

# Medicare (and More!) for Chiropractic, Made Easy

Presented by Evan M. Gwilliam, DC MBA  
CPC CCPC QMCC CPMA CPCO AAPC Fellow



[Evan.Gwilliam@Practisync.com](mailto:Evan.Gwilliam@Practisync.com)

1

The opinions expressed in this presentation and on the following slides are solely those of the presenter and not necessarily those of ChiroHealthUSA or Practisync. Every effort has been made to offer current and accurate information, but the accuracy or reliability of the information provided is not guaranteed and errors and omissions can occur. This presentation is intended for educational purposes only and does not replace independent professional or clinical judgement.

2

# Take Away

- Participation
- Indications
- Limitations
- Documentation
- Claims
- ABNs

3



4

# Sources

- Medicare Learning Network:
  - SE1101, SE1601, SE 1602, SE1603
  - Documentation Job Aid for Chiropractic Doctors
- Medicare Benefit Policy Manual, Ch. 15, section 240
- Medicare Claims Processing Manual, 100-4, Chapter 30 (ABN Guidelines)
- 42 Code of Federal Regulations 489.2  
 “Provider is presumed to have knowledge of published Medicare coverage rules.”

5

## Article Information

### General Information

**Article ID**  
A57889

CPT codes, descriptions and other data only are copyright 2023 American Medical Association. All Rights Reserved. Applicable FARS/HHSARS apply.

**Article Title**  
Chiropractic Services – Medical Policy Article

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

**Article Type**  
Article

Current Dental Terminology © 2023 American Dental Association. All rights reserved.

**Original Effective Date**  
01/01/2020

Copyright © 2024, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the American Hospital Association (AHA) copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312□

**Revision Effective Date**  
N/A

6

## Medicare

- CMS is "Centers for Medicare & Medicaid Services"
- Prior to 2001, it was HCFA, the "Healthcare Finance Administration"
- Medicare covers 55 million Americans, about 17 percent of the U.S. population.
- Medicare sets the standard for the health insurance industry
- Even if you refuse to deal with them, you need to know what they're thinking!

7

## Medicare

- Part A – Hospital/inpatient coverage
- Part B – physician/outpatient coverage
- Part C – MedAdvantage, HMO, replacement
- Part D – Prescription drug coverage
- MediGap/supplemental – covers copay and sometimes deductible
- Secondary – may cover non-covered services

2024 Deductible - \$240

2024 Premium - \$174.70/month

8

# Participation

9

# Participation

## Enrollment forms:

855-I Individual

855-B Corporation

855-R Employee Doctors of Corporation

855-S Durable Medical Equipment suppliers

Welcome to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)

(\*) Red asterisk indicates a required field.

PECOS supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information.

**New to PECOS?** View our [videos](#) at the bottom of this page.

<p><b>USER LOGIN</b></p> <p>Please use your I&amp;A (Identity &amp; Access Management System) user ID and password to log in.</p> <p>* <b>User ID</b></p> <input type="text"/>	<p><b>BECOME A REGISTERED USER</b></p> <p>You may register for a user account if you are: an Individual Practitioner, Authorized or Delegated Official for a Provider or Supplier Organization, or an individual who works on behalf of Providers or Suppliers.</p> <p><a href="#">Register for a user account</a></p>
--	--

10

# Participation

Should you participate?

PAR agrees to 4 things:

- Accept assignment
- Accept Medicare charge as payment in full
- Collect deductible and coinsurance
- Renew PAR status automatically annually

Chiropractors may not “opt out”



11

# Participation

PAR get the following “perks”

- 5% higher reimbursement than non-PAR
- Payment within 2 weeks
- Medicare Remittance Notice with each claim
- Provider Directory listing (MEDPARD)
- Medigap crossover

Non-PAR

- You can charge 15% more than the "allowed amount", called the "limiting charge" (if you don't accept assignment)

12

# Participation

Extra tips:

- All new enrollees and those changing anything (phone number, etc) must accept payment by EFT (must recertify every 5 years).
- Note that, as part of the agreement, Medicare may be allowed to pull money out of the account in the event of overpayment.
- Mitigate your risk by creating a separate account just for Medicare and pull the money out, leaving a minimum balance of \$50-\$100.

13

## Medicare Benefit Policy Manual

### Chapter 15 – Covered Medical and Other Health Services

#### 240 - Chiropractic Services - General

(Rev. 1, 10-01-03)

B3-2250, B3-4118

The term “physician” under Part B includes a chiropractor who meets the specified qualifying requirements set forth in §30.5 but only for treatment by means of manual manipulation of the spine to correct a subluxation.

Resource #1

14

## they do?

A Medicare Administrative Contractor (MAC) is a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries. CMS relies on a network of MACs to serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program. MACs are multi-state, regional contractors responsible for administering both Medicare Part A and Medicare Part B claims. MACs perform many activities including:

- Process Medicare FFS claims
- Make and account for Medicare FFS payments
- Enroll providers in the Medicare FFS program
- Handle provider reimbursement services and audit institutional provider cost reports
- Handle redetermination requests (1st stage appeals process)
- Respond to provider inquiries
- Educate providers about Medicare FFS billing requirements
- Establish local coverage determinations (LCD's)
- Review medical records for selected claims
- Coordinate with CMS and other FFS contractors

15

## Medicare Administrative Contractors



19

16

**Local Coverage Article:**  
CHIROPRACTIC **Services – Medical Policy Article (A57889)**

**Article - Billing and Coding: Chiropractic Services (A56273)**

**Resource #2 and 3**

17

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



**Resource #4a, 4b, 4c, 4d**

18

# Indications

19

## Medical necessity

Medicare definition of medical necessity under Title XVIII of the Social Security Act, section 1862 (a)(1)(A):

*No payment may be made under Part A or Part B for any expenses incurred for items or services, which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.*

**OATs, Treatment Goals, P.A.R.T.**

20

## Coverage

- Medicare limits coverage of chiropractic services to treatment by means of manual manipulation (that is, by use of the hands) of the spine to correct a subluxation.
- The patient must require treatment by means of manual manipulation of the spine to correct a subluxation.
- The manipulative services the doctor of chiropractic provides must have a direct therapeutic relationship to the patient's condition.

21

## Subluxation

A motion segment, in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact.

- Some common examples of acceptable descriptive terms for the nature of the abnormalities:
  - Off-centered, misalignment, malpositioning
  - Spacing: abnormal, altered, decreased, increased
  - Incomplete dislocation, rotation
  - Listhesis: antero, postero, retro, lateral, spondylo
  - Motion: limited, lost, restricted, flexion, extension, hypermobility, hypomobility, aberrant

• 22

22

## Subluxation

### Segmental and Somatic Dysfunction

Code Options	
M99.0-	Segmental and somatic dysfunction
<b>M99.00</b>	<b>Head region</b>
<b>M99.01</b>	<b>Cervical region</b>
<b>M99.02</b>	<b>Thoracic region</b>
<b>M99.03</b>	<b>Lumbar region</b>
<b>M99.04</b>	<b>Sacral region</b>
<b>M99.05</b>	<b>Pelvic region</b>
<b>M99.06</b>	<b>Lower extremity</b>
<b>M99.07</b>	<b>Upper extremity</b>
<b>M99.08</b>	<b>Rib cage</b>

TIP: Consider pointing the M99.0- diagnoses to only  
98940-98943 *Chiropractic Manipulative Treatment*

23

## Coding considerations

### “Subluxation”

- Other ICD-10-CM codes include the word “subluxation,” but it appears that they are not recognized by payers as indications to justify chiropractic manipulative treatment.
- Tip: Document “segmental dysfunction” to match the code description.

### Trauma

- The so-called traumatic subluxation codes, S13.1- Cervical, S23.1- Thoracic, S33.1- Lumbar include “sprain,” and therefore would not be reported on the same claim as sprains.

### PART

- Note that the sample documentation follows the Medicare principle of P.A.R.T. (which isn’t a bad idea for all payers and regulators)

24

24

# Medicare Terminology

**Chiropractic Manipulative Treatment-** manual treatment to influence joint and neurophysiological function

- The following terms can be used to describe the manual manipulation:
  - Spine or spinal adjustment by manual means
  - Spine or spinal manipulation
  - Manual adjustment
  - Vertebral manipulation or adjustment

• 25

25

# Medicare Terminology

- The word “correction” may be used in lieu of “treatment”
- Extraspinal (not covered) includes
  - Head
  - Lower extremities
  - Upper extremities
  - Rib cage
  - Abdomen



• 26

26

## Coverage

- Care must provide reasonable expectation of recovery or improvement of function.
- Doctors of chiropractic are limited to billing three Current Procedural Terminology (CPT) codes under Medicare:
  - 98940 (chiropractic manipulative treatment; spinal, one to two regions)
  - 98941 (three to four regions)
  - 98942 (five regions).

