demonstrated following the initial four weeks, continue for up to an additional month at a decreasing frequency commensurate with improvement in patient's condition.[22,4]

Lumbosacral Conditions (Non-Specific)

ROM and muscle re-education exercise to restore appropriate muscle control and support to the cervical region in patients with WAD should be implemented immediately.

There are five new RCTs (level II) and six systematic reviews (level I) reporting an active physical regime including exercise results in enhanced pain reduction and shortening of post-injury disability. The primary RCTs utilized a range of exercise approaches including range of motion, cervical muscle endurance, stabilization, co-ordination, cervical muscle strengthening, McKenzie method and functional capacity exercises.

State Insurance Regulatory Authority: Guidelines for the management of acute whiplash-associated disorders – for health professionals. Sydney: third edition 2014.

213

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/

214

- **97110 Therapeutic Exercises are movements and physical activities designed to restore function and flexibility, improve strength and decrease pain**
- 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. May be 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.

- If an exercise is taught to a patient and performed for the purpose of restoring functional strength, range of motion, endurance training, and flexibility, CPT code (97110) is the appropriate code.
- For example, a gym ball exercise used for the purpose of increasing the patient's strength should be considered as therapeutic exercise when coding for billing. Also, the minutes spent taping, such as McConnell taping, to facilitate a strengthening intervention would be counted under 97110.
- Documentation should describe new exercises added, or changes made to the exercise program to help justify that the services are skilled.

97110 Therapeutic exercises

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

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.

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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 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.

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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.

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

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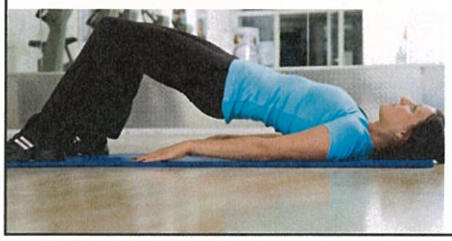
97530 Therapeutic activities

• 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-education of movement, balance, posture, coordination, and proprioception/kinesthetic sense.

- 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

- 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

- **97112 Neuromuscular Reeducation** This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, and proprioception to a person who has reduced balance, strength, functional capacity or mobility which has resulted from disease, injury, or surgery. The goal is to develop conscious control of individual muscles and awareness of position of extremities.
- The procedure may be considered medically necessary for impairments which affect the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination) that may result from musculoskeletal or neuromuscular disease or injury such as severe trauma to nervous system, post orthopedic surgery, cerebral vascular accident and systemic neurological disease.

- It is critical that the notes paint a picture of why the patient needs NMR if the patient does not have a true neuro diagnosis. Also, the flow sheet should support what activities are included in NMR vs Therapeutic Exercise to support the billing.

97150 Group Therapeutic Exercise

- Report 97150 for each member of the group.
- *Group therapy consists of therapy treatment provided simultaneously to two or more patients who may or may not be doing the same activities. If the therapist is dividing attention among the patients, providing only brief, intermittent personal contact, or giving the same instructions to two or more patients at the same time*, one unit of CPT code 97150 is appropriate per patient.

- Report 97150 for each member of the group.
- *Group therapy consists of therapy treatment provided simultaneously to two or more patients who may or may not be doing the same activities. If the therapist is dividing attention among the patients, providing only brief, intermittent personal contact, or giving the same instructions to two or more patients at the same time*, one unit of CPT code 97150 is appropriate per patient.

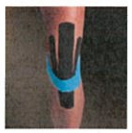
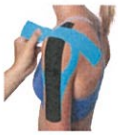
- Supervision of a previously taught exercise program or supervising patients who are exercising independently is not a skilled service and is not covered as group therapy or as any other therapeutic procedure. Supervision of patients exercising on machines or exercise equipment, in the absence of the delivery of skilled care, is not a skilled service and is not covered as group therapy or as any other therapeutic procedure.

- Strapping - the application of overlapping strips of adhesive tape to an extremity or body area to exert pressure and hold a structure in place, performed in the treatment of strains, sprains, dislocations, and certain fractures.
- Taping – the process of using an elastic cotton strip with an acrylic adhesive with the intent of treating pain and disability from athletic injuries and a variety of other physical disorders.
- Kinesio-Taping does not fit these definitions
-

- **29200** Thorax
- **29799** Unlisted procedure of casting or strapping and to be used for low back strapping
- **29240** Shoulder (eg, Valpeu)
- **29260** Elbow or wrist
- **29280** Hand or finger
- **29520** Hip
- **29530** Knee
- **29540** Ankle and/or foot
- **29550** Toes
- **29580** Unna Boot

Kinesiotaping = 97110 / 97112 if active therapy done in conjunction

- CPT® Assistant, March 2012, states that "Kinesio taping is a supply and therefore is included in the time spent in direct contact with the patient to provide either re-education of a muscle and movement or to stabilize one body area to enable improved strength or range of motion. This includes the application of Kinesio tape or McConnell taping techniques.

Remote Therapeutic Monitoring Overview

What is Remote Therapeutic Monitoring?
Remote Therapeutic Monitoring ("RTM") is monitoring non-physiologic information, such as medication reminders systems or self-reported patient outcome questionnaires. The billing codes, detailed below, include monitoring the musculoskeletal system, respiratory system status, adherence and response to therapy, pain level and the like.

What is an RTM Episode?
An "Episode" is the period of time from enrolling a patient in RTM to the first to occur of (a) resolution of treatment goals or (b) the revision of the patient's care plan based on their response to care. *The RTM Episode duration is a minimum of 16 days.*

What RTM data does WebExercises provide?

WebExercises' RTM module allows qualifying providers to monitor patient adherence, such as rate of perceived exertion (RPE), compliance with the provider-recommended sets and repetitions, patient self-reported pain levels, and general feedback. Providers can then modify the prescribed program to achieve the best outcomes.

WebExercises' digital outcome assessment questionnaires for the neck, back and SF-36 health survey are included and can also be assigned to remotely monitor patients. Once submitted by the patient, the questionnaires are automatically scored and support the efficacy of treatment.

What is WebExercises' maximum monitoring period per Episode?
12 weeks.

Is Remote Therapeutic Monitoring covered by insurance?
Currently only Medicare patients enrolled in an RTM care plan are covered.

