Chiropractic Insurance Billing

SCUHS Extravaganza

Presented by:
Samuel A. Collins
Director, Insurance Information Network
HJ Ross Company & National Chiropractic Council
800 562-3335

E mail
sam@hjrossnetwork.com
Twitter
www.twitter.com/samuelcollins
Web Site
www.hjrosscompany.com

National
Chiropractic Council
What target's a claim for review?

➢ High level E&M codes

➢ Routine billing of 4 or more services per visit

➢ No changes in treatment protocol

➢ Extended care for non complicated conditions

➢ Old onset date on claim form

➢ Unusual diagnostic testing

➢ Repeat diagnostic testing

➢ Long term disability

➢ Preventative or supportive care
**Diagnosis Coding Rules:**

► Code to highest level of specificity. Some codes are 3 digits while most are 4 or 5 digits. If you use a code with too few or too many digits the carrier will reject the entire claim.

Pay or not pay? Circle the correct code

847.0 or 847.00 Cervical strain sprain

726.1 or 726.10 Rotator cuff syndrome

346.0 or 346.00 Migraine headache

722.1 or 722.10 Lumbar disc displacement

734 or 734.0 Flat foot

► The primary diagnosis is the one that carries the highest degree of risk and is chiefly responsible for the services provided. (The most severe)

► Subluxation is a reasonable diagnosis for care if functional deficits are documented.

► Never use rule out, possible, probable, or suspected conditions as a diagnosis. If there is no definitive diagnosis simply code signs/symptoms.

► Diagnosis does not necessarily have to be dependent on lab or diagnostic findings; a diagnosis can be based on clinical judgment.

► Complicating conditions and co-morbidities should be included

► E Claims accept 8 diagnoses in block 21. Paper claims may have additional diagnoses in block 19 of the 1500 form
### COMMON DIAGNOSIS CODES

These common neuro-musculoskeletal conditions are taken from the INTERNATIONAL CLASSIFICATION OF DISEASES, 9th REVISION (ICD-9). These codes are provided to you as convenient reference and are not intended to limit your diagnosis in any manner. For a listing of all diagnosis codes you can go to www.ICD9CODING1.com

<table>
<thead>
<tr>
<th>CERVICAL SPINE</th>
<th>SACROILIAC</th>
<th>MISCELLANEOUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>353.0 Cervical Rib Syndrome</td>
<td>720.2 Sacroiliitis</td>
<td>346.0 Migraine</td>
</tr>
<tr>
<td>353.2 Cervical Nerve Root Lesion</td>
<td>724.6 Disorders of Sacroiliac Joint</td>
<td>307.81 Tension Headache</td>
</tr>
<tr>
<td>720.1 Spinal Enthesopathy</td>
<td>736.81 Unequal Leg Length (acquired)</td>
<td>784.0 Headache</td>
</tr>
<tr>
<td>721.0 Cervical Spondylosis</td>
<td>846.1 Sacroiliac Sprain or Strain</td>
<td>524.60 TMJ Dysfunction</td>
</tr>
<tr>
<td>721.1 Spondylosis with Myleopathy</td>
<td>COCCYX</td>
<td>524.61 TMJ Adhesions/ankylosis</td>
</tr>
<tr>
<td>722.4 Degeneration of Cervical IVD</td>
<td>724.70 Unspecified Disorder of the Coccyx</td>
<td>524.62 TMJ Arthralgia</td>
</tr>
<tr>
<td>722.7 Disc with myelopathy</td>
<td>724.71 Hypermobility of Coccyx</td>
<td>710.4 Polymyositis</td>
</tr>
<tr>
<td>722.81 Post laminectomy Syndrome</td>
<td>724.79 Coccygodynia</td>
<td>718.5 Ankylosis: (.1) shoulder, (.2) elbow, (.3) wrist, (.4) fingers, (.5) hip, (.6) knee, (.7) ankle, foot</td>
</tr>
<tr>
<td>722.91 Calcification of Cervical Disc</td>
<td>847.4 Coccyx Sprain or Strain</td>
<td>719.7 Difficulty walking</td>
</tr>
<tr>
<td>723.0 Cervical Spinal Stenosis</td>
<td>SHOULDER</td>
<td>720.0 Rheumatoid Arthritis</td>
</tr>
<tr>
<td>723.1 Cervicalgia</td>
<td>719.21 Synovitis, villonodular</td>
<td>721.90 Spondylitis Osteoarthritica</td>
</tr>
<tr>
<td>723.2 Cervicocranial Syndrome</td>
<td>726.10 Bursitis, Tenosynovitis</td>
<td>721.7 Traumatic Spondylitis</td>
</tr>
<tr>
<td>723.3 Cervicalbrachial Syndrome</td>
<td>726.2 Periarthritis</td>
<td>724.9 Synovitis, Spine</td>
</tr>
<tr>
<td>723.4 Brachial Neuritis</td>
<td>840.0 - 840.9 Sprain or Strain</td>
<td>733.00 Osteoporosis</td>
</tr>
<tr>
<td>723.4 Cervical Radiculitis</td>
<td>ELBOW AND FOREARM</td>
<td>728.85 Muscle Spasm</td>
</tr>
<tr>
<td>723.5 Torticollis</td>
<td>719.22 Synovitis, villonodular</td>
<td>729.0 Rheumatism Fibrositis unspec.</td>
</tr>
<tr>
<td>729.1 Myofascitis</td>
<td>726.31 Medial Epicondylitis</td>
<td>729.2 Neuralgia, Neuritis, Radiculitis</td>
</tr>
<tr>
<td>737.10 Aquired Kyphosis, loss of curve</td>
<td>726.32 Lateral Epicondylitis</td>
<td>729.4 Fascitis</td>
</tr>
<tr>
<td>756.10 Cervical Vertebral Anomaly</td>
<td>727.00 Tenosynovitis (NOS)</td>
<td>756.12 Spondylolisthesis</td>
</tr>
<tr>
<td>756.2 Cervical Rib</td>
<td>841.0 - 841.9 Sprain or strain</td>
<td>782.0 Parathesia</td>
</tr>
<tr>
<td>847.0 Cervical Sprain or Strain</td>
<td>WRIST</td>
<td>SUBLUXATION CODES</td>
</tr>
<tr>
<td>953.0 Cervical Nerve Root Injury</td>
<td>354.0 Carpal Tunnel Syndrome</td>
<td>739 Nonaliopathic Lesions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>739.0 Head region</td>
</tr>
<tr>
<td></td>
<td></td>
<td>739.1 Cervical region</td>
</tr>
<tr>
<td></td>
<td></td>
<td>739.2 Thoracic region</td>
</tr>
<tr>
<td></td>
<td></td>
<td>739.3 Lumbar region</td>
</tr>
<tr>
<td></td>
<td></td>
<td>739.4 Sacral region</td>
</tr>
<tr>
<td></td>
<td></td>
<td>739.5 Pelvic region</td>
</tr>
<tr>
<td></td>
<td></td>
<td>739.8 Rib (Costo-Thoracic)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839 Ill-Defined DIslocations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.00 Cervical vertebra, unspecified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.01 First cervical vertebra</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.02 Second cervical vertebra</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.03 Third cervical vertebra</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.04 Fourth cervical vertebra</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.05 Fifth cervical vertebra</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.06 Sixth cervical vertebra</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.07 Seventh cervical vertebra</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.08 Multiple cervical vertebra</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.2 Thoracic and Lumbar Vertebra, closed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.20 Lumbar vertebra (specify level)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.21 Thoracic vertebra (specify level)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dorsal (thoracic) vertebra</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.4 Other Vertebra, closed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.40 Vertebra, unspecified site, Spine NOS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.41 Coccyx</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.42 Sacrum, Sacroiliac (joint)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.6 Other Location, closed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.61 Sternum, Sternoclavicular joint</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.69 Pelvis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>THORACIC SPINE</th>
<th>HIP AND THIGH</th>
<th>KNEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>353.0 Thoracic Outlet Syndrome</td>
<td>719.25 Synovitis, villonodular</td>
<td>717.6 Loose Bodies (joint mice)</td>
</tr>
<tr>
<td>353.3 Thoracic Nerve Root Lesion</td>
<td>726.5 Bursitis</td>
<td>717.7 Chrondromalacia Patella</td>
</tr>
<tr>
<td>720.1 Spinal Enthesopathy</td>
<td>727.00 Tenosynovitis</td>
<td>719.26 Synovitis, villonodular</td>
</tr>
<tr>
<td>721.2 Spondylosis</td>
<td>843.0 Sprain or Strain</td>
<td></td>
</tr>
<tr>
<td>722.11 Intervertebral Disc</td>
<td>726.60 Bursitis</td>
<td></td>
</tr>
<tr>
<td>722.31 Schmor's nodes</td>
<td>727.00 Tenosynovitis</td>
<td></td>
</tr>
<tr>
<td>722.72 Disc with Myleopathy</td>
<td>836.0 Tars, Medial Meniscus</td>
<td></td>
</tr>
<tr>
<td>722.82 Post laminectomy Syndrome</td>
<td>836.1 Tars, Lateral Meniscus</td>
<td></td>
</tr>
<tr>
<td>724.1 Pain in Thoracic spine</td>
<td>844.0 - 844.9 Sprain or Strain</td>
<td></td>
</tr>
<tr>
<td>724.4 Neuritis or Radiculitis</td>
<td>LUMBAR/LUMBOSACRAL SPINE</td>
<td>ANKLE</td>
</tr>
<tr>
<td>725.1 Myofascitis</td>
<td>353.4 Lumbosacral nerve root lesion</td>
<td>719.27 Synovitis, villonodular</td>
</tr>
<tr>
<td>737.10 Kyphosis</td>
<td>726.79 Bursitis</td>
<td>727.06 Tenosynovitis</td>
</tr>
<tr>
<td>737.20 Lordosis</td>
<td>845.00 - 845.09 Sprain or Strain</td>
<td>845.00 - 845.19 Sprain or Strain</td>
</tr>
<tr>
<td>847.0 Lumbosacral Sprain or Strain</td>
<td>847.2 Lumbar Sprain or Strain</td>
<td>725.2 Degeneration of Lumbar Disc</td>
</tr>
<tr>
<td>847.3 Disc with myelopathy</td>
<td>Foot</td>
<td>727.06 Tenosynovitis</td>
</tr>
<tr>
<td>722.93 Calcification of Lumbar Disc</td>
<td>845.0 - 845.19 Sprain or Strain</td>
<td></td>
</tr>
<tr>
<td>724.2 Lumbalgia</td>
<td>ANKLE</td>
<td>727.06 Tenosynovitis</td>
</tr>
<tr>
<td>724.3 Sciatica</td>
<td>719.27 Synovitis, villonodular</td>
<td></td>
</tr>
<tr>
<td>724.4 Neuritis or Radiculitis</td>
<td>726.79 Bursitis</td>
<td></td>
</tr>
<tr>
<td>724.5 Backache, unspecified.</td>
<td>727.06 Tenosynovitis</td>
<td></td>
</tr>
<tr>
<td>Vertebrogenic Syndrome</td>
<td>FOOT</td>
<td>845.00 - 845.19 Sprain or Strain</td>
</tr>
<tr>
<td>725.1 Myofascitis</td>
<td>719.27 Synovitis, villonodular</td>
<td></td>
</tr>
<tr>
<td>737.10 Kyphosis</td>
<td>726.79 Bursitis</td>
<td></td>
</tr>
<tr>
<td>737.20 Lordosis</td>
<td>845.10 - 845.19 Sprain or Strain</td>
<td></td>
</tr>
</tbody>
</table>