27

## Coverage

- Doctors of chiropractic must use an Acute Treatment (AT) modifier to identify services that are active/corrective treatment of an acute or chronic subluxation.
- The AT modifier, when used appropriately, should indicate expectation of functional improvement, regardless of the chronic nature or redundancy of the problem.

28

## Active Treatment

- Acute subluxation- new injury
- Recurrence – previous condition returns after 30+ days
- Exacerbation – flare up
- Chronic subluxation – permanent condition, but function can improve

29

## Acute Subluxation

- Patient is being treated for a new injury, identified by x-ray or physical exam (PART).
- Result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.

30

## Chronic Subluxation

- “Condition is not expected to significantly improve or be resolved with further treatment, but where continued therapy can be expected to result in some functional improvement.”
- When clinical status has remained stable (no more objective clinical improvements), it is considered maintenance therapy.

• 31

31

## Chronic Sample

- 300 year old female with chronic low back pain and stage 3 degenerative disc disease
- Primary diagnosis = M99.03 Segmental dysfunction
- Secondary diagnosis = M51.36 DDD
- 5 or 6 weeks after a treatment patient loses the ability to stand for more than 15 minutes w/o pain. No exacerbation, just gradual onset.
- Treatment goal: enable patient to stand 1 hour w/o pain

• 32

32

# Medical Necessity

Some MACs specifically state:

“Strains, sprains, nerve pain and functional mechanical disabilities of the spine are considered to be reasonable and necessary therapeutic grounds for chiropractic manipulative treatment.”



33

33

# Contraindications

- Relative
  - Hypermobility
  - Severe demineralization
  - Benign bone tumors of spine
  - Bleeding disorders
  - Progressive radiculopathy
- Absolute
  - Acute arthropathies
  - Acute fractures
  - Malignancies of spine
  - Infections of spine
  - Myelopathy
  - Vertebrobasilar insufficiency syndrome
  - Major artery aneurysm

34

34

# Limitations

• 35

35

## Excluded services

- Excluded services are the beneficiary's responsibility.
- May bill patient without billing Medicare for
  - Acupuncture
  - Counseling/education
  - Dietary advice or nutritional supplements
  - Lab or other diagnostic tests
  - Modalities or therapeutic procedures (exercise, ultrasound)
  - Office visits
  - Supplies (pillows or vitamins)
  - Supportive devices (braces, orthotics)
- ○ X-rays

**Modifiers: GY  
and maybe GP**

• 36

36

## Other limitations

- The mere statement or diagnosis of “pain” is not sufficient to support medical necessity for treatment.
- Precise level of the subluxation must be specified to substantiate a claim for manipulation of each spinal region.
- The need for an extensive, prolonged course of treatment should be appropriate to the reported procedure code and documented clearly in the medical record.

• 37

37

## Related Symptoms

- “These symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine (spondyle or vertebral), muscle (myo),bone (osseo or osteo), rib (costo or costal) and joint (arthro)and be reported as pain (algia), inflammation (itis), or as signs such as swelling, spasticity, etc. “
- “Vertebral pinching of spinal nerves may cause headaches, arm, shoulder, and hand problems as well as leg and foot pains and numbness. Rib and rib/chest pains are also recognized symptoms, but in general other symptoms must relate to the spine as such.”

• 38

38

## Frequency

Chiropractic manipulation service only reimbursed once per day

The frequency and duration of chiropractic treatment:

- Must be medically necessary
- Based on the individual patient's condition and response to treatment

Medical necessity determines visits, i.e. there is no set visit limit

• 39

39

## Corrective treatment

- Goal driven
- Individualized treatment plan
- Short term
- Measurable progress towards goals
- "Pain" and "subluxation" alone is insufficient
- Use AT modifier with CPT codes 98940-98942

• 40

40

## Medical Necessity

- Coverage will be denied if there is not a reasonable expectation that the continuation of treatment would result in improvement of the patient's condition.
- Continued repetitive treatment without a clearly defined clinical end point is considered maintenance therapy and is not covered.

• 41

41

## Maintenance

- Services that seek to
  - Prevent disease (*wellness care*)
  - Promote health (*wellness care*)
  - Prolong or enhance quality of life (*wellness care*)
  - Maintain or prevent deterioration of a chronic condition (*supportive care*)
- Further clinical improvement cannot reasonably be expected from continuous ongoing care.
- Treatment is supportive rather than corrective in nature. (PRN care)

• 42

42

## Maintenance

- Mandatory claim submission
    - Requires providers to bill CMS, even if service might deny (98940-98942)
  - Do not append AT modifier
  - Consider using a diagnosis code like:
    - Z41.9 *Encounter for procedure for purposes other than remedying health state, unspecified*
  - Obtain ABN and use GA modifier
- (more on this later)

43

43

## Documentation

MLN1232664 Medicare Documentation Job Aid for Chiropractic, March 2022

44

44



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

# 2022 Medicare Fee-for-Service Supplemental Improper Payment Data

Resource #6

45

## Appendix E: Improper Payment Rates and Type of Error by Type of Service for Each Claim Type

Appendix E tables are sorted in descending order by improper payment rate. All estimates in these tables are based on a minimum of 30 lines in the sample. For a full listing of all services with 30 or more claims, see Appendix G.

Table E1: Top 20 Service Type Improper Payment Rates: Part B

Part B Services (BETOS Codes)	Improper Payment Rate	95% Confidence Interval	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Other - non-Medicare fee schedule	42.5%	22.9% - 62.0%	0.0%	98.0%	0.5%	0.4%	1.1%	0.1%
Chiropractic	31.3%	24.3% - 38.3%	2.3%	88.5%	4.1%	3.8%	1.2%	0.5%
Lab tests - other (non-Medicare fee schedule)	26.4%	21.8% - 31.1%	3.8%	91.2%	0.1%	0.0%	4.9%	3.7%
Lab tests - bacterial cultures	26.2%	5.8% - 46.6%	0.0%	100.0%	0.0%	0.0%	0.0%	0.1%
Specialist - other	24.5%	17.6% - 31.4%	3.2%	80.8%	0.0%	3.0%	13.1%	1.9%
Ambulatory	23.0%	10.4% - 35.6%	7.4%	90.8%	0.3%	0.0%	1.6%	0.8%

46



## Resource #5

47

### Initial Evaluation

- History
  - Date of initial treatment
  - Description of present illness
  - Symptoms bearing a direct relationship to level of subluxation causing patient to seek treatment
  - Family history (if relevant) (recommended)
  - Past health history (recommended)
  - Mechanism of trauma (recommended)
  - Quality and character of symptoms/problem (recommended)
  - Onset, duration, intensity, frequency, location and radiation of symptoms (recommended)
  - Aggravating or relieving factors (recommended)
  - Prior interventions, treatments, medication, and secondary complaints (recommended)
- Contraindications (e.g., risk of injury to patient from dynamic thrust, discussion of risk with patient) (recommended)
- Physical examination (P.A.R.T.)
  - Evaluation of musculoskeletal/nervous system through physical examination
- Documentation of presence or absence of subluxation must be included for every visit
- Treatment given on day of visit (if applicable)
  - Include specific areas/levels of spine where manipulation was performed
  - Manual devices that are hand-held with the thrust of the force of the device being controlled manually may be covered; however, no additional payment is made nor does Medicare recognize an extra charge for use of the device.