Who can bill for RTM?
RTM can be billed as general medicine services by physicians and other qualified health providers. Physical therapists (PT), occupational therapists (OT), speech-language pathologists, physician assistants, nurse practitioners, and clinical social workers may also be eligible to bill RTM codes.

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When can the RTM be billed?
The RTM can be billed after an initial 16 days of monitoring, however a minimum of 30 days is required before a new Episode can be set up and billed.

What if the program needs to be updated prior to 30 days?
An exercise program can be updated at any time, based on the patient's response to care.

What happens if the RTM Home Exercise Program ("HEP") is cancelled?
Canceling an RTM HEP Episode after 24 hours will require a new Episode to be established.

What is the difference between Remote Physiological Monitoring ("RPM") and Remote Therapeutic Monitoring ("RTM")?
While Remote Physiological Monitoring uses a medical device that transmits patient information, Remote Therapeutic Monitoring is self reported by the patient through a smartphone app or online platform.

How is the patient's information collected?
RTM information can be self-reported by the patient. While RTM codes still require that the equipment used fulfill the FDA's definition of a medical device, Center for Medicare Services ("CMS") indicates that self-reported RTM data (via a smartphone app or online platform) may qualify for reimbursement.

CPT Billing/Reimbursement Codes

CPT 98975
Reimbursement: $19.58[1]
Description: Initial set-up and patient education on equipment (*e.g.,* mobile device, tablet or computer) use for therapeutic monitoring billed once per episode during a 30 day calendar month.

Clinician Application: The healthcare provider creates a WebExercises home exercise program ("HEP") and provides patient education on use of device or equipment. If a smart phone is the patients' preferred method to access their HEP, the WebExercises QR Code (see below) can be scanned to quickly download the patient mobile app. The interaction, date, and billing code is documented in the RTM Activity section within WebExercises.

CPT 98977
Reimbursement: $57.11[1]
Remote therapeutic monitoring (*e.g.,* musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or

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programmed alert(s) transmission to monitor musculoskeletal system. Billed once per Episode during a 30 day calendar month.

Clinical Application: The healthcare provider initiates the HEP by emailing to the patient. The HEP includes tracking patient adherence, program feedback, pain level and exercise program difficulty. This is documented in the Activity section within the patient account.

CPT 98980
Reimbursement: $49.66[1]
Remote therapeutic monitoring allows reimbursement for the first 20 minutes of clinical time requiring at least one interactive communication with the patient/caregiver in a calendar month (*e.g.,* video chat or phone call).

Clinical Application: The healthcare provider remotely monitors patient HEP feedback and response to care or calls/video chat with the patient to discuss. The activity is documented in WebExercises including date, time spent, type of interaction with the patient, and billing code.

CPT 98981
Reimbursement: $40.84[1]
Reimbursement for each additional 20 minutes of clinical time with the patient/caregiver in a calendar month. Similar to CPT 98980, it requires at least one interactive communication (*e.g.,* video chat or phone call).

Clinical Application: The healthcare provider remotely monitors patient HEP feedback and response to care or calls/video chat with the patient to discuss. The activity is documented in WebExercises including date, time spent, type of interaction with the patient, and billing code.

[1] All amounts listed are approximations.

Patient Mobile App

Apple Devices

Android Devices

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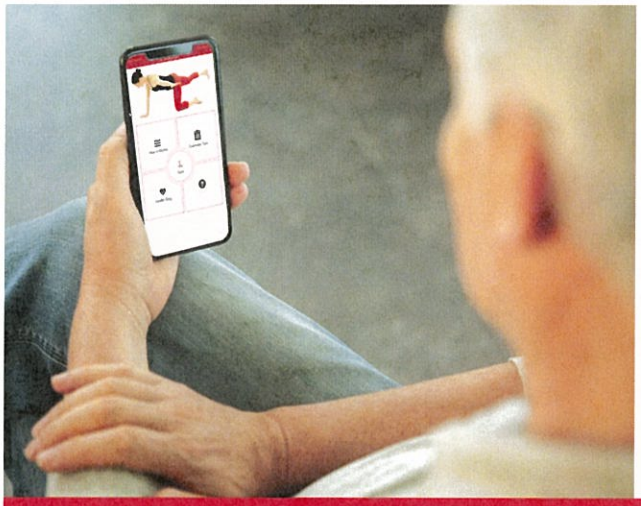

Remote Therapeutic Monitoring

Increase patient engagement while increasing your revenue.

Collect up to an additional $185 every 30 days for personal injury cases

WebExercises RTM increases your reimbursement and improves patient outcomes

New codes allow reimbursement for remote monitoring of home exercise

$25 Initial set-up
$60 Patient monitoring
$55 First 20 minutes of monitoring & updates
\+ **$45** Additional 20 minites of monitoring & updates

$185 per personal injury lien case every 30 days

Clinic Example:

10 personal injury cases
6 months of care each
= 60 total billable 30 day monitoring periods
x **$185** (per 30 day period billed at the end of each case)

That's $11,100 potential new revenue

4 Simple Steps

1 Prescribe
Create and digitally send home exercises

2 Monitor
Review feedbaack and document compliance

3 Engage
Communicate via phone or video call once every 30 days

4 Bill
Submit billing at end of case

WebExercises provides the tools and reporting necessary to meet the requirements for RTM billing.