### Courtesy of H. J. Ross Company
Samuel A. Collins, Director of Seminars and Network 800 562-3335
## DIAGNOSIS: CERVICAL REGION

<table>
<thead>
<tr>
<th>COMPLAINTS</th>
<th>OBJECTIVE EXAMINATION</th>
<th>DIFFERENTIAL DIAGNOSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>NECK PAIN</td>
<td>Cervical paraspinal muscles tender, reduced range-of-motion, grsity and segmentally. Orthopedic and neurologic exams normal. Local paraspinal muscle spasm.</td>
<td>720.1 Spinal Enthesopathy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>726.1 Myalgia, Myositis, Fibromyalgia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>723.0 Cervicalgia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>720.9 Rheumatism, unspecified and fibromyalgia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>728.95 Muscle spasm (secondary to above)</td>
</tr>
<tr>
<td>ACUTE NECK PAIN WITH RADIATION</td>
<td>Pain on motion, radiating pain on motion, Brode’s Pain, foraminal compression test, Cervical distraction test, Soto’s Hal test, Shoulder drop/depression test, Brachial stretch test, Depener’s test, Spurling’s test, Soto’s Hal test, hemicrania’s sign positive, DTR and sensory testing.</td>
<td>728.2 Neuralgia, Neuritis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>733.4 Cervical Radiculitis, Non Disc Related, Brachial Radiculitis/Neuritis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>335.0 Brachial Plexus Lesions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>335.2 Cervical Root Lesions not elsewhere classified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>723.3 Cervicalbrachial Syndrome</td>
</tr>
<tr>
<td></td>
<td></td>
<td>722.0 Cervical disc displacement without myelopathy</td>
</tr>
<tr>
<td>PERSISTENT NECK PAIN ON MOTION</td>
<td>Pain, swelling, redness, limited range-of-motion, difficult motion, foraminal compression test, Soto’s Hal test, cervical distraction, Spurling’s test, muscle strength testing, Shoulder drop/depression test, Brachial stretch test, Depener’s test, Spurling’s test, Soto’s Hal test, hemicrania’s sign positive, DTR and sensory testing.</td>
<td>729.2 Neuralgia, Neuritis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>723.4 Cervical Radiculitis, Non Disc Related, Brachial Radiculitis/Neuritis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>335.0 Brachial Plexus Lesions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>335.2 Cervical Root Lesions not elsewhere classified</td>
</tr>
<tr>
<td>HEADACHE</td>
<td>Positive nerve trajectory findings, foraminal compression test, Soto’s Hal test, cervical distraction, Spurling’s test, muscle strength testing, Shoulder drop/depression test, Brachial stretch test, Depener’s test, Spurling’s test, Soto’s Hal test, hemicrania’s sign positive, DTR and sensory testing.</td>
<td>784.0 Headache, Occipital Neuritis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>348.00 Headache, Migraine With Aura</td>
</tr>
<tr>
<td></td>
<td></td>
<td>348.10 Headache, Migraine Without Aura</td>
</tr>
<tr>
<td></td>
<td></td>
<td>330.01 Headache, Tension</td>
</tr>
<tr>
<td></td>
<td></td>
<td>339.00 Headache, Cluster</td>
</tr>
<tr>
<td></td>
<td></td>
<td>See page 9 for complete list of headache codes</td>
</tr>
<tr>
<td>NECK PAIN WITH SWELLING</td>
<td>Tenderness, cervical ganglia, cold, sweaty or clammy hands, reduced range-of-motion, foraminal compression test, Soto’s Hal test, cervical distraction, radial pules, reflexes, motor and sensory testing.</td>
<td>335.0 Brachial Plexus Lesions, Cervical rib syndrome</td>
</tr>
<tr>
<td></td>
<td></td>
<td>333.00 Cervical Ganglion, Cervical rib syndrome, &amp; Stellate Anticus Syndrome</td>
</tr>
<tr>
<td></td>
<td></td>
<td>723.0 Cervical Spinal Stenosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>335.2 Cervical root lesions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>729.2 Radicular Neuritis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>724.0 Facet Syndrome</td>
</tr>
<tr>
<td></td>
<td></td>
<td>724.9 Compression of Spinal Nerve Root</td>
</tr>
<tr>
<td>NECK PAIN RADIATING INTO LOWER SPINE WITH TARGET PAIN (LOWER BACK)</td>
<td>Cervical pain produces target pain in lower back. No objectivity in low back, Soto’s Hal test, hyndman’s test.</td>
<td>730.0 Ocicocervical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>731.0 Cervical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>839.00 Cervical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>See page 8 for complete list of subluxation codes</td>
</tr>
</tbody>
</table>

## RADIOGRAPHIC FINDINGS (Cervical Regions)

| 737.30 | Scoliosis                        |
| 737.10 | Decreased or Reversed Lordotic Curve |
| 737.30 | Increased Lordotic Curve          |
| 731.1  | Cervical Spondylosis with myelopathy           |
| 721.0  | Cervical spondylosis without myelopathy     |
| 721.0  | Spinal Stenosis without myelopathy         |
| 721.0  | Lipping and Spawning (osteoarthropathy formation) |
| 721.0  | Foraminal Enencroachment                 |
| 721.0  | Decrease Disc Spacing - Eburnation        |
| 721.0  | Reactive Sclerosis - Marginal Sclerosis   |
| 722.4  | Cervical Disc Degeneration               |
| 722.6  | Narrowing of Intervertebral disc           |
| 736.2  | Acquired deformity of neck               |
| 736.4  | Acquired spondylolisthesis               |
| 722.91 | Disc Calcification                      |
| 756.15 | Vertebral Fusion, congenital            |
| 722.30 | Scheurff’s Node                        |
| 722.71 | Intervertebral Disc Disorder with Myelopathy |
| 721.6  | Ankylosing vertebral hyperostosis        |
| 721.5  | Kissing Spine                         |
### Other Multiple and Ill-Defined Dislocations (Subluxations)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>739</td>
<td>Nonatlantal Lesions, not elsewhere classified</td>
</tr>
<tr>
<td>739.0</td>
<td>Head Region</td>
</tr>
<tr>
<td>739.1</td>
<td>Cervical Region</td>
</tr>
<tr>
<td>739.2</td>
<td>Thoracic Region</td>
</tr>
<tr>
<td>739.3</td>
<td>Lumbar Region</td>
</tr>
<tr>
<td>739.4</td>
<td>Sacral Region</td>
</tr>
<tr>
<td>739.5</td>
<td>Pelvic Region</td>
</tr>
</tbody>
</table>

### Incomplete, Ill-Defined Dislocations - Closed

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>839.0</td>
<td>Cervical Vert., closed</td>
</tr>
<tr>
<td>839.0.0</td>
<td>Cervical vertebrae, unspecified</td>
</tr>
<tr>
<td>839.0.1</td>
<td>First cervical vertebra</td>
</tr>
<tr>
<td>839.0.2</td>
<td>Second cervical vertebra</td>
</tr>
<tr>
<td>839.0.3</td>
<td>Third cervical vertebra</td>
</tr>
<tr>
<td>839.0.4</td>
<td>Fourth cervical vertebra</td>
</tr>
<tr>
<td>839.0.5</td>
<td>Fifth cervical vertebra</td>
</tr>
<tr>
<td>839.0.6</td>
<td>Sixth cervical vertebra</td>
</tr>
<tr>
<td>839.0.7</td>
<td>Seventh cervical vertebra</td>
</tr>
<tr>
<td>839.0.8</td>
<td>Multiple cervical vertebra</td>
</tr>
</tbody>
</table>