48

48



**mln**  
Educational Tool

KNOWLEDGE • RESOURCES • TRAINING

**Medicare Documentation Job Aid for Chiropractic Doctors**

#### Subsequent Visit

- History
  - Review of chief complaint
  - Changes since last visit
  - System (if relevant)
- Physical examination (P.A.R.T.)
  - Assessment of change in patient condition since last visit
  - Evaluation of treatment effectiveness (address objective measures included in treatment plan)
- Documentation of presence or absence of subluxation must be included for every visit
- Treatment given on day of visit (include specific areas/levels of spine where manipulation was performed)

49



## Documentation

1. Complaint in each region manipulated
2. Examination of each region manipulated, with a diagnosis.
3. Manipulative treatment of a condition involving each region

\*\*\*this means that five complaints and five exams and five+ diagnoses are needed for 98942

50

# Examination

Medicare says to use **PART** for the exam:

- **P**ain/tenderness
- **A**symmetry/misalignment
- **R**ange of motion
- **T**issue/tone changes

51

**P.A.R.T.**

## **P** Pain/tenderness

...evaluated in terms of *location, quality, and intensity*

Pain and tenderness findings may be identified through observation, percussion, or palpation, provocation, etc.



52

# P.A.R.T. A Asymmetry/misalignment

...may be identified on a sectional *or* segmental level through one or more of the following:

- Observation (posture and gait analysis),
- Static palpation for misalignment of vertebral segments,
- Diagnostic imaging



53

# P.A.R.T. R Range of Motion

...abnormalities may be identified through one or more of the following:

- Motion palpation
- Observation
- Stress diagnostic imaging
- Range of motion measurements (i.e. inclinometers)



54

# P.A.R.T. T

## Tissue/tone changes

... texture, and temperature changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament may be identified through one or more of the following procedures:

- Observation
- Palpation
- Use of instruments
- Test of length and/or strength



55

# P.A.R.T.

To demonstrate a subluxation based on examination at least **two criteria** must be documented, and **one must be**:

Asymmetry  
or  
Range Of Motion



56

## Sample documentation

*M99.Ø3 Segmental and somatic dysfunction, lumbar region*

**Subjective:** Patient reports lumbar spinal pain during regular activities.

**Objective:**

**P:** Pain is reproduced when the L3/L4 region is palpated.

**A:** The L3 spinous process is rotated to the right, and the L4 spinous is rotated left. The right hip appears higher than the left.

**R:** Right lumbar lateral bending and flexion are reduced as recorded by inclinometry.

**T:** Hypertonicity is palpated in the lumbar paraspinal region.

• 57

57

## • P.A.R.T.



S:

O:

P:

A:

R:

T:

A:

P:

58

P.A.R.T.



M99.0-



CMT



59



**mln**  
Educational Tool

KNOWLEDGE • RESOURCES • TRAINING

**Medicare Documentation Job Aid for Chiropractic Doctors**

**Treatment Plan**

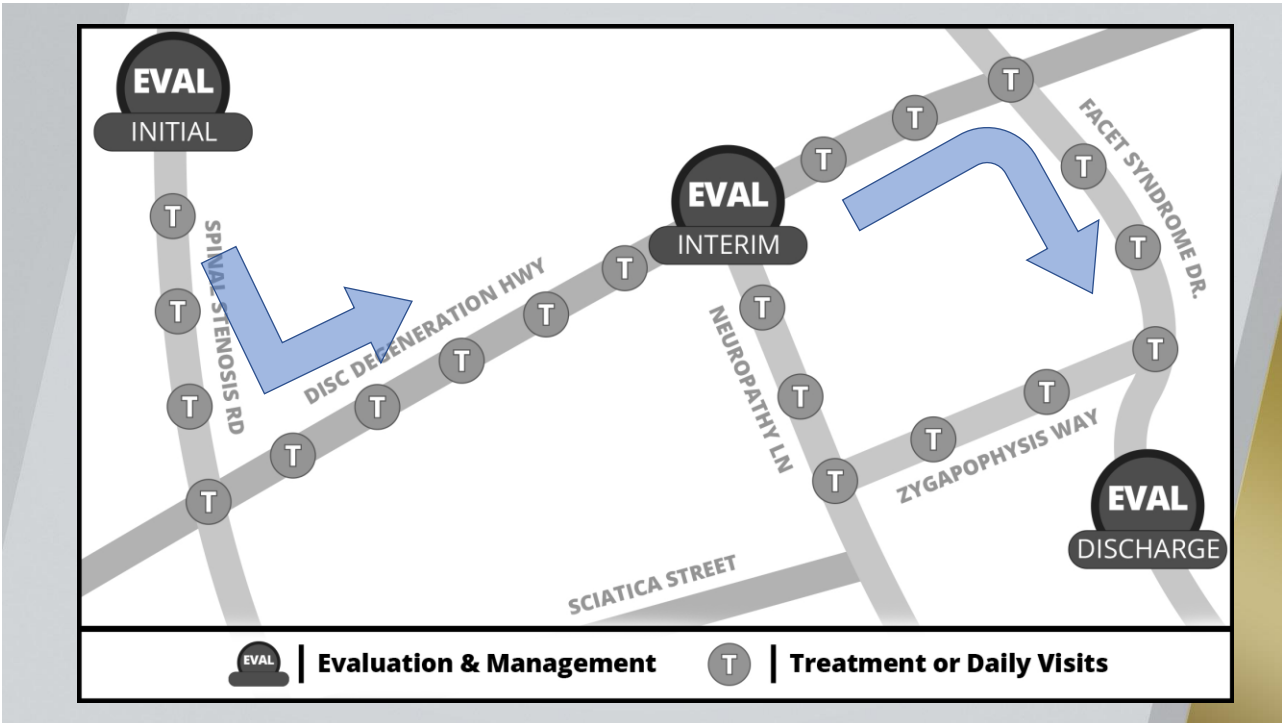
- Frequency and duration of visits (recommended)
- Specific treatment goals (recommended)
- Objective measures to evaluate treatment effectiveness (recommended)

60

60



61



62

### General Guidelines

- Ensure medical records submitted support the service is “corrective treatment,” rather than maintenance
  - For Medicare purposes, an AT modifier must be placed on a claim when providing active/ corrective treatment to treat acute or chronic subluxation
    - Do not use Modifier AT when maintenance therapy has been performed
    - Modifier AT must only be used when chiropractic manipulation is “reasonable and necessary” as defined by national and local policy
    - **NOTE:** Presence of the AT modifier may not in all instances indicate the service is reasonable and necessary. As always, contractors may deny if appropriate after medical review.  
Be aware of these policies along with any local coverage determination in your area to better understand how active/corrective chiropractic services are covered.
- Submit records for all dates of service on claim
- Documentation shall be legible and complete (including signatures)
- Legible signatures/credentials of professionals providing services
  - If signatures are missing or illegible, include a completed signature attestation statement
  - For illegible signatures, include a signature log
  - For electronic health records, include a copy of electronic signature policy and procedures describing how notes and orders are signed and dated. Validating electronic signatures depends on obtaining this information.
- Abbreviation key (if applicable)
- Any other documentation provider deems necessary to support medical necessity of services billed, as well as documentation specifically requested in the additional documentation request (ADR) letter
- Copy of Advance Beneficiary Notice of Noncoverage (if applicable)

63

63

**CHAP11-CPTcodes90000-99999**

**Revision Date: 5/1/2022**

**CHAPTER XI**

**MEDICINE**

**EVALUATION AND MANAGEMENT SERVICES**

**CPT CODES 90000 - 99999**

**FOR**

**NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL**

**FOR MEDICARE SERVICES**

**Resource #7**

64

RELI Group  
7125 Ambassador Drive, Suite 100  
Windsor Mill, MD 21244



January 31, 2022

Chiropractic Manipulative Treatment (CMT) of the Spine

[Redacted]

[Redacted]

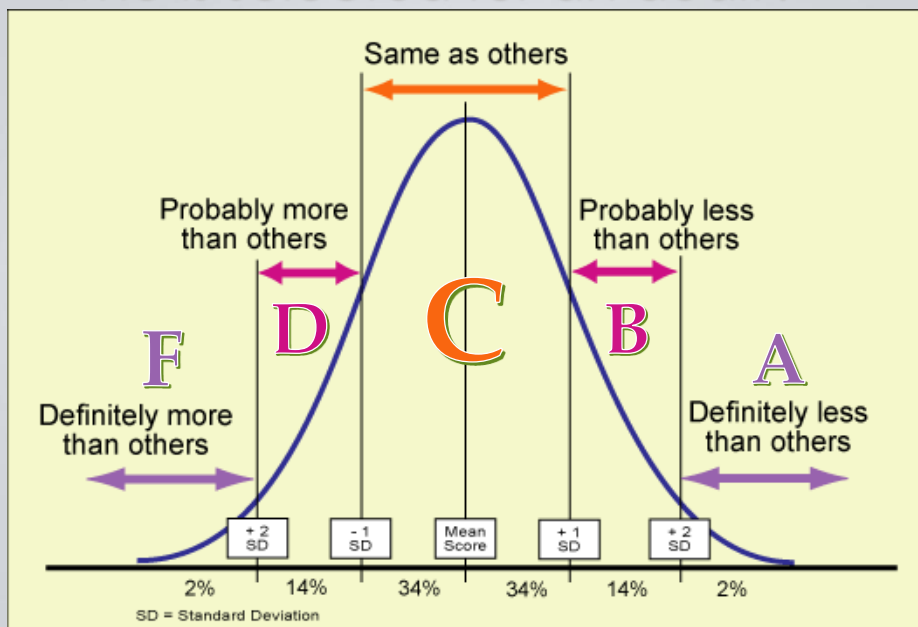
Dear Medicare Provider:

The Centers for Medicare & Medicaid Services (CMS) strives to protect the Medicare Trust Fund and effectively manage Medicare resources. To support these goals, CMS has contracted with the RELI Group to develop this **Comparative Billing Report (CBR)** and to support providers with its use.