info@webexercises.com | 866.411.4825 | webexercises.com

	X-Ray Common Codes for Chiropractic
CPT Code	Description
	Head and Neck Soft Tissue
70140	Facial bones, less than 3 views
70160	Nasal bones, min 3 views
70328	Temporomandibular joint, unilateral
70330	Temporomandibular joint, bilateral
70360	Neck, soft tissue
	Chest
71045	Chest, single view
71046	Chest, 2 views
71047	Chest, 3 views
71048	Chest, 4 or more views
71100	Ribs, unilateral, 2 views
71110	Ribs, bilateral, 3 views
	Spine
72020	Spine, single view, specify level. Use 72081 if view includes entire thoracic spine.
72040	Cervical spine, 2 or 3 views
72050	Cervical spine, minimum 4 or 5 views
72052	Cervical spine, 6 or more views
72070	Thoracic spine, 2 views
72072	Thoracic spine 3 views
72074	Thoracic spine, 4 views
72080	Thoracolumbar, 2 views
72081	Spine entire thoracic and lumbar including skull 1 view
72082	Spine entire thoracic and lumbar including skull 2-3 views
72083	Spine entire thoracic and lumbar including skull 4-5 views
72084	Spine entire thoracic and lumbar including skull 6 views
72100	Lumbosacral spine, 2 or 3 views
72110	Lumbosacral spine, minimum 4 views
72114	Lumbosacral spine, minimum 6 views
72120	Lumbosacral spine, bending only 2 or 3 views
	Pelvis
72170	Pelvis, 1 or 2 views
72190	Pelvis complete, minimum 3 views
72200	Sacroiliac joints, less than 3 views
72202	Sacroiliac joints, 3 or more views
72220	Sacrum and coccyx, minimum 2 views
	Upper Extremities
73000	Clavicle, Complete
73010	Scapula, Complete
73020	Shoulder, 1 view
73030	Shoulder, complete, minimum 2 views
73050	Acromioclavicular joints bilateral with or without weighted distraction
73060	Humerus, minimum 2 views
73070	Elbow, 2 views
73080	Elbow, complete, minimum 3 views

73090	Forearm, 2 views
73092	Upper extremities, infant, minimum 2 views
73100	Wrist, 2 views
73110	Wrist, complete, minimum 3 views
73120	Hand, 2 views
73130	Hand, minimum 3 views
73140	Fingers, minimum 2 views
	Lower Extremities
73501	Radiologic exam hip, unilateral with pelvis when performed 1 view
73502	Radiologic exam hip, unilateral with pelvis when performed 2-3 views
73503	Radiologic exam hip, unilateral with pelvis when performed 4 views
73521	Radiologic exam, hips bilateral with pelvis when performed 2 views
73522	Radiologic exam, hips bilateral with pelvis when performed 3-4 views
73523	Radiologic exam, hips bilateral with pelvis when performed minimum 5 views
73525	Radiologic examination, hip, arthography, supervision and interpretation
73551	Radiologic examination, femur, 1 view
73552	Radiologic examination, femur, 2 views
73560	Knee, 1 or 2 views
73562	Knee, 3 views
73564	Knee, complete 4 or more views
73565	Knees, both standing anteroposterior
73590	Tibia and Fibula, 2 views
73600	Ankle, 2 views
73610	Ankle, complete, minimum 3 views
73620	Foot, 2 views
73630	Foot, complete, minimum 3 views
73650	Calcaneus, minimum 2 views
73660	Toes, minimum 2 views
	Consultation & other
76140	Consultation on x-ray made elsewhere, 2nd opinion and report
76499	Unlisted radiogrpahic procedure

Data Driven Care

- Tracking changes in restrictions of activities of daily living
- Quality based care model

CHIRO-2.1: Recommended Standardized Assessments

Standardized assessment tools are used to assess and track changes in restrictions in Activities of Daily Living. Recommended standardized assessment tools are listed below:

Measure of Function	Reference
Disabilities of Arm, Shoulder, Hand (DASH and QuickDASH)	Franchignoni 2014; Angst 2011; Rysstad 2020
Hip Disability and Osteoarthritis Outcome Score (HOOS)	Ornetti 2009
Knee Injury and Osteoarthritis Outcome Score (KOOS)	Roos 2003; Ornetti 2009
Lower Extremity Functional Scale (LEFS)	Williams 2012; Binkley 1999
Neck Disability Index (NDI)	Young 2019; MacDermid 2009
Oswestry Disability Index (ODI)	Davidson 2002; Maughan 2010; Clohesy 2018
Patient Specific Functional Scale (PSFS)	Horn 2012; Helford 2012; Maughan 2010; Rysstad 2020
Roland Morris Disability Questionnaire (RMDQ)	Stratford 1996; Ostelo 2004; Clohesy 2018; Maughan 2010
Short Form-12 of the Short Form-36 Health Survey (SF-12)	Diaz-Arribas 2017; Cheak-Zamora 2009; McHorney 1994; Davidson 2002
Shoulder Pain and Disability Index (SPADI)	Schmidt 2014; Angst 2011

CHIRO-2.2: Mental Health Considerations

Referral to a qualified mental health professional is required when there are signs of an unmanaged behavioral health disorder. Immediate referral to a counselor or helpline is required if there are ANY indications of thoughts or plans for self-harm. The National Suicide Prevention Lifeline is available 24 hours every day at 1-800-273-8255.

PROMIS
Patient Reported Outcome Measurement Instruments

- General Pain Index
- Patient Specific Functional Scale
- PROMIS Short Form – Pain Interference
- Pain and Functional Rating Scale (VA & DOD)
- Oswestry (LBP index)
- Neck Disability Index

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 _____

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?.....	☐	☐	☐	☐	☐

Participant Format © 2008-2015 PROMIS Health Organization and PROMIS Cooperative Group

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

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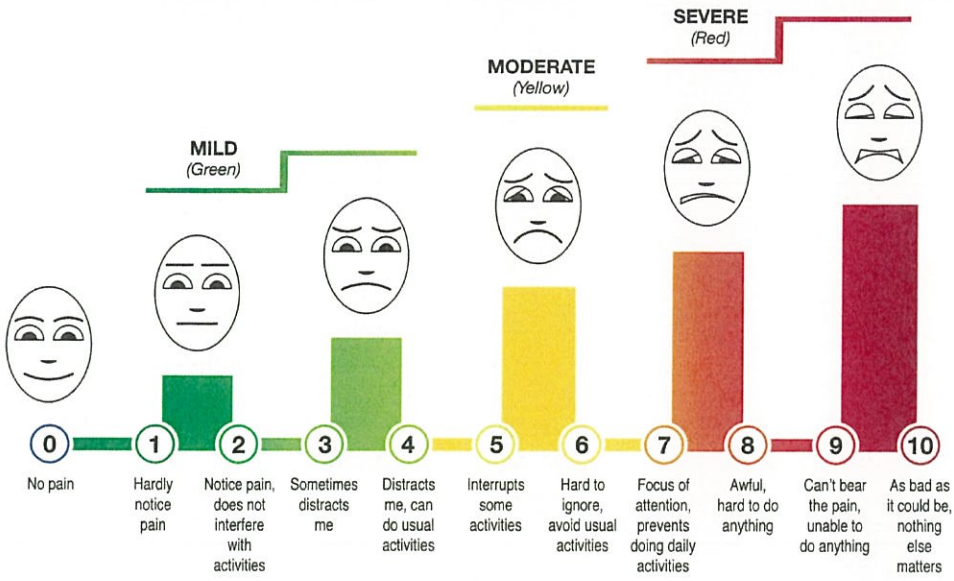
Defense and Veterans Pain Rating Scale



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229

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 ACTIVITY:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere — Completely interferes

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

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere — Completely interferes

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

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not affect — Completely affects

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

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

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.