### Thoracic and Lumbar Vertebrae, closed

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>839.20</td>
<td>Lumbar Vertebrae, specify level</td>
</tr>
<tr>
<td>839.21</td>
<td>Thoracic Vertebrae, specify level</td>
</tr>
</tbody>
</table>

### Dorsal (thoracic) vertebrae

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>839.3</td>
<td>Other Vertebrae, closed</td>
</tr>
</tbody>
</table>

### Cervical Diagnoses

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>847.1</td>
<td>Thorn</td>
</tr>
<tr>
<td>846.2</td>
<td>Cocey</td>
</tr>
<tr>
<td>847.3</td>
<td>Coccy</td>
</tr>
<tr>
<td>847.4</td>
<td>Cocey</td>
</tr>
<tr>
<td>847.5</td>
<td>Coceyon</td>
</tr>
<tr>
<td>847.6</td>
<td>Cocey</td>
</tr>
<tr>
<td>847.7</td>
<td>Cocey</td>
</tr>
<tr>
<td>847.8</td>
<td>Cocey</td>
</tr>
<tr>
<td>847.9</td>
<td>Cocey</td>
</tr>
</tbody>
</table>

### Other Location, closed

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>839.61</td>
<td>Stamm, Staminuralknotelj</td>
</tr>
<tr>
<td>839.62</td>
<td>Other Pelvisals</td>
</tr>
</tbody>
</table>

### Cervical

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>839.8</td>
<td>Multiple and Ill-Defined dislocations, open</td>
</tr>
</tbody>
</table>

### Additional Diagnosis - Regional

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>723.0</td>
<td>Cervical spondylosis without myelopathy</td>
</tr>
<tr>
<td>723.1</td>
<td>Cervical spondylosis with myelopathy</td>
</tr>
<tr>
<td>723.2</td>
<td>Cervical stenosis syndrome</td>
</tr>
<tr>
<td>723.3</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>723.4</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>723.5</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>723.6</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>723.7</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>723.8</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>723.9</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>724.0</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>724.1</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>724.2</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>724.3</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>724.4</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>724.5</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>724.6</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>724.7</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>724.8</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>724.9</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>725.0</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>725.1</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>725.2</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>725.3</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>725.4</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>725.5</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>725.6</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>725.7</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>725.8</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>725.9</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>726.0</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>726.1</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>726.2</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>726.3</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>726.4</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>726.5</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>726.6</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>726.7</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>726.8</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>726.9</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>727.0</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>727.1</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>727.2</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>727.3</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>727.4</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>727.5</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>727.6</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>727.7</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>727.8</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>727.9</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>728.0</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>728.1</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>728.2</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>728.3</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>728.4</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>728.5</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>728.6</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>728.7</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>728.8</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>728.9</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>729.0</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>729.1</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>729.2</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>729.3</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>729.4</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>729.5</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>729.6</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>729.7</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>729.8</td>
<td>Cervical stenosis</td>
</tr>
<tr>
<td>729.9</td>
<td>Cervical stenosis</td>
</tr>
</tbody>
</table>
Medicare Secondary Diagnosis

The following sections represent ICD-9 codes, associated diagnoses, and utilization guidelines (number of treatments per rolling year) for each ICD-9-CM by CMS. All of the codes may not be utilized for your individual state Medicare intermediary. Therefore when billing Medicare and the secondary diagnoses specific for your state must be adhered to. These are presented as an overall guide of visit allowance based on the specific diagnosis and not solely for Medicare based claims.

CATEGORY I - ACUTE SUBLUXATION

A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression of patient's condition.

307.81 Tension headache 18
333.83 Spasmodic torticollis 12
350.1 Trigeminal neuralgia 16
350.2 Atypical face pain 16
351.0 Bell's palsy 24
352.3 Disorders of pneumogastric (10th) nerve 16
352.9 Disorders of other cranial nerves 16
355.5 Tarsal tunnel syndrome 16
381.4 Non supplicative otitis media, not specified as acute or chronic 12
716.68 Other symptoms referable to joint, involving other specified sites 12
719.40-719.68 Pain in joint 18
719.69 Other symptoms referable to joint, involving multiple sites 24
719.80 Other specified disorders of joint, site unspecified 24
719.81 Other specified disorders of joint, shoulder region 24
719.82 Other specified disorders of joint, upper arm 24
719.83 Other specified disorders of joint, forearm 24
719.84 Other specified disorders of joint, hand 24
719.85 Other specified disorders of joint, pelvic region and thigh 24
719.86 Other specified disorders of joint, lower leg 24
719.87 Other specified disorders of joint, ankle and foot 24
719.88 Other specified disorders of joint, other specified sites 24
719.89 Other specified disorders of joint, multiple sites 24
723.1 Cervicalgia 12
723.2 Cervicocranial syndrome 18
723.8 Other syndromes affecting cervical region 18
724.1 Pain in thoracic spine 18
MY CASE IS SPECIAL

Complicating Conditions: Medicare determines that these conditions by themselves do not constitute a need for care, however conditions superimposed on them will increase the need (length) for care.

721.5 Kissing spine
721.6 Ankylosing vertebral hyperostosis
722.31 Schmorl's nodes Thoracic spine
722.32 Schmorl's nodes Lumbar spine
733.01 Senile Osteoporosis
737.10 Kyphosis (acquired, postural)
737.12 Kyphosis postlaminctomy
737.20 Lordosis (acquired, postural)
737.21 Lordosis postlaminctomy
737.22 Other post surgical lordosis
737.30 Scoliosis and kyphoscoliosis (idiopathic)
737.34 Thoracogenic Scoliosis
738.2 Acquired deformity of neck
754.2 Congenital scoliosis
756.11 Spondylosis, lumbosacral region
756.13 Absence of vertebra, congenital
756.14 Hemivertebra
756.15 Fusion of spine (vertebra), congenital
756.16 Klippel-Feil syndrome

Mercy Conference Guidelines: Factors hat Delay Recovery

- Pain > 8 days 1.5x
- Severe Pain 2.0x
- > three previous episodes 2.0x
- Injury superimposed 1.5-2.0x

Other Factors

1. Recurrences, exacerbations and flare-ups
2. Underlying diseases (Diabetes)
3. Posture (antalgia)
4. Gait
5. Stress and Depression
SPINAL CURVATURE
737.10 Kyphosis, acquired
737.20 Lordosis, acquired
737.30 Scoliosis and kyphoscoliosis, idiopathic
737.34 Thoracogenic scoliosis
737.8 Other curvature of the spine
737.9 Unspecified curvature of spine
738.2 Acquired deformity of the neck
738.4 Acquired spondylolisthesis
756.12 Spondylolisthesis
736.81 Unequal leg length, acquired
781.91 Loss of height
781.92 Abnormal posture

LIGAMENT
728.4 Laxity of ligament
728.5 Hypermobility syndrome
728.89 Calcification of ligament
717.9 Relaxation of joint

MUSCLE
728.81 Interstitial myositis
728.85 Spasm of muscle
728.87 Muscle weakness, generalized
728.9 Other disorders of muscle
729.0 Rheumatism, unspecified and fibrosis
729.1 Myalgia and myositis
728.11 Progressive myositis ossificans
728.12 Traumatic Mysosis ossificans
728.2 Muscular wasting
729.4 Fascitis, unspecified
729.82 Cramp in limbs
726.90 Enthesopathy of unspecified site

LATE EFFECTS
905.7 Late effect of strain and sprain
905.8 Late effect of tendon injury
907.3 Late effect of injury to nerve root
907.3 Late effect of injury to nerve of upper limb
907.5 Late effect of injury to nerve of lower limb

MISCELLANEOUS
780.71 Chronic Fatigue Syndrome
780.79 Other malaise or fatigue
782.0 Numbness, tingling etc
782.3 Edema
278.00 Obesity
278.01 Severe Obesity
300.4 Depression
250.00 Diabetes
780.52 Insomnia, unspecified
733.00 Osteoporosis, unspecified
733.01 Senile Osteoporosis
733.02 Idiopathic osteoporosis
760.4 Dizziness and Giddiness
386.10 Peripheral vertigo
386.11 Benign paroxysmal positional vertigo

PAIN
338.11 Acute pain due to trauma
338.19 Other acute pain
338.21 Chronic pain due to trauma
338.29 Other chronic pain
780.96 Generalized pain NOS
719.4x Joint pain (5th digit will dictate joint)

X-RAY
721.0 Cervical spondylosis w/o myleopathy
721.1 Cervical spondylosis with myleopathy
721.2 Thoracic spondylosis w/o myleopathy
721.3 Lumbar spondylosis w/o myleopathy
721.41 Thoracic spondylosis with myleopathy
721.42 Lumbar spondylosis with myleopathy
722.4 Degeneration of cervical disc
722.51 Degeneration of thoracic or thoracolumbar disc
722.52 Degeneration of lumbar or lumbosacral disc
722.6 Degeneration of disc unspecified
Blue Cross Blue Shield Insurance Chiropractic policy
The following is excerpted from the BC/BS guide for chiropractic services. Note the relationship of severity, the limits to ADL’s, and co-morbidities and how they influence the care plan.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Mild (1)</th>
<th>Moderate (2)</th>
<th>Severe (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain/discomfort intensity</td>
<td>1-3</td>
<td>4-7</td>
<td>8-10</td>
</tr>
<tr>
<td>by visual analog scale (VAS) 0=no pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10=most severe pain ever</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activities of daily living (ADL) limitations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>annoying to some limitations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-morbidities impeding patient recovery</td>
<td>Not a factor</td>
<td>Somewhat a factor</td>
<td>Significant factor</td>
</tr>
<tr>
<td>Overall severity (taking into consideration the above three factors)</td>
<td>mild (1)</td>
<td>moderate (2)</td>
<td>severe (3)</td>
</tr>
</tbody>
</table>