**Resource #8**

65

# Who is selected for an audit?



66



67

## Office of the Inspector General



### Mission:

The Office of Inspector General's (OIG) mission is to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries.

Since 1976, the OIG has focused on fighting fraud and abuse in Medicare and Medicaid.

68

## Office of the Inspector General

- Has 1600 employees conducting audits, investigations, and evaluations
- Makes cost saving or policy recommendations to decision makers and the public
- Helps develop cases for criminal and civil and administrative enforcement
- Educates the public about fraudulent schemes so they can protect themselves and report suspicious activities

69

69

## OIG and Chiropractic

A search on the OIG web site reveals that fourteen reports about chiropractic have been released since 2005.

<p><b>Report in Brief</b> Date: August 2019 Report No. A-04-16-07065</p>	<p>U.S. DEPARTMENT OF HEALTH &amp; HUMAN SERVICES <b>OFFICE OF INSPECTOR GENERAL</b></p> 
<p><b>Why OIG Did This Review</b> In calendar years (CYs) 2014 and 2015, Medicare allowed payments of approximately \$1.3 billion for chiropractic services provided to Medicare beneficiaries nationwide. Previous OIG reviews found that</p>	<p><b>Twin Palms Received Unallowable Medicare Payments for Chiropractic Services</b></p> <p><b>What OIG Found</b> Some chiropractic services that Twin Palms billed were not allowable in</p>

70

70

## June 2005: Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis

(39 pages)

### Findings:

- 67% error rate (2001 claims), mostly due to maintenance visits
- \$285 million in improper payments
- 94% of bad claims lacked supporting documentation
- >12 visits → usually lack medical necessity

### Recommendations:

- CMS should do more reviews of documentation, focusing on all visits in an episode
- CMS should educate chiropractors on documentation requirements

71

71

## May 2009: Inappropriate Medicare Payments for Chiropractic Services

(36 pages)

### Findings:

- 47% error rate (2006 claims)
- \$178 million inappropriately paid
- Chiro use AT modifier inappropriately with maintenance visits
- Only half of treatment episodes remained active/corrective, especially after the 20<sup>th</sup> visit.
- 83% of claims failed to meet documentation requirements

### Recommendations:

- Create a new modifier to indicate start of an episode
- Implement a cap on number of visits
- CMS should review complete episodes, especially when more than 12 visits
- CMS should only pay if documentation requirements are met.

72

72

November 2013:  
Diep Chiropractic Wellness, Inc.  
Received Unallowable Medicare Payments for  
Chiropractic Services

(33 pages)

Findings:

- 93 of 100 sampled services were not allowable
  - 70 were medically unnecessary (maintenance)
  - 11 were incorrectly coded
  - The rest were not documented correctly
  - 82% were billed as 98942

Recommendations:

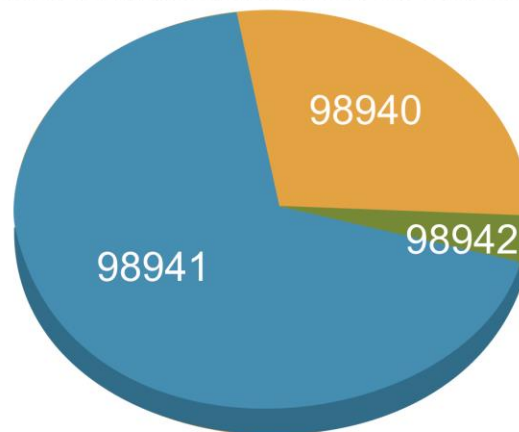
- Pay back \$708,022 of the \$879,658 that was paid in 2010 and 2011
- Establish policies and procedures to correctly document and code for services billed to CMS

73

73

**Spinal Manipulation Code Distribution and Allowed Amount**

Based on Aggregated Infindi Clearinghouse Data Records from 2019 for Providers in Chiropractic Speciality



●	98940 Avg. Allowed \$ 28.55	27.90%
●	98941 Avg. Allowed \$ 39.08	69.33%
●	98942 Avg. Allowed \$ 47.55	2.77%

74

74

May 2015:  
Advanced Chiropractic Services  
Received Unallowable Medicare Payments for  
Chiropractic Services  
(35 pages)

Findings:

- All of the 105 service line items reviewed did not support medical necessity.
- 98942 was billed 98% of the time.
- One patient received 273 services over two years

Recommendations:

- ACS should pay back \$369,335, and maybe \$737,111
- Establish policies and procedures to correctly document services billed to CMS

75

75

July 2015:  
Alleviate Wellness Center  
Received Unallowable Medicare Payments for  
Chiropractic Services  
(23 pages)

Findings:

- 100 of 100 sampled services were not allowable
  - 56 were medically unnecessary (maintenance)
  - 23 were insufficiently documented
  - 21 were not documented
  - 84% were billed as 98941

Recommendations:

- Pay back \$482,867 to the Federal Government
- Establish policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary and adequately documented

76

76

## September 2015: CMS Should Use Targeted Tactics to Curb Questionable and Inappropriate Payments for Chiropractic Services

(36 pages)

### Findings:

- In 2013, \$76 million in Medicare payments to chiroso were questionable
- Half were maintenance
- 2% of chiropractors were responsible for the questionable payments

### Recommendations:

- CMS should figure out a better way to identify maintenance care and questionable payments
- CMS should go after chiropractors with questionable payments
- CMS should collect overpayments
- CMS should only pay for Medicare-covered diagnoses

77

77

## August 2016: A Michigan Chiropractor Received Unallowable Medicare Payments for Chiropractic Services

(33 pages)

### Findings:

- Of 100 sampled services, 92 were not allowable.
- Records did not support medical necessity
- 98942 was billed 93% of the time

### Recommendations:

- Refund \$339,625 to the Federal Government
- Establish policies and procedures to ensure that chiropractic services billed to Medicare are adequately documented

78

78

## October 2016: Hundreds of Millions in Medicare Payments for Chiropractic Services Did Not Comply with Medicare Requirements

(29 pages)

### Findings:

- Of the 105 sampled services, 94 were not allowable because they were medically unnecessary (maintenance)
  - 1-12 services: 26 of 35 medically unnecessary
  - 13-30 services: 33 of 35 medically unnecessary
  - 31+ services: 35 of 35 medically unnecessary

### Recommendations:

- CMS should set a limit and review all services above that number
- CMS should not pay for services above some set limit
- CMS should educate chiropractors about what is covered
- CMS should set more controls like limiting the number of days

79

79

## August 2017: A Brooklyn Chiropractor Received Unallowable Medicare Payments for Chiropractic Services

(26 pages)

### Findings:

- Of 100 sampled services, none were allowable.
- 78% were billed 98941, 22% 98942.

### Recommendations:

- Refund \$672,805 to the Federal Government
- Identify other overpayments outside the audit period (2011 and 2012) and pay them back too.