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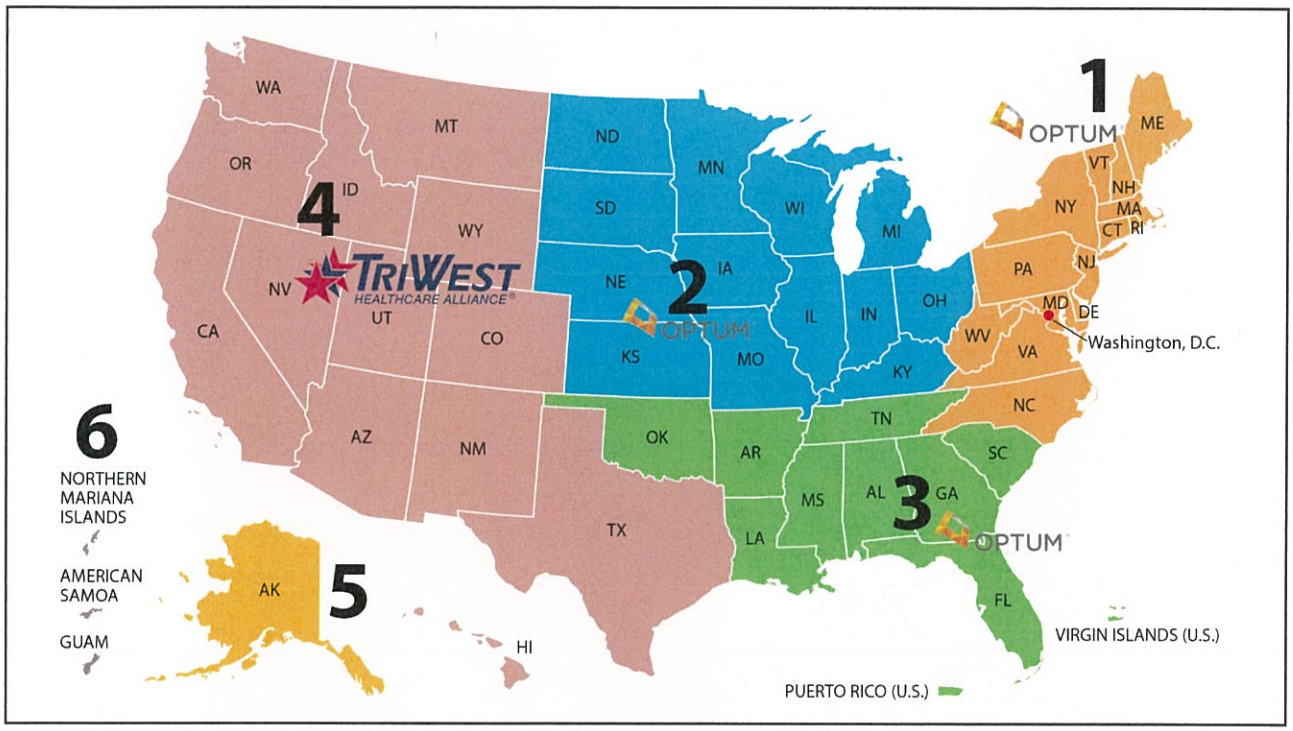
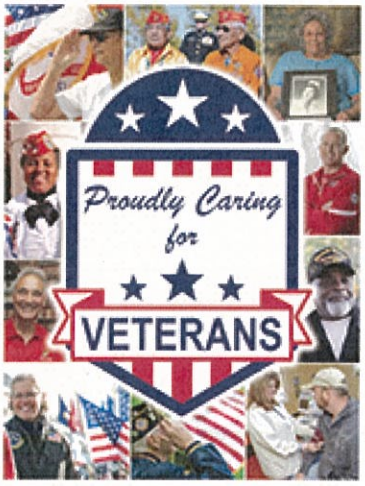
230





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

EmpowerChiro
A Family Health America Company

- EmpowerChiro must be utilized to be part of the **TriWest** VA Choice provider network
- www.empowerchiro.com
- **(800) 819-9571**
- You may opt out their affiliated plans that are for PI and WC but must accept their other plans
- **TriWest Customer Service:** 877-266-8749

EmpowerChiro

Network Form – NATIONAL

Contracting networks have plans that include Health, Personal Injury (auto), Workers' Compensation, Medicare and/or Medicaid. Please check the type of products you WILL accept:

___Health
___Workers' Compensation
___Auto/Personal Injury (PI)
___Medicare_____#
___Medicaid_____#

Note: You will automatically be included in specific plans where indicated.

To be included in other plans, please select your networks by checking either "Yes" or "No", initial each page and sign the last page. ***IF THIS FORM IS NOT RETURNED TO EMPOWERCHIRO, YOU WILL AUTOMATICALLY BE INCLUDED IN ALL PLANS.***

The allowed amount may not be what insurance pays and may include the patient's liability (copay, coinsurance and/or deductible, etc.) and may include codes that are not allowed and/or not paid under self-funded or other types of plans.

If you are billing with a group tax id number, if only one provider in the group has been credentialed by EmpowerChiro, all claims for all providers in the group may be processed as in network.

Note – Family Health America, LC, dba EmpowerChiro, (FHA) selects the plan or plans in which it chooses to participate. Even if you opt into a specific Health Plan, or general type of plan, you

now or may in the future (this includes individual accounts FHA may opt out of which are within an overall Health Plan). For any or no reason, FHA has the right to remove you from any plan or plans.