Once the severity of each component has been determined, the clinician should use the overall severity to determine the number of visits or weeks of treatment.
<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Description</th>
<th>Severity</th>
<th>Treatment weeks</th>
<th>Treatment number</th>
<th>X-ray</th>
</tr>
</thead>
<tbody>
<tr>
<td>729.2/353.8</td>
<td>Intercostal Neuralgia/Neuritis</td>
<td>1</td>
<td>4</td>
<td>10</td>
<td>72070</td>
</tr>
<tr>
<td>739.8</td>
<td>Costo-vertebral Dysfunction</td>
<td>2</td>
<td>5</td>
<td>12</td>
<td>72070</td>
</tr>
<tr>
<td>353.0</td>
<td>Thoracic Outlet Syndrome</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>72070</td>
</tr>
<tr>
<td>847.2</td>
<td>Lumbar Strain/Sprain</td>
<td>1</td>
<td>4</td>
<td>8</td>
<td>72100</td>
</tr>
<tr>
<td>846.0</td>
<td>Lumbosacral Strain/Sprain</td>
<td>1</td>
<td>4</td>
<td>8</td>
<td>72100</td>
</tr>
<tr>
<td>846.1</td>
<td>Sacroiliac Strain/Sprain</td>
<td>1</td>
<td>4</td>
<td>8</td>
<td>72100</td>
</tr>
<tr>
<td>739.3</td>
<td>Lumbar Segmental Dysfunction</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>72100</td>
</tr>
<tr>
<td>739.4</td>
<td>Sacroiliac Segmental Dysfunction</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>72100</td>
</tr>
<tr>
<td>724.8</td>
<td>Lumbar facet syndrome</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>72100</td>
</tr>
<tr>
<td>724.3</td>
<td>Sciatic Neuralgia</td>
<td>1</td>
<td>4</td>
<td>10</td>
<td>72110</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Description</th>
<th>Severity</th>
<th>Treatment weeks</th>
<th>Treatment number</th>
<th>X-ray</th>
</tr>
</thead>
<tbody>
<tr>
<td>722.10</td>
<td>Lumbar Intervertebral Disc Syndrome</td>
<td>1</td>
<td>4</td>
<td>14</td>
<td>72100</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>8</td>
<td>20</td>
<td>72100</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>10</td>
<td>24</td>
<td>72100</td>
</tr>
</tbody>
</table>
Aetna Insurance Chiropractic Policy

Aetna considers chiropractic services medically necessary when all of the following criteria are met:

1. The member has a neuromusculoskeletal disorder, and
2. The medical necessity for treatment is clearly documented, and
3. Improvement is documented within the initial 2 weeks of chiropractic care.

If no improvement is documented within the initial 2 weeks, additional chiropractic treatment is considered not medically necessary unless the chiropractic treatment is modified.

If no improvement is documented within 30 days despite modification of chiropractic treatment, continued chiropractic treatment is considered not medically necessary.

Once the maximum therapeutic benefit has been achieved, continuing chiropractic care is considered not medically necessary.

Chiropractic manipulation in asymptomatic persons or in persons without an identifiable clinical condition is considered not medically necessary.

Chiropractic care in persons, whose condition is neither regressing nor improving, is considered not medically necessary.

The primary focus of the profession is the vertebral column; however, all other peripheral articular structures and adjacent tissues may be treated, depending on state chiropractic scope of practice laws.

Neuromusculoskeletal conditions commonly treated by chiropractic physicians include:

- Spondylolisthesis
- Osteoarthritis - Intervertebral disc disorders of the spine such as disc protrusion, bulging, degeneration, and displacement
- Peripheral joint trauma
- Degenerative conditions of the joints
- Repetitive motion injuries
- Contractures
- Sprains and strains
- Headaches (including tension headaches, migraines, and vertebrogenic-type headaches)
- Noninfectious inflammatory disorders of the joints, muscles, and ligaments of the spine and extremities
- Myalgia, myofibrositis and fibrosis
- Neuralgias and radiculopathies
- Spinal facet syndromes
- Spondylolisthesis.

The chiropractor may treat multiple neuromusculoskeletal conditions during a single visit.
Optum Health Chiropractic General Guidelines

All ICD-9-CM diagnosis codes and CPT treatment and procedure codes must be validated in the patient chart and coordinated as to the diagnoses and treatment code descriptors. A valid diagnosis is the most appropriate ICD-9-CM code that is supported by subjective symptoms, physical findings, and diagnostic testing/imaging (if appropriate).

Documentation should be recorded on the day of the patient visit and include all of the following:
1. A subjective record of the patient complaint i.e., location, quality, and intensity
2. Physical findings to support manipulation in a region or segment e.g., regional/segmental asymmetry or misalignment, range of motion abnormality, soft tissue tone and/or tenderness characteristics
3. Assessment of change in patient condition, as appropriate
4. A record of the specific segments manipulated

98940 Chiropractic manipulative treatment (CMT); spinal, one to two regions
Documentation must include a validated diagnosis for one or two spinal regions and support that manipulative treatment occurred in one to two regions of the spine (region as defined by CPT).

98941 Chiropractic manipulative treatment (CMT); spinal, three to four regions
Documentation must support that manipulative treatment occurred in three to four regions of the spine (region as defined by CPT) and one of the following:
1. Validated diagnoses for three or four spinal regions
2. Documented soft tissue and segmental findings

98943 Chiropractic manipulative treatment (CMT); extraspinal, one to five regions
Documentation must support that manipulative treatment occurred in one or more extraspinal regions (as defined by CPT), and there is a validated diagnosis for one or more extraspinal regions for which manipulation has been shown to be both safe and efficacious per appropriate OptumHealth Physical Health medical policy.

Regardless of how many segments are manipulated in any defined spinal region, it counts as one region under the CMT codes. The CMT code 98943 applies to one or more extraspinal regions, where manipulation is performed.

The 97140 manual therapy CPT code may be billed on the same date of service as a CMT code when the manual therapy service is provided to a different body region than the CMT. When these procedures are billed together, modifier -59 is required to be appended to the 97140 CPT code in order to delineate that an independent procedure was performed.
# E & M

## EVALUATION AND MANAGEMENT SERVICES

### NEW PATIENT

A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Evaluation/Management - Limited</td>
</tr>
<tr>
<td></td>
<td>Presenting problem(s) are self-limited or minor; requires a problem focused history, problem-focused examination and straightforward medical decision-making. Physicians typically spend 10 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99202</td>
<td>Evaluation/Management - Expanded</td>
</tr>
<tr>
<td></td>
<td>Presenting problem(s) are of low to moderate severity; requires an expanded problem focused history, an expanded problem-focused examination and straightforward medical decision-making. Physicians typically spend 20 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99203</td>
<td>Evaluation/Management - Detailed</td>
</tr>
<tr>
<td></td>
<td>Presenting problem(s) are of moderate severity; requires a detailed history, a detailed examination and medical decision-making of low complexity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99204</td>
<td>Evaluation/Management - Comprehensive</td>
</tr>
<tr>
<td></td>
<td>Presenting problem(s) are of moderate to high severity; requires a comprehensive history, a comprehensive examination and medical decision-making of moderate complexity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99205</td>
<td>Evaluation/Management - Complex</td>
</tr>
<tr>
<td></td>
<td>Presenting problem(s) are of moderate to high severity; requires a comprehensive history, a comprehensive examination and medical decision-making of high complexity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.</td>
</tr>
</tbody>
</table>

### ESTABLISHED PATIENT

An established patient is one who has received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Evaluation/Management - Minimal</td>
</tr>
<tr>
<td></td>
<td>Presenting problem(s) are minimal; does not require the presence of a physician. Typically 5 minutes are spent performing or supervising these services.</td>
</tr>
<tr>
<td>99212</td>
<td>Evaluation/Management - Limited</td>
</tr>
<tr>
<td></td>
<td>Presenting problem(s) are self-limited or minor; requires a problem-focused history, a problem-focused examination and straightforward decision-making. Physicians typically spend 10 minutes face-to-face with the patient.</td>
</tr>
<tr>
<td>99213</td>
<td>Evaluation/Management - Expanded</td>
</tr>
<tr>
<td></td>
<td>Presenting problem(s) are of low to moderate severity; requires an expanded problem-focused history, an expanded problem-focused examination and medical decision-making of low complexity. Physicians typically spend 15 minutes face-to-face with the patient.</td>
</tr>
<tr>
<td>99214</td>
<td>Evaluation/Management - Detailed</td>
</tr>
<tr>
<td></td>
<td>Presenting problem(s) are of moderate to high severity; requires a detailed history, a detailed examination and medical decision-making of moderate complexity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99215</td>
<td>Evaluation/Management - Comprehensive</td>
</tr>
<tr>
<td></td>
<td>Presenting problem(s) are of moderate to high severity; requires a comprehensive history, a comprehensive examination and medical decision making of high complexity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.</td>
</tr>
</tbody>
</table>
Billing Exams

- Initial visit
- Re-exams (may be as short as 3-6 visits)
- But never greater than 1 month
- Final visit
- E&M services are highly valued and necessary.

UCR Values

- Insurance
- Cash
- Workers’ compensation
- Insurance code 10176 - Equality

Choosing The Right Code

- Not time
- Severity and complexity
- Minimal
- Low
- Moderate
- High
- If time is a major factor...
PROLONGED SERVICES

Added Time During Evaluation and Management

There may be instances where more time needed to fully explore the history, examination and counseling and may extend beyond the time associated with the given level of the E&M code appropriate based on severity and complexity.