80

80

February 2018:  
 Medicare Needs Better Controls to Prevent Fraud,  
 Waste, and Abuse Related to Chiropractic Services

(27 pages)

Portfolio Highlights:

- Medicare still makes hundreds of millions in improper payments
- CMS controls are inadequate

Recommendations:

- CMS should set a review threshold for medically unnecessary services

81

81

July 2018:  
 Medicare Improperly Paid Providers for Items and  
 Services offered by Chiropractors

(17 pages)

Portfolio Highlights:

- From 2013 to 2016 Medicare made \$6.7 million in overpayments to chiropractors

Recommendations:

- CMS should recover the \$6.7 million
- CMS should get providers to investigate themselves to pay back more
- CMS should revise claims edits to ensure that all claims are denied

82

82

September 2018:  
Etheridge Chiropractor  
Received Unallowable Medicare Payments for  
Chiropractic Services  
(24 pages)

Findings:

- Of 100 sampled services, 33 were not allowable
- 82% were billed 98941

Recommendations:

- Refund \$169,737 to the Federal Government
- Identify other overpayments outside the audit period and pay them back too
- Establish policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary and adequately documented

83

83

December 2018:  
Queens Chiropractor  
Received Unallowable Medicare Payments for  
Chiropractic Services  
(34 pages)

Findings:

- Of 100 sampled services, 95 did not comply with CMS requirements
- 98% were billed 98940

Recommendations:

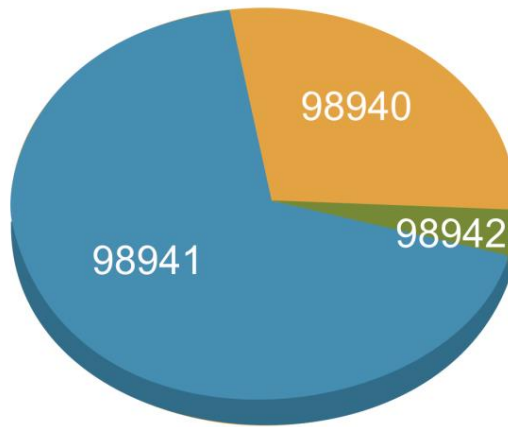
- Refund \$518,821 to the Federal Government
- Identify other overpayments outside the audit period and pay them back too
- Establish policies and procedures to ensure that chiropractic services billed to Medicare comply with CMS requirements

84

84

### Spinal Manipulation Code Distribution and Allowed Amount

Based on Aggregated Infindi Clearinghouse Data Records from 2019 for Providers in Chiropractic Speciality



- 98940 Avg. Allowed \$ 28.55 27.90%
- 98941 Avg. Allowed \$ 39.08 69.33%
- 98942 Avg. Allowed \$ 47.55 2.77%

85

85

## August 2019: Twin Palms Received Unallowable Medicare Payments for Chiropractic Services

(41 pages)

### Findings:

- Of 100 sampled services, 54 were not allowable
  - 42 were medically unnecessary (maintenance)
  - 11 were insufficiently documented
  - 1 was incorrectly coded
- 82% were billed 98941

### Recommendations:

- Refund \$317,038 to the Federal Government
- Establish policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary, adequately documented, and coded correctly

86

86

## Lessons learned

- Don't bill 98942 unless you meet the criteria
- Document the services rendered as CMS has outlined
- Don't bill CMS for services that are defined as maintenance care
  - Clearly outline an episode of care
  - Be prepared for extra scrutiny beyond 12 visits
- Learn the "Chain of Medical Necessity"

87

87

## Other Common Errors

- Illegible records
- Missing dates
- Missing signature
- Missing informed consent
- Missing re-assessment
- Missing patient identifiers
- Missing metrics/objective
- Blanks used to indicate "WNL"
- Missing legend for abbreviations
- Missing care plan
- Cloned records
- Billing only 98940 or only 98941
- Using travel cards

88

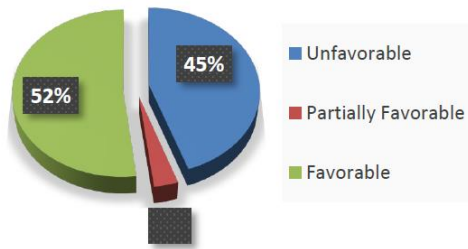
88



**mln**  
BOOKLET  
KNOWLEDGE • RESOURCES • TRAINING

**Medicare Parts A & B Appeals Process**

Part B Redeterminations



**Resource #9a  
and 9b**



**mln**  
FACT SHEET  
KNOWLEDGE • RESOURCES • TRAINING

**Beneficiaries Dually Eligible for Medicare & Medicaid**

**Resource #12**

# Medicare Claims Processing Manual

## Chapter 12 - Physicians/Nonphysician Practitioners

Table of Contents  
*(Rev. 11842, 02-09-23)*

Resource #14

91

## Claim Forms Can

- Prompt an audit
- Determine Medical Necessity
- Identify possible over or under coding
- Identify services that may not have been performed
- Identify suspected Fraud or Abuse

92

# Claims



Adobe Acrobat Professional - [1500 claim form #5.pdf]

File Edit View Document Comments Tools Advanced Window Help

Search Create PDF Comment & Markup Send for Review Security Sign Forms Select 100% YW Help

Page Signatures Bookmarks

Comments Attachments

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0012

**Boxes/Items  
1 thru 8 are  
straightforward**

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare) (Medicaid) (CM/CoCo) (Chronic Care) (GHP) (GHP) (GHP)</small>	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)	
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) YES NO c. OTHER ACCIDENT? YES NO	11. INSURED'S POLICY GROUP OR FECA NUMBER  8. INSURED'S DATE OF BIRTH: MM DD YY M F 9. OTHER CLAIM ID (Designated by NUCC)	
9. RESERVED FOR NUCC USE	4. INSURANCE PLAN NAME OR PROGRAM NAME 10a. CLAIM CODES (Designated by NUCC)	6. INSURANCE PLAN NAME OR PROGRAM NAME  d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>If yes, complete items 8, 9a, and 9b.</small>	
<p><b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b></p> <p>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.</p>			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY		15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
16. OTHER DATE MM DD YY		18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY	

CARRIER

PATIENT AND INSURED INFORMATION

## Box 9, 9a, 9b, 9c, 9d

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

9a. OTHER INSURED'S POLICY OR GROUP NUMBER

9b. RESERVED FOR NUCC USE

9c. RESERVED FOR NUCC USE

9d. INSURANCE PLAN NAME OR PROGRAM NAME

95

## Box 10

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT?

YES     NO

b. AUTO ACCIDENT?

YES     NO    PLACE (State) \_\_

c. OTHER ACCIDENT?

YES     NO

96



## Box 11d

11d. IS THERE ANOTHER HEALTH PLAN?

YES     NO    *If yes, complete items 9, 9a and 9d.*

NUCC: When appropriate, enter an X in the correct box. If marked "YES", complete 9, 9a and 9d. Only one box can be marked.

99

## Box 9, 9a, 9d

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

**Michelle Smith**

9a. OTHER INSURED'S POLICY OR GROUP NUMBER

**01234567890-99**

9d. INSURANCE PLAN NAME OR PROGRAM NAME

**AARP – United Healthcare**

100

## Box 10

<b>10. IS PATIENT'S CONDITION RELATED TO:</b>	
<b>a. EMPLOYMENT?</b>	
<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
<b>b. AUTO ACCIDENT?</b>	
<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO PLACE (State) <u>SI</u>
<b>c. OTHER ACCIDENT?</b>	
<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO

101

## Box 11d

<b>11d. IS THERE ANOTHER HEALTH PLAN?</b>	
<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO <i>If yes, complete items 9, 9a and 9d.</i>

NUCC: When appropriate, enter an X in the correct box. If marked "YES", complete 9, 9a and 9d. Only one box can be marked.

102

# Box 9, 9a, 9d

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

**Michael Jones**

9a. OTHER INSURED'S POLICY OR GROUP NUMBER

**99-01234567890**

9d. INSURANCE PLAN NAME OR PROGRAM NAME

**State Farm**

103

**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0012

**CARRIER**

**PATIENT AND INSURED INFORMATION**

1. MEDICARE  MEDICAID  TRICARE  CHAMPVA  GROUP HEALTH PLAN (GHP)  FECA (FMLA/COG)  OTHER  1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M  F ) 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED (Self  Spouse  Child  Other ) 7. INSURED'S ADDRESS (No., Street)

CITY STATE CITY STATE

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

8. 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

8. EMPLOYMENT (Current or Previous)  YES  NO 8. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M  F )

9. RESERVED FOR NUCC USE 9. AUTO ACCIDENT? PLACE (State)  YES  NO 9. OTHER CLAIM ID (Designated by NUCC)

9. RESERVED FOR NUCC USE 9. OTHER ACCIDENT?  YES  NO 9. INSURANCE PLAN NAME OR PROGRAM NAME

9. RESERVED FOR NUCC USE 10b. CLAIM CODES (Designated by NUCC) 9. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES  NO # yes, complete items 8, 9a, and 9b.