Chiropractor Directory Search

___Yes ___No - Patients from across America visit this search page daily to find a chiropractor. The EmpowerChiro Chiropractor Directory Search Page is a sponsored listing which enables patients in each city to locate a chiropractor. As a preferred provider, unless you notify us otherwise, you automatically receive a FREE listing of your practice information (name, address, phone and fax) on the "Find-A-Chiro" page of our website, www.empowerchiro.com. To add "About Us" and "Driving Directions" or photos, please email the information to help@empowerchiro.com.

NeedaChiro
Helping Patients Find a Quality Chiropractor

___Yes ___No - A directory website to assist patients in locating our most esteemed member chiropractors. As part of your EmpowerChiro membership, you receive a "mini website" at www.NeedAChiro.com which includes photos and information about your practice.

TRIWEST HEALTHCARE ALLIANCE

YOU WILL BE AUTOMATICALLY INCLUDED IN: TriWest Healthcare Alliance (TriWest) was founded in 1996 to provide Service Members and Veterans with access to high quality health care and customer service. Through the Veterans Affairs **Patient-Centered Community Care (VAPC3)** and the Veterans Affairs **Community Care Network (CCN)** program chiropractors may treat Veterans REFERRED from the VA through TriWest's referral program. TriWest will process the referral from the VA, schedule appointments, track medical documentation and pay claims.

Reimbursement is based on the TriWest Addendum included with this packet.

AMERICAN PPO
The Organization Preferred

___Yes ___No - **American PPO Inc (APPO)** is a large national PPO. **APPO will discount provider's billed charges 15%.**

___Yes ___No - **Atlantic Integrated Health,** is a large medical PPO located in **North Carolina**. The AIH fee schedule is as follows:

CPT	ALLOWED FEE	CPT	ALLOWED FEE
99201	$ 48.45	97026	$ 11.03
99202	$ 75.71	97035	$ 17.00
99203	$111.50	97530	$ 36.75
99204	$162.50	72010	$151.26
99205	$205.50	72020	$ 57.43
99211	$ 26.00	72040	$ 82.28
99212	$ 45.00	72050	$121.63
99213	$ 62.00	72052	$147.32
99214	$ 97.00	72070	$ 86.51
99215	$144.00	72100	$ 89.79
97010	$ 10.18	72110	$123.34
97012	$ 18.90	98940	$ 24.50
97014	$ 18.23	98941	$ 33.91
97016	$ 22.05	98942	$ 44.37
97024	$ 11.03	98943	$ 22.71

Note: For any CPT4 or HCPCS code not listed on the fee schedule, reimbursement will be 80% of provider's billed charges.

stratose

Since 1995, Stratose (formerly known as Coalition America) has served payors of all kinds, including insurance carriers, third-party administrators (TPAs), health maintenance organizations, stop-loss carriers, Labor/Taft-Hartley funds and health plans. We currently serve the medical, dental and workers' compensation payor markets.

___Yes ___No - **Health (STRATOSE)** Insurance Plans reimbursement will be 105% of the Medicare fee schedule for each applicable region.

___Yes ___No - **Workers' Compensation Plans (STRATOSE) –** Unless otherwise required by law, the contract rate for workers' compensation plans shall be equal to ninety (90) percent of the fees listed under the state or federal workers' compensation fee schedule less any copayments, deductibles and coinsurance, if applicable.

___Yes ___No - **Devon Health Services Inc (Devon)** is a PPO that covers approximately 3 million Union health plan members in **Connecticut, Delaware, Maryland, New Jersey, New York, Ohio, Pennsylvania and Virginia.** The majority of these plans allow members at least 30 visits per year with no PCP referral. Note: All

CPT	ALLOWED FEE	CPT	ALLOWED FEE
72020	$ 24.00	73600	$ 27.00
72050	$ 50.00	73610	$ 29.00
72052	$ 61.00	76125	$ 44.00
72070	$ 36.00	97010	$ 5.00
72072	$ 39.00	97014	$ 16.00
72100	$ 37.00	97032	$ 14.00
72110	$ 50.00	97035	$ 11.00
72114	$ 63.00	97110	$ 20.00
72120	$ 45.00	97112	$ 21.00
72200	$ 29.00	97124	$ 17.00
72220	$ 30.00	97530	$ 25.00
73030	$ 31.00	98940	$ 23.00
73080	$ 30.00	DEVON CONTINUED NEXT PAGE	

Optum Health

- **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)

- 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

VA Claims Require Pre-Authorization

The Veteran works his or her local VAMC to confirm CCN eligibility and request chiropractic care.

- If the Veteran is eligible, VA may refer the Veteran to a community provider and either appoints the Veteran to a CCN provider, delegates appointing to TriWest or Optum, or allows the Veteran to self-schedule.
- VA will then send the authorization information for administrative purposes.

Authorization

Veteran patient may use https://www.myhealth.va.gov/mhv-portal-web/user-login to make requests or get help in accessing care

- 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 the region and chiropractic care IS NOT limited to spinal CMT
- 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
Chiropractic Care SEOC 1.0.1
SEOC ID: PMR_CHIROPRACTIC_1.0.1
Description: This authorization covers services associated with all medical care listed below for the referred condition.
Duration: 365 days
Frequency: 12 visits per year
Procedural Overview 1. Initial outpatient evaluation and manual manipulation therapy for the referred condition indicated on the consult. 2. Standard imaging relevant to the referred condition should be completed at VA to extent possible. 3. Office visits for this episode of care are limited to 12 visits per year. Chiropractic care justification must include a detailed plan with specific timeline linke to objective measureable improvement. 4. Expectations of service for chiropractic treatment include: a. Significant durable pain intensity decrease b. Functional improvement demonstrated by: clinically meaningful improvement on validated disease-specific outcomes instruments; return to work; and/or documented improvement in activities of daily living 5. Documented decreased utilization of pain-related medications
** All requests for additional therapeutic modalities, including heat/cold modalities and massage therapy require VA review/approval.
** All requests for supplements will be routed through the VA. ** Additional consultations needed relevant to the patient complaint/condition require VA review and approval. ** DME, prosthetics and orthotics will be reviewed by the VA for provision. ** All routine medications will be provided 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.