In these instances it would be appropriate to add a prolonged service code in addition to the E&M code billed on the same date. These codes are for increased time associated with history, examination, medical decision making, counseling, and coordination of care.

To specifically qualify

- The prolonged service must be face to face by the chiropractor (provider) only. Staff time with the patient taking history or other evaluation services do not qualify.
- The minimum additional time must be at least 30 minutes beyond the time associated with the E&M service associated. If the added time is less than 30 minutes it is not appropriate. For example if a 99203 is used the total time spent face-to-face must be a minimum of 60 minutes, as 99203 has a face-to-face time average of 30 minutes.
- The time need not be consecutive but must be during a single visit. For example a chiropractor may take the history, then excuse to another patient and return later and complete the evaluation.
- Total face-to-face time must be documented in the file.

Special note that it is not appropriate to use this code for a separate visit report of findings

<table>
<thead>
<tr>
<th>Total duration of prolonged service</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 30 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>30-74 minutes</td>
<td>99354 x 1</td>
</tr>
<tr>
<td>75-104 minutes</td>
<td>99354 x 1 and 99355 x 1</td>
</tr>
<tr>
<td>105 minutes or more</td>
<td>99354 x 1 and 99355 x 2 or more for each additional 30 minutes</td>
</tr>
</tbody>
</table>
CHIROPRACTIC MANIPULATIVE TREATMENT (CMT)

Chiropractic Manipulative Treatment (CMT) is a form of manual treatment to influence joint and neurophysiological function. This treatment may be accomplished using a variety of techniques.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>98940</td>
<td>Chiropractic manipulative treatment (CMT); spinal, one to two regions</td>
</tr>
<tr>
<td>98941</td>
<td>Chiropractic manipulative treatment (CMT); spinal, three to four regions</td>
</tr>
<tr>
<td>98942</td>
<td>Chiropractic manipulative treatment (CMT); spinal, five regions</td>
</tr>
<tr>
<td>98943</td>
<td>Chiropractic manipulative treatment (CMT); extraspinal, one or more regions (not for Medicare purposes)</td>
</tr>
</tbody>
</table>

SPINAL REGIONS

For purposes of CMT, the five spinal regions referred to are:
Cervical region (includes atlanto-occipital joint);
Thoracic region (includes costovertebral and costotransverse joints);
Lumbar region;
Sacral region; and
Pelvic region (sacro-iliac joint).

EXTRASPINAL REGIONS

The five extraspinal regions referred to are:
Head region (including temporomandibular joint, excluding atlanto-occipital);
Lower extremities;
Upper extremities;
Rib cage (excluding costotransverse and costovertebral joints), and
Abdomen.

E&M Code Billed as Manipulation

99213 or similar E&M codes should not be billed as manipulation, as those codes describe an evaluation and management service and/or examination. CPT rules mandate that the code chosen should offer the best description of the service provided. Manipulation done by a chiropractor should therefore be billed with the appropriate CMT code. Note that within the CMT code there is a component of evaluation and management service. This describes preservice, intraservice and postservice elements of the manipulation service.
CMT PROCEDURE INCLUDES E & M ASSESSMENT

The chiropractic manipulative treatment codes include a pre-manipulation patient assessment.

PRE & POST SERVICES INCLUDED IN THE CMT PROCEDURE

PRE-SERVICE work includes: review of history, response to prior care, discussion of new/resolved subjective findings, clinical objective findings, and diagnostic interpretation.

INTRA-SERVICE work includes: assessment of current condition, coordinating/modifying treatment plan, evaluate new complaints, patient preparation and instruction for procedure, assess need for additional areas or re-application of procedure, and post-adjustment instruction.

POST-SERVICE work includes medical chart documentation, modification of treatment plan, update diagnostic impressions, communication, and referrals.

CMT PROCEDURE PLUS EVALUATION & MANAGEMENT SERVICES

Additional Evaluation and Management services may be reported separately if and only if the patient’s condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the procedure. These circumstances would include: a new or aggravated condition, a disability evaluation, report of findings, change in the treatment plan, re-examine and evaluate the patient’s response to treatment, discharge examination, etc.

When reporting an Evaluation & Management Service along with a CMT procedure, add the modifier -25 to the Evaluation & Management procedure code. This modifier indicates that the Evaluation & Management service was a significant, separately identifiable service, above and beyond the usual preservice and postservice work already included in the CMT procedure.

example: 98940 CMT 1-2 regions
          99213-25 Evaluation & Management Service

You should not charge an Evaluation & Management Service along with a CMT procedure code on a routine patient follow-up visit.

UNUSUAL TIME NEEDED FOR MANIPULATION SERVICE MODIFIER 22

When a patient presents and requires a procedural service (ie. manipulation), that requires substantially greater time and effort than is typically needed. Those services may be identified by adding modifier -22 to the procedure code.

This scenario would be from increased intensity, time, technical difficulty of procedure, severity of the patient's condition, physical and mental effort required. For instance patient may be extremely obese or have some underlying disease which requires the provider spend much more time and effort to provide their service.

By adding this modifier it increases the fee 50%.

Documentation must support the substantial, additional work and the reason for the additional work. This is not intended to be used with every patient based on a specific technique or style of service but by unusual circumstances.

This modifier is not to be used with E&M services
PHYSICAL MEDICINE & REHABILITATION
CPT CODES (97010 - 97799)

The following CPT codes are current as of January 1, 2011. The 2010 Chiropractic Diagnostic Corollary contains specific definitions, related diagnosis, and proper documentation of PMR codes.

This list represents only a selected amount of Physical Medicine Codes. For a complete list of CPT codes available to you, you will need to purchase the complete CPT Code Book which is available from P.M.I.C. (800) 633-7467, ext.#530. or AMA 800 621-8335

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

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

Therapeutic procedure, one or more areas, 15 min;

97110 Therapeutic exercises to develop strength and endurance, range of motion and flexibility.
97112 Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception.
97113 Aquatic therapy with therapeutic exercises
97116 Gait training (includes stair climbing)
97124 Massage, including effleurage, petrissage, tapotement (stroking, compression, percussion)
97139 Unlisted therapeutic procedure (specify)
97140 Manual therapy techniques, one or more regions. (for example: mobilization/manipulation, manual traction, manual lymphatic drainage) 1999

ADDITIONAL PROCEDURES

97150 Therapeutic procedure(s), group (2 or more)
97530 Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 min.
97535 Self care/home management training (eg. activities of daily living (ADL) and compensatory training, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes.
97537 Community/work reintegration training (eg. avocational activities and/or work environment/ modification analysis, work task analysis), direct one on one contact by provider, each 15 minutes.
97542 Wheelchair mgmt/propulsion training, each 15 min.
97545 Work hardening/conditioning; initial 2 hrs.
97546 each additional hour
97799 Unlisted physical medicine/rehabilitation service.

ORTHOTIC FITTING AND TRAINING

97760 Orthotics management and training upper and lower extremities extremities, or trunk each 15 min.
97762 Checkout for ortho-prosthetic use, established patient, each 15 minutes

TESTS & MEASUREMENTS

97750 Physical performance test / measurement with written report, each 15 min.

MAINTENANCE CARE

98990 Physical or manipulative therapy performed for maintenance rather than restoration.
Modalities v Procedures

- Modalities
- No time value
- Billed once regardless of number of regions or time applied

- Procedures
- Time value of 15 minutes
- May be billed based on the amount of time spent
- Regardless of number of regions

Units

- 1 unit 8-22 minutes
- 2 units 23-37 minutes
- 3 units 38-52 minutes
- 4 units 53-67 minutes
- Multiple Timed Procedures are Billed in Units Based on Cumulative Time

- 97110 10 minutes
- 97124 10 minutes
- Should or can each code be billed for 1 unit if done the same date of service?
- 97124 5 minutes
- 97124 -52
CIGNA Insurance Chiropractic policy

CIGNA covers chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) as medically necessary when ALL of the following conditions are met:

1. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function.
2. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law.
3. The individual is involved in an ongoing treatment program that clearly documents all of the following:
   - a prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time
   - the symptoms being treated
   - diagnostic procedures and results
   - frequency, duration and results of planned treatment modalities
   - anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals
   - demonstrated progress toward significant functional gains and/or improved activity tolerances

Response to chiropractic treatment typically occurs within four weeks. Continuation of chiropractic care is considered medically necessary until a maximum therapeutic benefit has been reached, when the patient fails to show improvement, or when a pre-injury level of functioning has been reached. Chiropractic physicians should document in clinical records the objective findings and subjective complaints that support the necessity for a chiropractic treatment regimen. A treatment plan should be developed with planned modalities (frequency and duration), measurable and attainable goals (short- and long-term), and anticipated duration of care. There should be a reasonable expectation that the identified goals will be met. The following are recommended:

- If conservative care is appropriate, a short course (not to extend beyond four weeks) is warranted. If the patient demonstrates objective evidence of improvement, up to an additional four weeks of care may be appropriate.

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

- The utilization of more than 2–3 passive modalities per office visit is excessive and is not supported as necessary.

- These rules hold true for acute, chronic and postsurgical cases. No matter what specific treatment is chosen, it must yield identifiable, objective outcomes to establish the necessity of care.

Adjunct Modalities

In addition to spinal manipulation, which is a manual therapy, other modalities, both passive and active, are often used as adjunct treatments. Passive modalities are most effective during the acute phase of treatment, as they are typically directed at reducing pain and swelling. They may also be used during the acute phase of an exacerbation of a chronic condition. The optimal duration of a course of passive modalities is a maximum of one to two months, after which their effectiveness diminishes, and patient dependency may develop.