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. 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 DATE SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY) 14. OTHER DATE (MM DD YY) 14. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY)

104

## Box 12

**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.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

- “Signature on file” – do you have it?

105

## Box 13

**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” – do you have it?

106

The screenshot shows a medical claim form with the following sections:

- SIGNED** and **DATE** fields for the provider.
- 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)**: MM DD YY, QUAL.
- 16. OTHER DATE**: MM DD YY, QUAL.
- 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE**: IFA, IFL, NPI.
- 18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)**.
- 19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**: Fields A-L, ICD ICD.
- 20. OUTSIDE LAB?** YES/NO, \$ CHARGES.
- 21. RESUBMISSION CODE** and **22. PRIOR AUTHORIZATION NUMBER**.
- 24. A. DATES OF SERVICE**: From MM DD YY To MM DD YY.
- B. PLACE OF SERVICE**: EMR, EMG, GP, NCP, PCS, MODIFIER.
- C. PROCEDURES, SERVICES, OR SUPPLIES**: (Specify Unusual Circumstances).
- D. DIAGNOSIS POINTER**.
- E. \$ CHARGES**.
- F. DENIAL DATE**.
- G. REPT FROM**.
- H. NPI**.
- I. QUAL**.
- J. RENDERING PROVIDER ID #**.

107

## Box 14

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

- Enter the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date of the first date of the present illness, injury, or pregnancy.
- For pregnancy, use the date of the last menstrual period (LMP) as the first date.
- Enter the applicable qualifier to identify which date is being reported.
  - 431 Onset of Current Symptoms or Illness
  - 484 Last Menstrual Period

14. DATE OF CURRENT ILLNESS, INJURY or PREGNANCY (LMP)			
10	15	20XX	QUAL. : 431

108

109

## Box 15

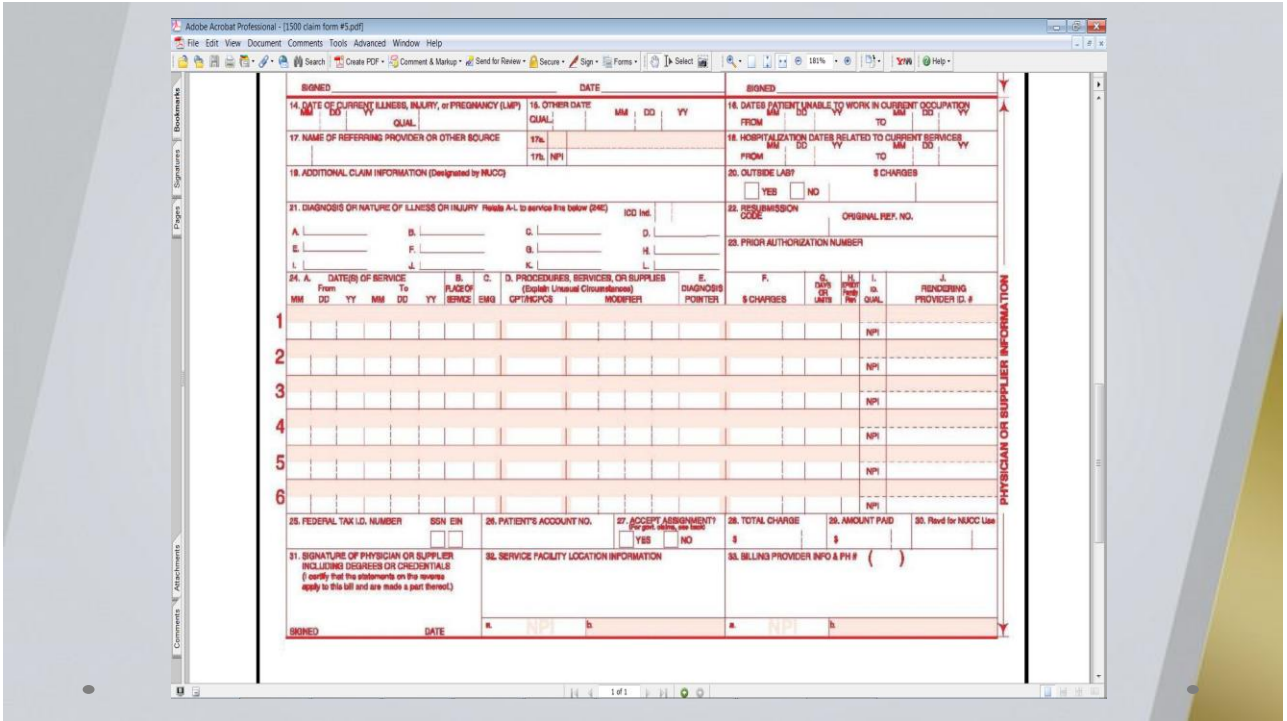
15. OTHER DATE			
QUAL.	MM	DD	YY

- Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format.
- Enter the applicable qualifier to identify which date is being reported.

454 Initial Treatment  
 304 Latest Visit or Consultation  
 453 Acute Manifestation of a Chronic Condition  
 439 Accident  
 455 Last X-ray  
 471 Prescription  
 090 Report Start (Assumed Care Date)  
 091 Report End (Relinquished Care Date)  
 444 First Visit or Consultation

15. OTHER DATE			
QUAL.	454	11	15 20XX

110



111

## Boxes 17 & 17b

### 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim.

Enter the applicable qualifier to identify which provider is being reported.

- DN Referring Provider
- DK Ordering Provider
- DQ Supervising Provider

### 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

**DN** : Michael Smith MD                      **17b. NPI** 12-3456789

112

Adobe Acrobat Professional - [1500 claim form #5.pdf]

File Edit View Document Comments Tools Advanced Window Help

Search Create PDF Comment & Markup Send for Review Secure Sign Forms Select 100% YWV Help

**SIGNED** **DATE** **SIGNED**

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 16. OTHER DATE 18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  
 MM DD YY QVAL MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 19a. IFA: 19b. NPI: 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES  
 FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES  
 YES  NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Fields A-L to service the below (PAC) ICD ICD ICD ICD  
 A: B: C: D: E: F: G: H: I: J: K: L:

24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURES, SERVICES, OR SUPPLIES D. DIAGNOSIS POINTER E. CHARGES F. DENIAL REASONS G. PAYMENT PERIOD H. QUALIFYING PROVIDER ID.#  
 MM DD YY MM DD YY SERVICE EMG GP/PHYSICIAN MODIFIER

1 2 3 4 5 6

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gen. bills, use "NO") 28. TOTAL CHARGE 29. AMOUNT PAID 30. Paid for NUCC Use  
   YES NO \$ \$ \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on this invoice apply to this bill and are made a part thereof) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ( )

SIGNED DATE a. NPI b. NPI

113

# Box 19

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

- May need to enter the date x-rays were taken or the date of the P.A.R.T. evaluation.

114

Adobe Acrobat Professional - [1500 claim form #5.pdf]  
 File Edit View Document Comments Tools Advanced Window Help  
 Search Create PDF Comment & Markup Send for Review Secure Sign Forms Select 100% YWY Help

**SIGNED** **DATE** **SIGNED**

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 16. OTHER DATE 18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  
 MM DD YY Q1AL MM DD YY FROM TO  
 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 19a. ICD INC. 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES  
 TRS NPI MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES  
 YES  NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Inc. 22. RESUBMISSION CODE ORIGINAL REF. NO.  
 A. \_\_\_\_\_ B. \_\_\_\_\_ C. \_\_\_\_\_ D. \_\_\_\_\_  
 E. \_\_\_\_\_ F. \_\_\_\_\_ G. \_\_\_\_\_ H. \_\_\_\_\_  
 I. \_\_\_\_\_ J. \_\_\_\_\_ K. \_\_\_\_\_ L. \_\_\_\_\_

24. A. DATES OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURES, SERVICES, OR SUPPLIES D. DIAGNOSIS POINTER E. CHARGES F. DENIAL REASONS G. PAYMENT PERIOD H. QUALIFIER I. RENDERING PROVIDER ID. #  
 MM DD YY MM DD YY SERVICE EMG GP/PC/PCS MODIFIER

1  
2  
3  
4  
5  
6

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX ID. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. bills, use 0) 28. TOTAL CHARGE 29. AMOUNT PAID 30. Paid for NUCC Use  
   YES NO \$ \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on this invoice apply to this bill and are made a part thereof) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ( )

SIGNED DATE a. NPI b. a. NPI b.