U.S. Department of Veterans Affairs

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
Chiropractic Initial	20560, 20561, 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72081, 72082, 72083, 72084, 72100, 72110, 72114, 72120, 72170, 72190, 73020, 73030, 73501, 73502, 73503, 73521, 73522, 73523, 73560, 97012, 97026, 97112, 97124, 97140, 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 0552T, G0463, G0466, G0467, G0468
Chiropractic Continuation of Initial	20560, 20561, 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72081, 72082, 72083, 72084, 72100, 72110, 72114, 72120, 72170, 72190, 73020, 73030, 73501, 73502, 73503, 73521, 73522, 73523, 73560, 97012, 97026, 97112, 97124, 97140, 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 0552T, G0463, G0466, G0467, G0468
Chiropractic Pain Management	20560, 20561, 97012, 97026, 97112, 97124, 97140, 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 0552T, G0463, G0466, G0467, G0468

Medical Records and Documentation Requirements

- Medical records and documentation are required for all provided services. Providers are required to submit medical documentation directly to the authorizing VAMC, preferably via upload.
- As for how often to submit, VA requires providers submit the following medical documentation for each episode of care:
  - Initial medical documentation – associated with the first appointment of a Standardized Episode of Care (SEOC).
  - Final medical documentation – covers the entire SEOC.

Medical Necessity & Request For Services (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

- **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

2

Optum

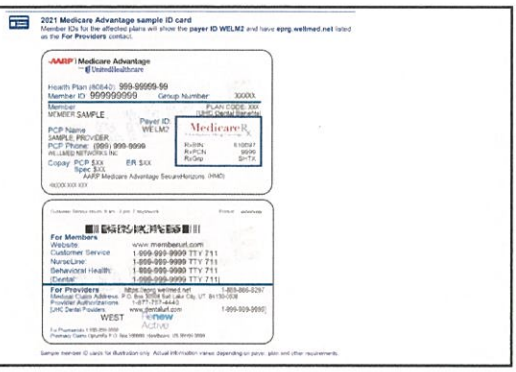
- E Payer ID: VACCN

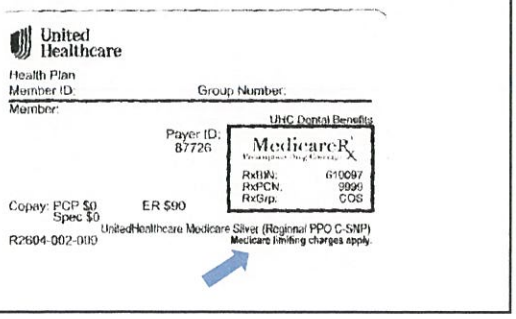
Mailing Address:
VA CCN Optum P.O. Box 202117
Florence, SC 29502

- Secure Fax: 833-376-3047

- *10,000 baby boomers are reaching retirement age every day*

According to the AARP, 10,000 baby boomers are turning 65 every single day, and this is expected to continue into the 2030s. This means that nearly seven baby boomers are turning 65 every minute.





EXPLANATION OF MEDICARE BENEFITS FOR CHIROPRACTIC SERVICES

_____
Patient's Name

DEDUCTIBLE
Medicare requires that you pay a yearly deductible of $226 towards your Part B medical expenses before they will begin paying for covered services. If you have already been treated by other doctors this year, those may apply to your deductible.

MEDICARE COVERAGE
Medicare in a chiropractic office only covers manual manipulation of the spine (commonly referred to as a spinal adjustment or CMT) Medicare pays 80% of the service and you are liable for 20% after the deductible is met. All other services other than spinal manipulation are your responsibility and are outlined below in detail.

EXAMINATIONS
To determine the extent of your condition and the type of treatment you will need, the doctor will examine you before the initiation of treatment, and periodically thereafter. Medicare will not reimburse you for examination charges; therefore, you are responsible for these charges.

X-RAYS
Medicare does not require x-rays as a requirement for chiropractic care. However, your condition may require x-rays as necessary to fully assess your condition. If x-rays are taken or ordered by your chiropractor, they are not covered by Medicare. Medicare will not reimburse for x-ray charges

PHYSICAL MEDICINE, SUPPLEMENTS, AND SUPPORTS
During your treatment in this office, the doctor may determine that certain physical therapy modalities or procedures, vitamin supplements, or orthopedic supports may be necessary to assist in the treatment of your condition. Medicare will not reimburse you for any of these services; therefore, you are personally responsible for those charges.

I understand that although the Chiropractic services listed above may be required for the treatment of my condition, these charges are not covered by Medicare, and I will be personally responsible for the payment of these charges.

_____ _____
Patient's Signature **Date**

CENTERS FOR MEDICARE & MEDICAID SERVICES

Chiropractic & Medicare in 3 Steps

<u>Step 1</u> Diagnosis

Subluxation diagnosis must be primary

Subluxation may be determined by x-ray or physical examination. If by x-ray block 19 must include the date of the x-ray and state "x-ray"
Note NJ and PA require PART in block 19 (Novitas MAC)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
Xray and date of x-ray (if using x-ray for subluxation)
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide a reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine as demonstrated by an x-ray or physical exam.

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

A. M9901	B. M5412	C. M9902	D. M546
E. M9903	F. M545	G.	H.
I.	J.	K.	L.

States managed by National Government Services (NGS) may report subluxation only however secondary diagnosis must be in the chart notes.

The frequency and duration of chiropractic treatment must be medically necessary and based on the individual patient's condition and response to treatment. Prolonged or repeated courses of treatment are more likely to undergo medical review.

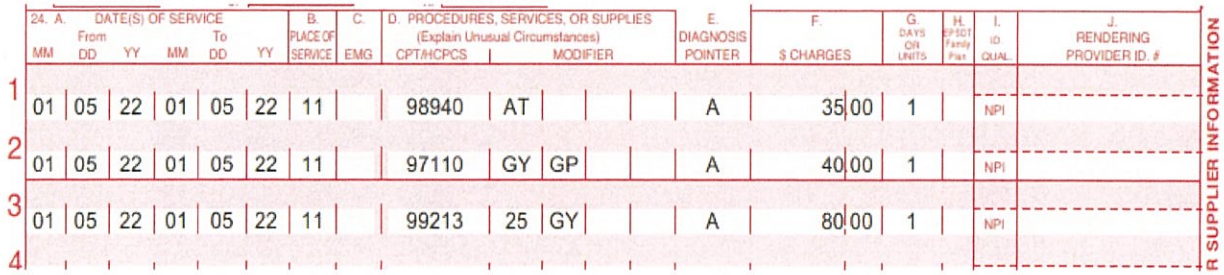
There are no caps/limits in Medicare for covered chiropractic care rendered by chiropractors who meet Medicare's licensure and other requirements as specified in the "Medicare Benefit Policy Manual, "Chapter 15, Section 30.5

Each Medicare Administrative Contractor (MAC) may have review screens (numbers of visits at which the MAC might require a review of documentation before allowing further care), but caps/limits are not allowed. Hence the necessity of a secondary NMS diagnosis as care allowances will vary based on the complexity and severity of the patient's condition.