As swelling and inflammation are reduced, the need for stabilization and support is replaced by the need to increase range of motion and restore function. Active modalities include increasing range of motion, strengthening primary and secondary stabilizers of a given region, and increasing endurance capabilities of the muscles. Active modalities focus on patients’ active participation in their exercise programs. Progressive resistive exercises are considered an active modality.
Therapeutic exercise 97110 The application of exercise as a method to improve tone, strength, flexibility, endurance and facilitate healing. Can be active, active-assisted, or passively implemented. Indicated for weakness, contracture, stiffness secondary to spasm, spasticity, decreased range of motion, gait problem, balance and/or coordination deficits, abnormal posture, muscle imbalance. Also provided to improve mobility, stretching, strengthening, coordination, control of extremities, dexterity, range of motion, or endurance as part of activities of daily living training, or re-education. Objectively it should be demonstrated by loss of joint motion, strength, or mobility. Specific exercises should be listed as to the type, method, sets, repetitions and time. Goals should be set and recorded regularly for change. This could include stretching exercises, both static and facilitated, or progressive resistance strength/endurance exercises such as isometric, isotonic and isokinetic. The amount of weight, repetitions and sets should be noted. If you’re using Theraband or similar equipment you should include the resistance level. Long term and short term goals should be identified. Changes in methods should be highlighted and typically follow a progressive manner. Medicare Local Coverage Determination is 12-18 visits. This code may be billed for multiple units in 15 minute increments.

Append with modifier 59 when billed with Chiropractic Manipulative Therapy. Note there is no requirement for a separate region from CMT.

Diagnosis associated with 97110

Gout 274.0, 274.9
Degenerative Diseases of CNS, Other Disorders of CNS 332.0, 332.1, 333.0, 333.83, 333.90, 333.91, 334.0-334.8, 335.0, 335.10-335.19, 335.20-335.9,356.0, 336.8, 337.20-337.29, 338.21, 338.29, 338.4, 340, 341.1, 341.20-341.9, 342.00-342.02,342.10-342.12, 342.80-342.82, 342.90-342.92, 343.0-343.9, 344.00-344.2, 344.30-344.32,344.40-344.5, 344.60, 344.61, 344.81-344.9, 348.1
Disorders of Peripheral Nervous System 351.0, 353.0-353.9, 354.0-354.9, 355.0-355.6, 355.71-355.79, 356.0-356.9, 357.0-357.7, 357.81, 357.89, 357.9, 358.00-358.9, 359.0-359.22, 359.29, 359.3-359.6, 359.89, 359.9
Visual Disturbances/Blindness and Low Vision 368.41, 368.45-368.47, 369.01, 369.03, 369.04, 369.06-369.08, 369.12-369.14, 369.16-369.18, 369.22, 369.24, 369.25
CVA 436, 438.20-438.53, 438.84
Lymphedema 457.0, 457.1
TMJ 524.61-524.64
Cellulitis 681.00-681.02, 681.10, 681.11, 682.2-682.7

Courtesy HJ Ross Seminars and Network National Chiropractic Council
Neuromuscular reeducation 97112 Performance of specific activities to improve balance, coordination, kinesthetic sense, posture, and proprioception. Common uses are when the patient has loss of deep tendon reflexes and vibration sense accompanied by paresthesia, burning, or diffuse pain of the feet, fingers and extremities in general. Additionally indicated in patients having nerve palsies, such as perineal nerve injury causing foot drop. Also muscular weakness or flaccidity as a result of a cerebral dysfunction, a nerve injury or disease, or having had a spinal cord disease or trauma. Be aware this therapy closely associated with rehabilitation following stroke, surgery, fracture, etc. where the motor system needs to be “re-patterned” for normal activities but may also be done for patients with a deficit of the aforementioned factors. This service also includes poor static or dynamic sitting/standing balance, loss of gross or fine motor coordination, and hypo/hypertonicity. Methods typically entail a form of repeated active movements under a variety of mechanical conditions. Examples include proprioceptive neuromuscular facilitation, Janda, Feldenkrais, Bobath, Alexander, cross crawl, etc. Balance boards and similar equipment could be documented under this code. Medicare Local Coverage Determination 12-18 visits. Append with modifier 59 when billed with Chiropractic Manipulative Therapy. Note there is no requirement for a separate region from CMT.

Therapeutic activities 97530 Therapeutic activities are considered reasonable and necessary for patients needing a broad range of rehabilitative techniques that involves movement. Movement activities can be for a specific body part or could involve the entire body. This procedure involves the use of functional activities (e.g. bending, lifting, carrying, reaching, catching, transfers, 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 skills of a therapist and
are designed to address a specific functional need of the patient. These dynamic activities must be part of an active treatment plan and be directed at a specific outcome.

➢ Massage Therapy (CPT code 97124):
  Massage is the application of systemic manipulation to the soft tissues of the body for therapeutic purposes. Although various assistive devices and electrical equipment are available for the purpose of delivering massage, use of the hands is considered the most effective method of application, because palpation can be used as an assessment as well as a treatment tool. Massage Therapy, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion) may be considered reasonable and necessary if at least one of the following conditions is present and documented:

A. the patient having paralyzed musculature contributing to impaired circulation;
B. the patient having sensitivity of tissues to pressure;
C. the patient having tight muscles resulting in shortening and/or spasticity of affected muscles;
D. the patient having abnormal adherence of tissue to surrounding tissue;
E. the patient requiring relaxation in preparation for neuromuscular re-education or therapeutic exercise;
F. the patient having contractures and decreased range of motion.

Document targeted muscles and soft tissues with the technique(s) or styles used. Also included in this code is the use of a Genie Rub, Thumper, G5, etc. Patient subjective responses such as tenderness and jump responses should be highlighted. Objective factors such as spasm and rigidity should also be outlined. The time spent must also be included. **Be careful that you do not confuse massage with myofascial release.** Use of tools or probes would still qualify as they are still manually applied. This code is considered a hands on procedure and requires the doctor/therapist to be in constant attendance with the patient. Therefore, massage beds, tables, or chairs do not qualify for this code. For that style of therapy the unlisted modality code would be more appropriate.
# RADIOLOGY

## HEAD & NECK
- 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
- 71010 Chest, single view, frontal
- 71100 Ribs, unilateral, 2 views
- 71110 Ribs, bilateral, 3 views

## SPINE
- 72010 Spine, entire, survey study, AP and Lat
- 72020 Spine, single view, specify level
- 72040 Cervical spine, 2 or 3 views
- 72050 Cervical spine, min. 4 views
- 72052 Cervical spine, complete, w/ flex & ext
- 72069 Thoraco-Lumbar spine, standing, (scoliosis)
- 72070 Thoracic spine, AP and lateral
- 72074 Thoracic spine, complete, w/ oblique
- 72080 Thoracolumbar, AP & lateral
- 72090 Scoliosis Study, inc. supine & erect
- 72100 Lumbosacral spine, 2 or 3 views
- 72110 Lumbosacral spine, minimum 4 views
- 72114 Lumbosacral spine, complete w/bending
- 72120 Lumbosacral spine, bending only

## PELVIS
- 72170 Pelvis, AP only
- 72190 Pelvis, min. 3 views
- 72200 Sacroiliac joints, less than 3 views
- 72202 Sacroiliac joints, 3 or more views
- 72220 Sacrum and coccyx, min 2 views

## UPPER EXTREMITIES
- 73000 Clavical, Complete
- 73010 Scapula, Complete
- 73020 Shoulder, 1 view
- 73030 Shoulder, complete, min. 2 views
- 73060 Humerus, min. 2 views
- 73070 Elbow, AP and lateral
- 73080 Elbow, complete, min. 3 views
- 73090 Forearm, AP & lateral
- 73092 Upper extremities, infant, min 2 views
- 73100 Wrist, AP and lateral
- 73110 Wrist, complete, min. 3 views
- 73120 Hand, 2 views
- 73130 Hand, min. 3 views
- 73140 Fingers, min. 2 views

## LOWER EXTREMITIES
- 73500 Hip, unilateral, one view
- 73510 Hip, complete, min. 2 views
- 73520 Hip, bilateral
- 73540 Hips & Pelvis, child or infant
- 73550 Femur, AP & lateral
- 73560 Knee, AP and lateral
- 73562 Knee, AP and lateral w/ oblique(s)
- 73565 Knees, both, standing, AP
- 73590 Tibia and Fibula, AP & lateral
- 73600 Ankle, AP and lateral
- 73610 Ankle, complete, min. 3 views
- 73620 Foot, AP and lateral
- 73630 Foot, complete, min. 3 views
- 73650 Calcaneus, min 2 views
- 73660 Toes, min 2 views

## OTHER
- 76140 Consultation on x-ray made elsewhere, written report
Services provided in the office at times other than regularly scheduled office hours or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service.

Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic services.

Service(s) provided between 10:00 PM and 8:00 AM at a 24 hour facility, in addition to basic service.

Service(s) typically provided in the office, provided out of the office at request of the patient, in addition to the basic service.

Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to the basic service.

Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic services.

Supplies and materials provided by the physician over and above those usually included with the office visit or other services rendered (specify). Do not use this code but the corresponding HCPCS code.

Educational supplies, such as books, tapes, and pamphlets, provided by the physician for the patient's education at cost to physician.

Medical Testimony

Physician educational services rendered to patients in a group setting

Special reports (e.g., narratives, review of medical records): When information more than that necessary to establish or to clarify a patient's status is requested (e.g., more than the standard reporting form) or a request is made for review of medical records and report, a charge adequate to cover the value of the additional service is justified.