115

# Box 21

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

A. \_\_\_\_\_ B. \_\_\_\_\_ C. \_\_\_\_\_ D. \_\_\_\_\_  
 E. \_\_\_\_\_ F. \_\_\_\_\_ G. \_\_\_\_\_ H. \_\_\_\_\_  
 I. \_\_\_\_\_ J. \_\_\_\_\_ K. \_\_\_\_\_ L. \_\_\_\_\_

- Enter the codes to identify the patient's diagnosis and/or condition.
- List no more than 12 ICD-10 diagnosis codes.
- Relate lines A - L to the lines of service in 24E by the letter of the line.
- Report ICD-10 codes to the highest level of specificity.
- Do not provide the narrative description of the codes in this field.
- For ICD Ind. use 0 for ICD-10.

116

117

## Box 24B

<p><b>24B. PLACE OF SERVICE</b></p> <p><b>11</b> (office)</p>	<p><b>24B. PLACE OF SERVICE</b></p> <p><b>12</b> (home)</p>
<p><b>24B. PLACE OF SERVICE</b></p> <p><b>18</b> (worksite)</p>	<p><b>24B. PLACE OF SERVICE</b></p> <p><b>32</b> (nursing facility)</p>

118

119

## Box 24D – CPT/HCPCS & Modifiers

24D. PROCEDURES, SERVICES  
 CPT/HCPCS MODIFIERS  
**99213 25**

24D. PROCEDURES, SERVICES  
 CPT/HCPCS MODIFIERS  
**97140 59**

24D. PROCEDURES, SERVICES  
 CPT/HCPCS MODIFIERS  
**98940 AT**

Medicare

120

# Box 24E

24E. DIAGNOSIS POINTER  
**A B C D**

24E. DIAGNOSIS POINTER  
**A - D**

# Box 21

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

A. | B. | C. | D. |

E. | F. | G. | H. |

I. | J. | K. | L. |

121

# Diagnosis pointing

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.	
										0	
A. M9906		B. M9903		C. M9902		D. M9901					
E. M722		F. M25551		G. M5030		H. M5136					
I.		J.		K.		L.					
24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER		
06	19	24	06	19	24	11		97150			ABCD
06	19	24	06	19	24	11		98941			ABCD
06	19	24	06	19	24	11		98943			ABCD

122

Adobe Acrobat Professional - (1500 claim form #5.pdf)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) QUAL. DATE  
 15. OTHER DATE QUAL. MM DD YY  
 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO MM DD YY  
 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. TRN NPI  
 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO MM DD YY  
 19. ADDITIONAL CLAIM INFORMATION (Designated by MUCC)  
 20. OUTSIDE LAB? \$ CHARGES YES NO  
 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Specify A-L to service this below (HIC) ICD Ind.  
 22. RESUBMISSION CODE ORIGINAL REF. NO.  
 23. PRIOR AUTHORIZATION NUMBER **24J**  
 24. A. DATES OF SERVICE B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES E. DIAGNOSIS F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. JV. JW. JX. JY. JZ. KA. KB. KC. KD. KE. KF. KG. KH. KI. KJ. KL. KM. KN. KO. KP. KQ. KR. KS. KT. KU. KV. KW. KX. KY. KZ. LA. LB. LC. LD. LE. LF. LG. LH. LI. LJ. LK. LL. LM. LN. LO. LP. LQ. LR. LS. LT. LU. LV. LW. LX. LY. LZ. MA. MB. MC. MD. ME. MF. MG. MH. MI. MJ. MK. ML. MM. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NN. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UU. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.

25. FEDERAL TAX ID. NUMBER SSN EIN  
 26. PATIENTS ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For prior authorization) YES NO  
 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Paid for MUCC Use  
 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING BUSINESS OR CREDENTIALS (I certify that the statements on this invoice apply to this bill and are made a part thereof.)  
 32. SERVICE FACILITY LOCATION INFORMATION  
 33. BILLING PROVIDER INFO & PH # ( )

123

## Box 24F

**24F. \$ CHARGES**

\$XXX.00

## Box 24G

**24G. DAYS OR UNITS**

1 = 97012  
2 = 97140 (23 min)

## Box 24J

**24J. RENDERING PROVIDER ID #**

1234567890

## Box 25

**25. FEDERAL TAX ID # SSN EIN**

98-01234567 X

## Box 26

**26. PATIENTS ACCOUNT NO.**

12345-00

124

# Box 27

## 27. ACCEPT ASSIGNMENT?

YES     NO

- In-network and par providers must accept assignment.
- Out-of-network and non-par providers do not have to accept assignment.
- True cash practices should not accept assignment.

125

The image shows a screenshot of a medical claim form titled "1500 claim form #5.pdf" in Adobe Acrobat Professional. The form is divided into several sections:

- SIGNED** and **DATE** fields at the top.
- 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)** and **16. OTHER DATE** with MM/DD/YY format.
- 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE** with fields for provider type (TYL, NPI).
- 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES** with FROM/TO MM/DD/YY.
- 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)**.
- 20. OUTSIDE LAB?** with YES/NO checkboxes and **\$ CHARGES**.
- 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY** with fields A-L and **ICD Inc.**.
- 22. RE submission CODE** and **23. PRIOR AUTHORIZATION NUMBER**.
- 24. A. DATES OF SERVICE** (From/To MM/DD/YY), **B. PLACE OF SERVICE** (SNG, EMG, OP, IN, PCS), **C. MODIFIER**, **D. PROCEDURES, SERVICES, OR SUPPLIES** (Specify Unusual Circumstances), **E. DIAGNOSIS POINTER**, **F. \$ CHARGES**, **G. DEDUCTIBLE**, **H. COINSURANCE**, **I. CO-PAY**, **J. RECEIVING PROVIDER ID.#**.
- 25. FEDERAL TAX I.D. NUMBER**, **SSN**, **EIN**, **26. PATIENT'S ACCOUNT NO.**, **27. ACCEPT ASSIGNMENT?** (YES/NO), **28. TOTAL CHARGE**, **29. AMOUNT PAID**, **30. Paid for NUCC Use**.
- 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS** (Certify that the statements on this reverse apply to this bill and are made a part thereof).
- 32. SERVICE FACILITY LOCATION INFORMATION**.
- 33. BILLING PROVIDER INFO & PH #**.
- SIGNED** and **DATE** fields at the bottom.

Box 27 is highlighted with a red border. The form also includes a vertical label on the right side: "PHYSICIAN OR SUPPLIER INFORMATION".

126

## Box 28

28. TOTAL CHARGE

\$XXX.00

## Box 29

29. AMOUNT PAID

\$XXX.00

## Box 31

31. SIGNATURE INCLUDING CREDENTIALS

*Dr. Name* 10/15/20XX

## Box 32

32. SERVICE FACILITY LOCATION

Address

127

## Box 33a

33a. BILLING PROVIDER INFO & PH #

12-3456789 (ind.)

33a. BILLING PROVIDER INFO & PH #

98-7654321 (group)

128

# Claims

- Claims must be submitted for covered or *potentially* covered services
  - Providers may not charge for this paperwork
- Bill direct only for non-covered/ statutorily-excluded services
- If beneficiary requests, providers must bill Medicare for non-covered services
  - Typically a requirement for Medicare Secondary Payers

• 129

129

# ABNs

• 130

130

**Form Instructions**  
**Advance Beneficiary Notice of Non-coverage (ABN)**  
**OMB Approval Number: 0938-0566**

**Resource #10**

131

# ABN

## Advance Beneficiary Notice (Form CMS-R-131)

- Issued by providers to original Medicare fee for service (i.e. Part B).
- Used in situations when Medicare payment is expected to be denied.
- Transfers potential financial liability to the Medicare Beneficiary.



132

132

## ABN

- The ABN will not allow you to see Medicare beneficiaries without being enrolled in Medicare.
- The ABN cannot be used to “opt-out” of Medicare.
- The ABN can’t be given to everyone just in case.
- The ABN can’t be signed without it being filled out ahead of time.
- The expiration date at the bottom of the form is currently 1/31/2026. The current version is mandatory.