Step 2 **Reporting claim with proper CPT codes & modifiers**

-AT

Spinal manipulation must have modifier **AT** to indicate care is active or corrective and therefore medically necessary. The absence of modifier **AT** indicates care is not necessary and is an automatic denial

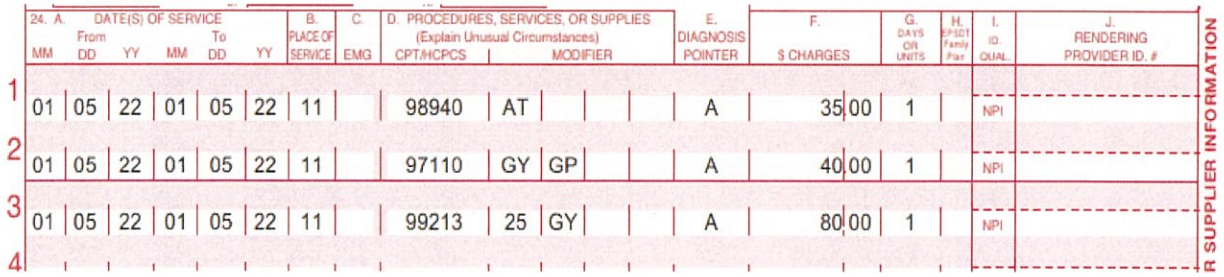


	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER			E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	05	22	01	05	22	11		98940	AT			A	35 00	1		NPI	
2	01	05	22	01	05	22	11		97110	GY	GP		A	40 00	1		NPI	
3	01	05	22	01	05	22	11		99213	25	GY		A	80 00	1		NPI	
4																		

R SUPPLIER INFORMATION

-GY

All services other than spinal manipulation, when billed to Medicare, should have modifier **GY**. **This modifier indicates a service excluded (not paid) by Medicare** *(E&M, X-ray et al any code that is not spinal CMT)*



	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	05	22	01	05	22	11		98940	AT			A	35 00	1		NPI	
2	01	05	22	01	05	22	11		97110	GY	GP		A	40 00	1		NPI	
3	01	05	22	01	05	22	11		99213	25	GY		A	80 00	1		NPI	
4																		

R SUPPLIER INFORMATION

-GP

All physical medicine services 97012-97799 also require in addition to the GY for excluded services also require GP. If this modifier is not included Medicare will not provide a proper denial for the secondary plan to make payment.

Medicare Excluded Services
Medicare does not require providers to submit claims for services that are excluded by statute under Section 1862(a)(1)(A) of the Social Security Act. Contact the customer service department of the secondary insurer to verify coverage of services that are statutorily non-covered by Medicare. Many insurance companies do not require a denial for such services. Verify whether a Medicare denial is needed for coverage consideration

When manipulation is maintenance or not covered –

-GA

GA = patient has signed the Medicare ABN (Advance Beneficiary Notice) accepting personal liability for manipulation.

Meaning care (CMT to spine) is maintenance or not covered by Medicare and the patient agrees to pay for the service.

	MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS	MODIFIER	POINTER	$ CHARGES	UNITS
1	01	05	22	01	05	22	11		98940	GA	A	35 00	1

ABN must be signed by the patient and may be used for a period of time or visits not to exceed one year. Therefore need not be signed on each visit.

Medicare claims processing manual section 50.9
A beneficiary who has been given a properly delivered ABN and agrees to pay may be held liable. The charge may be the healthcare provider or supplier's usual and customary fee for that item or service and is not limited to the Medicare fee schedule. If the beneficiary does not receive proper notice when required, s/he is relieved from liability.

Step 3 **1500 Claim form format**

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 may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

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.

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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.

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☐ **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 supplier doesn't accept payment from Medicare for the item(s) listed in the table above. If I checked Option 1 above, I am responsible for paying the supplier's charge for the item(s) directly to the supplier. If Medicare does pay, Medicare will pay me the Medicare-approved amount for the item(s), and this payment to me may be less than the supplier's charge."

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 may ask to receive a copy.

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Medicare Claim

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

1. MEDICARE [X] (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): 444556666A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Madden, Poppy

3. PATIENT'S BIRTH DATE MM DD YY: 09 02 1934 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): (only use if Medicare is secondary)

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

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: None (to indicate when MC is primary)

a. OTHER INSURED'S POLICY OR GROUP NUMBER: XDU555555 (secondary ins to Medicare)

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: Blue Cross Blue Shield

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 07 15 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): X-Ray and date if using x-ray (NJ and PA PART or X-Ray and Date)

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. M9901 B. M5412 C. M9902 D. M546

E. M9903 F. M545 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	07 15 22	07 15 22	11		98940	AT		A	35 00	1		NPI	
2	07 15 22	07 15 22	11		97110	GY	GP	A	40 00	1		NPI	
3	07 15 22	07 15 22	11		99213	25	GY	A	80 00			NPI	
4												NPI	
5												NPI	
6												NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 987654321 [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 155 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: Jane Smith DC, 54321 Spine Ave, Any City

a. NPI b.