Unusual travel (e.g., transportation and escort of patient)

Analysis of information data stored in computers (e.g., blood pressures, hematologic data)

Medical records copying fee, administrative

Medical records copying fee, per page

Vertebral Axial Decompression, per session (Do not use this code for Medicare. For Medicare use code 97799 and in block 19 of the CMS 1500 enter VAX-D)
Modifiers
Listed services may be modified under certain circumstances. When applicable, the modifying circumstances against general guidelines should be identified by the addition of the appropriate modifier code, which may be reported in either of two ways. The modifier may be reported by a two digit number placed after the usual procedure number, from which it is separated by a hyphen. Or the modifier may be reported by a separate five digit code that is used in addition to the procedure code.

-22 **Unusual Procedural Services:** When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding the modifier '-22' to the usual procedure number or by use of the separate five digit modifier code 09922. A report may also be appropriate.

-25 **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure or Other Service:** The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative or postoperative care associated with the procedure that was performed. This circumstance may be reported by adding the modifier '-25' to the appropriate level of E/M service, or the separate five digit modifier 09925 may be used.

-26 **Professional Component:** Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '-26' to the usual procedure number or the service may be reported by use of the separate five digit modifier code 09926.

-50 **Bilateral Procedure:** Service identifies bilateral procedures and is appended to procedure codes that do not already incorporate bilateral within the Current Procedural Terminology (CPT) definition.

-51 **Multiple Procedures:** When multiple procedures, other than Evaluation and Management Services, are performed on the same day or at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier '-51' to the additional procedure or service code(s) or by the use of the separate five digit modifier 09951. This modifier should not be appended to designated "add-on" codes.

-52 **Reduced Services:** Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '-52,' signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Modifier code 09952 may be used as an alternative to modifier '-52.'

-59 **Distinct Procedural Service:** Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier "-59" is used to identify procedures/services that are not normally reported together but are appropriate under the circumstances. Modifier code 09959 may be used as an alternative to modifier "-59".

-76 **Repeat Procedure by Same Physician:** The physician may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier '-76' to the repeated service or the separate five digit modifier code 09976 may be used.

-90 **Reference (Outside) laboratory:** When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding the modifier '-90' to the usual procedure number or by using the separate five digit modifier code 09990.
HCPCS Codes

HCPCS (pronounced “hick-picks”) is a uniform coding system designed for health care providers to report supplies and other professional services. Many health insurance companies are now requiring the use of these codes to identify supports and or other supplies provided to your patients. The following list are the most commonly used supplies in chiropractic offices. A complete list of codes is available in the HCPCS Code Book which can be purchased from AMA 800 621-8335

97760 - Orthotics management and training upper and lower extremities or trunk each 15 min.

97762 - Orthotic Checkout for orthotic-prosthetic use, established patient, each 15 min.

Vitamins and Non Rx
A9150 Nonprescription drug or similar substance
A9152 Single vitamin/mineral/trace element, per dose
A9153 Multiple vitamins, w or w/ minerals, per dose

Tens and Supplies
E0720 TENS Unit (two lead)
E0730 TENS Unit (four lead)
A4595 Electrodes (per pair) TENS or similar
A4558 Conductive paste or gel Tens, NMES device
A4559 Conductive paste or gel Ultrasound device

Exercise Equipment
A9300 Exercise equipment (any type)

Heat and Cryotherapy
E0210 Electric Moist Heat Pad
E1399 Unlisted DME. May be used for hot or cold packs but must be sent with explanation
A9273 Hot water bottle, ice cap or collar, heat and or cold wrap, any type

Pillow or Wedge
E0190 Pillow/ Wedge or support, any (neck, low back, leg spacer etc)

Foot Orthoses
L3010 Foot insert, molded to patient model longitudinal arch support
L3020 Foot insert, molded to patient model longitudinal/metatarsal support
L3030 Foot insert, removable, formed to patient foot
L3040 Full Foot, arch support removable premolded, each foot
L3060 Foot arch support, removable, premolded
Supports and Braces
A4565 Sling
A4570 Splint
A4450 Tape
A6445 Ace Wrap / Elastic Tape cotton/latex
L0120 Cervical Collar (foam)
L0140 Cervical Collar (plastic)
L3650 Clavicle/Shoulder Brace figure 8 design, prefabricate
L0210 Thoracic, rib belt non custom
L0220 Thoracic, rib belt, custom fabricated
L0625 Lumbar support, flexible and prefabricated
L0628 Lumbosacral orthoses, flexible
L3908 Wrist hand orthoses, wrist extension control cock up, prefabricated (includes fitting and adjustment)
L3710 Elbow orthoses elastic with metal joints, prefabricated (includes fitting and adjustment)
L3999 Upper limb orthoses not otherwise specified
L1810 Knee Support elastic with joints prefabricated (includes fitting and adjustment)
L1820 Knee Support elastic with condylar pad and joints with or without patellar control prefabricated (includes fitting and adjustment)
L1902 Ankle Gauntlet prefabricated (includes fitting and adjustment)
L2999 Lower extremity orthoses not otherwise specified

§9070 Supplies and materials (except spectacles), provided by the physician over and above those usually included in the office visit (list or describe specific item)

Modifiers for Durable Medical Equipment
RR = Rental
NU = New
RT = Right
LT = Left
HEALTH INSURANCE LAWS

LATE PAY - 30 Working Days - Health & Safety Code, Section 1371
A health care service plan which covers hospital, medical, or surgical expenses shall reimburse claims or any portion of any claim, whether in state or out of state, for those expenses, as soon as practical, but no later than 30 working days after receipt of claim. (letter)

ASSIGNMENT - YES - California Insurance Code, Section 10133(a)
"Upon written consent of the insured first obtained with respect to a particular claim, any disability insurer shall pay group insurance benefits contingent upon, or for expenses incurred on account of medical or surgical aid, to the person or persons furnishing the hospital or medical or surgical aid..." (letter)

COORDINATION OF BENEFITS - Insurance Code 10270.98
Group policies may require benefits payable subject to reduction if the individual insured has any other Group or Medicare coverage resulting in being eligible for more than 100 percent of the covered expense.

NOT INCLUDING MED PAY BENEFITS - CCR2232.55(d) The language may not include the medical payment benefits customarily included in traditional automobile contracts.

BIRTHDAY RULE - CCR2232.56(2)... the benefits of a plan which covers a dependent person (child) shall be determined by the person whose date of birth, excluding year of birth, occurs earlier in a calendar year.

EQUALITY - Insurance Code 10176
In disability insurance, the policy may provide for payment of medical, chiropractic, physical therapy...expenses upon a reimbursement basis, or for the exclusion of any of these services. No such policy shall prohibit the insured from selecting any person who is the holder of a certificate or license under Section 1000, 1634, 2050...of the B&P Code to perform the particular services covered under the terms of the policy, the certificate holder or licensee being expressly authorized by law to perform those services.

MISREPRESENTATION OF BENEFITS - Insurance Code 790.03
The following is an "unfair and deceptive act or practice" in the business of insurance: (h)(1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverage's at issue. (letter)

MEDICAL RECORDS - Health & Safety Code 123110
(b) Any patient or patient's representative shall be entitled to copies of all or any portion of the patient records which he or she has a right to inspect, upon presenting a written request to the health care provider specifying the records to be copied, together with a fee to defray the cost of copying, which shall not exceed twenty-five cents ($0.25) per page or fifty cents ($0.50) per page for records that are copied from microfilm and any additional reasonable clerical costs incurred in making the records available. The health care provider shall ensure that the copies are transmitted within 15 days after receiving the written request.
California Evidence Code Section 1560-1567

- Not more than $.10 per page for 8.5x14 inches or less
- $.20 per page for microfilm copies
- actual costs for the reproduction of oversize documents or the reproduction of documents requiring special processing which are made in response to a subpoena
- reasonable clerical costs incurred in locating and making the records available to be billed at the maximum rate of twenty-four dollars ($24) per hour per person, computed on the basis of six dollars ($6) per quarter hour or fraction thereof
- actual postage charges

Evidence Code Section 1158

If a patient's attorney requests the medical records:

- Ten cents ($.10) per page for documents 8.5x14 inches or less
- Twenty cents ($.20) per page for document copies from microfilm
- Actual costs for oversize documents or special processing
- Reasonable clerical costs to retrieve records; $4.00 per quarter hour or less
- Actual postage charges

Subpoena's are limited to $15 per hour plus actual costs

Billing codes for record copy

S9981  Record copy fee administrative
S9982  Record copy fee per page fee
MISREPRESENTATION
OF INSURANCE POLICY COVERAGE
CALIFORNIA

Date

Double Standards Insurance Company
1000 Error Highway
Mistaken, CA 90000

Policy #
Dates of Service:

Attention Claims Review:

On October 15, 20XX my office contacted your benefits representative to verify chiropractic coverage on Sally Adam's insurance policy. We were quoted by Ms. Rockenbacher the following coverage's: chiropractic treatment - 80%, physical therapy procedures - 80%, diagnostic tests - 90%, orthotic supports - not covered, a yearly deductible of $200, and the patient was not restricted by a provider list doctor (see enclosed insurance verification form).

Upon receiving this information, we quoted this coverage to our patient, Sally Adams, prior to rendering any services. She was made aware of her out-of-pocket expenses, signed a financial agreement, and as agreed, she has paid her percentage due upon receiving her services with the understanding that you, her carrier, would pay the remaining amount as quoted.

Today, we received a denial of payment/reduced reimbursement payment of only 25% coverage. Upon receiving this information we immediately contact your company to explain the difference in coverage. We were informed that your representative made an error to our office and quoted an incorrect policy benefits. Your company is now denying responsibility to reimburse the amount that was actually quoted to our office on behalf of your insured. Based on this new information, the patient may be placed in a hardship situation by making her responsible to pay more than she was anticipating for these services.