133

133

## ABN Rules

Pub.100-04, Claims Processing Manual, Chapter 30, Section 30

- ABN is proof that the beneficiary knows a service was going to be denied, and passes liability for disallowed claims to them.
- When a furnished service does not meet locally acceptable standards of practice, the healthcare provider is considered to have known that Medicare payment would be denied and should then provide the ABN.

134

134

# ABN Rules

## Pub.100-04, Claims Processing Manual, Chapter 30, Section 40

- The written notice allows the beneficiary to:
  - make an informed decision whether or not to receive the service, and
  - better participate in his/her own health care treatment decisions.
- ABN should be furnished to the beneficiary by a healthcare provider before the service is furnished, far enough in advance for him/her to make an informed choice.
- Simply stating “medically unnecessary” or the equivalent is not an acceptable reason, as it does not explain why the healthcare provider believes the service will be denied as not reasonable and necessary.

135

135

# ABN Rules

## Pub.100-04, Claims Processing Manual, Chapter 30, Section 40

- A written notice will **not** be considered as acceptable evidence of knowledge if the written notice is:
  - Unreadable, illegible, or otherwise incomprehensible, or the individual beneficiary is incapable of understanding the written notice due to the particular circumstances (even if others may understand);
  - Given during any emergency, or the beneficiary is under great duress, or the beneficiary is, in any way, coerced or misled by the notifier, by the contents of the written notice, and/or by the manner of delivery of the written notice;
  - Routinely given to all beneficiaries for whom the notifier furnishes services;
  - No more than a statement to the effect that there is a possibility that Medicare may not pay for the services; or
  - Delivered to the beneficiary more than one year before the services are furnished. (\*changed 1/1/2022)

136

136

# ABN Rules

Pub.100-04, Claims Processing Manual, Chapter 30, Section 40

- A written notice:
  - Should be delivered in person to the beneficiary whenever possible. Delivery is the notifier's responsibility;
  - Must be prepared with an original and at least two copies. The notifier should retain the original and give the copy to the beneficiary. Can be stored electronically.
  - Copy should be given to the beneficiary immediately after the beneficiary signs it.

• 137

137

# ABN Rules

Pub.100-04, Claims Processing Manual, Chapter 30, Section 50

- The ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. It is not used for items or services provided under the Medicare Advantage (MA) Program (Part C).
- The voluntary ABN serves as a courtesy to the beneficiary in forewarning him/her of impending financial obligation.
  - When an ABN is used as a voluntary notice, the beneficiary should not be asked to choose an option box or sign the notice.
  - Consider creating your own "Notice of Patient Liability" form with friendlier language.

• 138

138

## Mandatory ABN

- For covered services
  - Chiropractic manipulative treatment (98940, 98941, 98942)

## Voluntary ABN

- For statutorily excluded services
  - Evaluation & management
  - Radiography
  - Modalities
  - Therapies
  - DME

139

# ABN Rules

Pub.100-04, Claims Processing Manual, Chapter 30, Section 50

- ABNs should be retained for five years from completion of delivery of care.
- The ABN can remain effective as long as it is applicable and the form is the current one (used to be limited to one year.)
- The ABN cannot be retroactively dated.
- Providers are permitted to charge and collect the usual and customary fees; therefore, funds collected are not limited to the Medicare allowed amounts.

140

140

# Completing the form

- There are 10 blanks for completion in this notice, labeled from (A) through (J).
- Blanks (A)-(F) and blank (H) may be completed prior to delivering the notice, as appropriate.
- Entries may be handwritten or typed, but try to use 12-point font.

141

141

<b>A. Notifier:</b>		
<b>B. Patient Name:</b>		<b>C. Identification Number:</b>
<b>Advance Beneficiary Notice of Non-coverage (ABN)</b>		
<b>NOTE:</b> If Medicare doesn't pay for <b>D.</b> _____ 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 <b>D.</b> _____ below.		
<b>D.</b>	<b>E. Reason Medicare May Not Pay:</b>	<b>F. Estimated Cost</b>

- Notifiers must place their name, address, and telephone number at the top of the notice.
- This information may be incorporated into a notifier's logo at the top of the notice by typing, hand-writing, pre-printing, using a label or other means.

142

142

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

- Notifiers must enter the first and last name of the beneficiary receiving the notice, and a middle initial should also be used if there is one on the beneficiary's Medicare card.

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

- Use of this field is optional.
- Medicare numbers (HICNs), Medicare beneficiary identifiers (MBIs), or Social Security numbers should not appear on the notice.

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

- Notifier must list the specific name of the services believed to be non-covered.
- For repetitive or continuous non-covered care, notifiers must specify the frequency and/or duration of the service.
- All 7 blank (D) fields must be completed on the ABN in order for the notice to be considered valid.

145

145

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

- Notifiers must explain, in beneficiary friendly language, why they believe the items or services listed in the column under Blank (D) may not be covered by Medicare.
- For example: "Medicare does not pay for chiropractic manipulation that is considered maintenance care."

146

146

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

- Notifiers must complete the column under Blank (F) to ensure the beneficiary has all available information to make an informed decision about whether or not to obtain potentially non-covered services.
- Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed under Blank (D) within \$100 or 25% .

147

147

**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.

- This option allows the beneficiary to receive the items and/or services at issue and requires the notifier to submit a claim to Medicare. This will result in a payment decision that can be appealed.
- Option 1 must be modified for people who are dually enrolled in both Medicare and Medicaid to make sure the claim is adjudicated correctly.

148

148

**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.

- This option allows the beneficiary to receive the non-covered items and/or services and pay for them out of pocket.
- No claim will be filed, and Medicare will not be billed.
- Thus, there are no appeal rights associated with this option

149

149

**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.

- This option means the beneficiary does not want the care in question.
- By checking this box, the beneficiary understands that no additional care will be provided; thus, there are no appeal rights associated with this option.

150

150

**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.

- The beneficiary must choose only one of the three options.
- The notifier must not decide for the beneficiary which of the 3 checkboxes to select.

151

151

**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](https://www.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.

Form CMS-R-131 (Exp.01/31/2026)

Form Approved OMB No. 0938-0566

- Notifiers may use this space to provide additional clarification that they believe will be of use to beneficiaries.
- If non-par and not accepting assignment, strike the last sentence of option 1, then add:

“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.”

152

152

**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.

<b>I. Signature:</b>	<b>J. Date:</b>
----------------------	-----------------

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

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.

Form CMS-R-131 (Exp.01/31/2026)

Form Approved OMB No. 0938-0566

- The beneficiary (or representative) must sign the notice to indicate that he or she has received the notice and understands its contents.
- The beneficiary (or representative) must write the date he or she signed the ABN.
- This box cannot be completed in advance of the rest of the notice.

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.

<b>I. Signature:</b>	<b>J. Date:</b>
----------------------	-----------------

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

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.

Form CMS-R-131 (Exp.01/31/2026)

Form Approved OMB No. 0938-0566

## Modifiers

- **AT: Active Treatment**
  - Care is medically necessary
  - Only attached to 98940, 98941, 98942
- **GA: Advanced Beneficiary Notice (ABN) on file**
  - A covered service is expected to be denied
  - Only attached to 98940, 98941, 98942
- **GZ: Advanced Beneficiary Notice (ABN) not on file**
  - ABN should have been signed, but wasn't.
  - Only attached to 98940, 98941, 98942

• 155

155

## Modifiers

- **GX: Voluntary ABN signed**
  - ABN voluntarily used to notify beneficiary of a non-covered service
  - Anything other than 98940, 98941, 98942
  - If you disclose these services on your own form, you won't have to use this modifier
- **GY: Non-covered service**
  - Lets Medicare know that the services are statutorily excluded
  - Ensures a quick denial
  - Anything other than 98940, 98941, 98942
  - Not for maintenance care

• 156

156

# Take Away

- Participation
- Indications
- Limitations
- Documentation
- Claims
- ABNs

157

# Medicare (and More!) for Chiropractic, Made Easy

Presented by Evan M. Gwilliam, DC MBA  
CPC CCPC QMCC CPMA CPCO AAPC Fellow

**ChiroHealthUSA<sup>®</sup>**  
The Network That Works for Chiropractic!

[Evan.Gwilliam@Practisync.com](mailto:Evan.Gwilliam@Practisync.com)

158