33. BILLING PROVIDER INFO & PH # (555) 111-2222: Jane Smith DC, 54321 Spine Ave, Any City

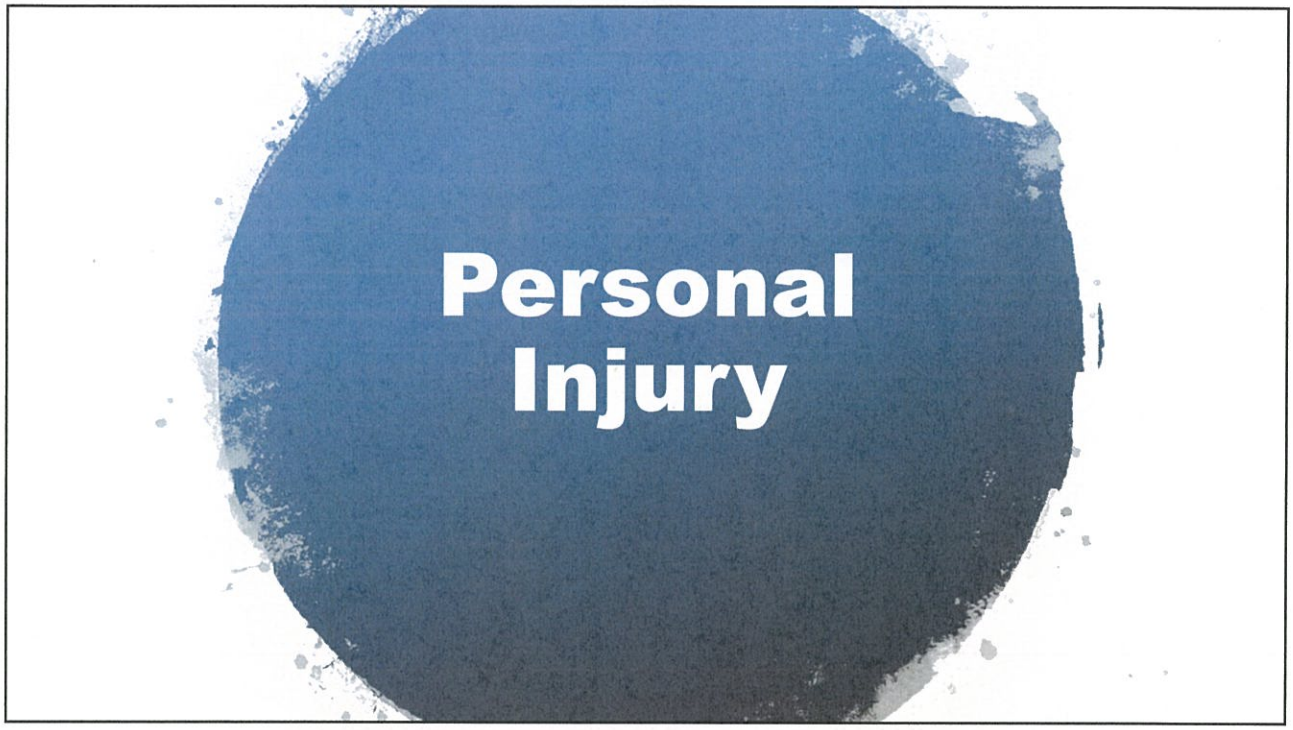
a. 222333444 b.

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

Medicare Advantage Plans Part C

- Format like Medicare
- Subluxation and secondary diagnosis
- AT on all CMT
- GP on physical medicine
- You are limited to the amounts of the plan "deemed provider"

- Humana requires modifier 97 on all PT and Chiro services (not an AT or GP) Note if 59 is needed then it would be added to the 97
- Humana's policy · Healthcare providers must append:
- – Modifier 96 to service codes for habilitative therapies
- – Modifier 97 to service codes for rehabilitative therapies
- · Requirement applies when billing Humana plans with separate benefits for habilitative and rehabilitative services that follow Essential Health Benefits.
- · Requirement applies to services including, but not limited to:
- – Audiology
- – Cognitive therapy
- – Occupational therapy
- – **Physical therapy**
- – Speech therapy
- – **Spinal manipulations and adjustments**



How are claims paid?

First Party – Med Pay

- 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

C0SI — 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

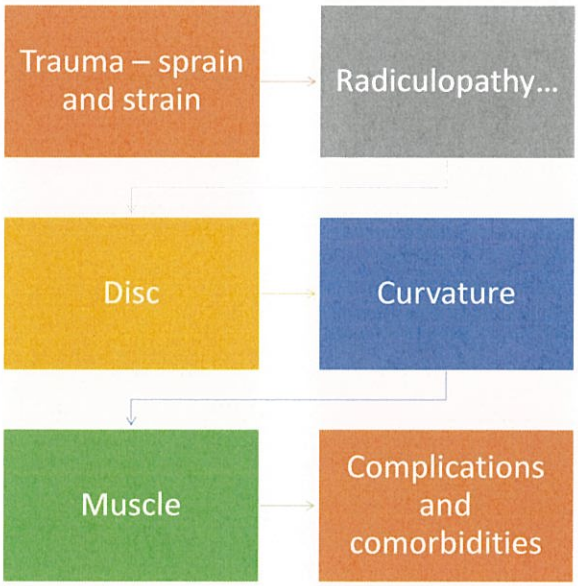
The patient has no medical payments so there is no direct payment to the provider and the patient should sign and understand their direct responsibility for payment. Patients must be made aware of the cost of services and receive copies of all accountable billings and reports.

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.

Diagnosis



Can I Claim to Health Insurance?

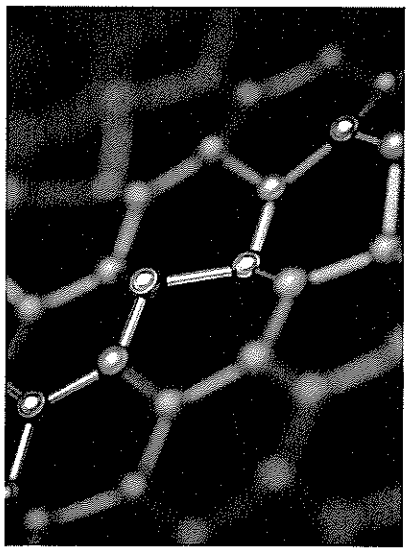
Claims may be made to health insurance to cover costs of personal injury claims

If the provider is "in network" or contracted with this carrier the maximum amount will be limited to the contract rate and provider is prohibited from collecting any balance above the contracted rate

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.

https://www.hjrosscompany.com/platinum-network

HJ Ross Network

Expert Help to assure full payment & compliance