I am requesting that your company take the responsibility for the inaccurate information that was quoted to our office and reimburse the amount that was expected in good faith. Otherwise, we will seek assistance from the Department of Insurance for the violation of the Prohibited Acts & Practices, Section 790.03 (h) (1), of the California Insurance Code.

Sincerely,
John S. Smith
cc: Sally Adams
In a Nebraska case,\(^2\) the carrier contended that it mistakenly paid claims beyond the policy limits. The Court held that the insurance company could not recover the money. If we subjected a hospital to possible refund liability and the insurer later discovers a mistake overpayment, lasting until the statute of limitations expires on all paid claims, we place an undue burden on hospitals. Further, the insurance company is in the best position to know what the policy limits are and must bear the responsibility for their own mistake.

In Texas, Lincoln National Life Insurance mistakenly paid claims after its policy had expired. The Court denied recovery, stating, "Here the insurer knew its own policy payment provisions, but failed to notify the health care provider as to these provisions; and the insurer alone made the mistake of paying beyond its responsibility. The health care provider made no misrepresentations, had no knowledge or notice of the insurer's mistake, extended valuable services based on the assignment of payment by the insured, was not unjustly enriched, and simply had no reason to suspect that any of the payments for services rendered were in error. In the normal course of such business, the hospital has no responsibility to determine if an insurance carrier is properly tendering to its business."\(^3\)

A similar case was decided in 1990 in Mississippi, reaching the same conclusion.\(^4\)

**In conclusion:**

We are faced with this scenario all too often. Although not mentioned in any of these cases, the doctor's staff has usually called or written to the carrier to verify coverage in advance. The request for refund arrives well after the patient has been treated and released.

The full citation to all four cases follows this article. Use them as your shield the next time a carrier says: "We're sorry, but we made a mistake... please send money!"

2. *In Federated Mutual Insurance Company vs. Good Samaritan Hospital* (Neb. 1974) 214 N.W. 2d 493.

Mr. Calton's law practice is located in Laguna Niguel, California, and is concentrated in the field of health care law, representing health care providers in their practices, in litigation, and before administration licensing agencies throughout the country. For further information, please call Mr. Calton at (949) 495-3350.
INSURANCE COMPANY REQUESTING
REFUND ON OVERPAYMENT

Note this is not applicable to Medicare, Workers' Compensation, and Managed Care

Date

Blue Shaft Insurance Co.
P.O. Box 90009
Los Angeles, CA 90000

Re: Sally Adams
Claim # 44-8980
Dates of Service: (dates)

Dear Sirs:

On (date), we received a letter from your company requesting that we refund the amount of $276.00 to Blue Shaft for a payment that was made in error (beyond policy limits) back in (date).

First of all, I reviewed Ms. Adams records and I do not show that we have an overpayment resulting in a credit on her account.

Secondly, I do not feel that you have the right to place this burden upon my office by asking us to correct your error, chase down this past patient and ask her to make additional payment to our office for a new balance that simply appeared out of nowhere!

I would like to bring to your attention the cases of: In Federated Mutual Insurance Company vs. Good Samaritan Hospital, (Neb.1974) 214 N.W.2d 493, where the court held that the insurance company could not recover the mistaken overpayment and determined that "the insurance company is in the best position to know what the policy limits are and must bear the responsibility for their own mistake." As well as, The City of Hope National Center vs. Western Life Insurance Company, 2 Daily Journal D.A.R. 10728, Decided July 31, 1992, where the court held that, in the absence of fraud, a health care provider is not legally obligated to refund payments it receives from an insurer if the insurer subsequently determines that they were paid in error.

Based on these and other court decisions, I will not be sending your company a refund for $276.00 for the erroneous reimbursement payment you are claiming as due.

Sincerely,
John C. Smith, DC
HEALTH CARE PROVIDER REQUEST FOR ASSISTANCE (HPRFA)

Patient’s Name

Provider/Facility Name

Provider’s Address

City Zip

Provider Contact Name (Last, First)

Phone Number

Providers may submit complaints for services rendered on or after January 1, 2006. Before you file for a case review with the Department of Insurance, you must first exhaust the Dispute Resolution (DR) process with the insurance company. You must allow the insurer up to 60 calendar days to complete their review or send you a written determination, whichever period is shorter. If you submit a complaint to the Department without going through the dispute resolution process first, the Department will not be able to conduct a case review.

To ensure proper review of the case, a copy of the completed Health Care Provider Request for Assistance form and other documentation submitted by you will be provided to the insurance company, agent or the broker.

1. Complete name of insurance company involved: ____________________________

2. Type of Insurance: Individual Health ☐ Group Health ☐

3. Do you have an existing contract with the insurance company? Yes ☐ (Provide copy) No ☐

4. Primary policyholder’s name if different than the patient: ____________________________

Claim Number: ____________________________ Policy/Certificate/ID Number: ____________________________

Group Name: ____________________________ Group Number: ____________________________

Date(s) of Medical Service(s) Provided: ____________________________

CPT Codes: ____________________________

5. Does the complaint concern the payment of a specific claim? Yes ☐ No ☐

If yes, provide: Billed Amount $ _____ Paid Amount $ _____ Amount in Dispute $ _____

6. Have you contacted the insurance company and exhausted the Dispute Resolution Process? Yes ☐ (Provide copies of all correspondence) No ☐
7. Have you reported this to any other governmental agency? Yes ☐ No ☐
   Name of agency: ___________________________ File number, if known: ___________________________

8. Have you previously written to the Department of Insurance about this matter?
   Yes ☐ No ☐ File number (if available) __________________________

9. Is there attorney representation in this matter? Yes ☐ No ☐

10. Has a lawsuit been filed? Yes ☐ No ☐ If yes, our ability to mediate this matter is limited, but we will investigate your inquiry for any regulatory issues. We may defer the regulatory investigation until the finality of the litigation. We ask that you still complete this form so we have a record of your issue. Once the matter is concluded, we would welcome any information regarding violations of law by the insurer that you or your attorney are willing to provide.

11. Briefly describe the disputed issue. Use additional paper as needed.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

The following documents must accompany this form. Failure to provide all or any part of the information requested may preclude or delay the Consumer Services Division of the Department of Insurance from reviewing your complaint.

☐ Copy of the patient’s (signed) Assignment of Benefits, if applicable

☐ Copy of claim forms submitted to the insurance company (UB 92, HCFA 1500, etc.)

☐ Copies of all correspondence between the provider and the insurance company, including all related EOBs

☐ Copy of the Dispute Resolution Process determination letter

☐ Copy of the patient’s insurance identification card – both sides

☐ Copy of the provider’s contract with the insurance company, if any

_________________________________________  ___________________________
Provider’s Signature                          Date
Cash Discounts

- B&P 657
- Not a cash discount as much as it is a no insurance discount
- No insurance reimbursement is expected
- Discounted fee cannot be used by insurance as UCR

Pre-Pay Plans

- Are they legal?
- Make a clear contract that patient signs and understands
- Patient must be afforded refunds for unused services

- Department of Managed Health Care
  Office of Health Plan Oversight
  980 9th Street, Suite 500
  Sacramento, CA 95814-2725
(a) The Legislature finds and declares all of the following:

(1) Californians spend more than one hundred billion dollars ($100,000,000,000) annually on health care.

(2) In 1994, an estimated 6.6 million of California's 32 million residents did not have any health insurance and were ineligible for Medi-Cal.

(3) Many of California's uninsured cannot afford basic, preventative health care resulting in these residents relying on emergency rooms for urgent health care, thus driving up health care costs.

(4) Health care should be affordable and accessible to all Californians.

(5) The public interest dictates that uninsured Californians have access to basic, preventative health care at affordable prices.

(b) To encourage the prompt payment of health or medical care claims, health care providers are hereby expressly authorized to grant discounts in health or medical care claims when payment is made promptly within time limits prescribed by the health care providers or institutions rendering the service or treatment.

(c) Notwithstanding any provision in any health care service plan contract or insurance contract to the contrary, health care providers are hereby expressly authorized to grant discounts for health or medical care provided to any patient the health care provider has reasonable cause to believe is not eligible for, or is not entitled to, insurance reimbursement, coverage under the Medi-Cal program, or coverage by a health care service plan for the health or medical care provided. Any discounted fee granted pursuant to this section shall not be deemed to be the health care provider's usual, customary, or reasonable fee for any other purposes, including, but not limited to, any health care service plan contract or insurance contract.

(d) "Health care provider," as used in this section, means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.
Pre-Paid Plans

In response to inquiries regarding use of pre-paid plans in chiropractic offices as a method of payment for services, the following information is provided:

- As a general rule, any pre-paid plan which involves the assumption of a risk may be the business of insurance. Persons or organizations intending to offer any pre-paid plan, whether for a certain number of visits or a certain period of time may be required to conform with the provisions of the Insurance Code and Health & Safety Code.

- Prior to instituting such a program, licensees must contact the following agencies for additional information and provide a detailed description of the proposed plan:

  Department of Managed Health Care  
  Office of Health Plan Oversight  
  980 9th Street, Suite 500  
  Sacramento, CA 95814-2725

- Licensees are hereby notified that any attempt to implement a pre-paid plan without first obtaining an opinion regarding that plan from the Department of Managed Health Care may be in violation of provisions of the Insurance and Health & Safety Codes and, therefore, subject to discipline for unprofessional conduct.

- Licensees who advocate or teach methods of using pre-paid plans without following and disseminating the above guidelines will be considered to have acted in an unprofessional manner and may be subject to disciplinary action.

(Rev. 8/04)
FINANCIAL HARDSHIP PAYMENT AGREEMENT

DATE_____________________

PATIENT NAME_____________________

DOCTOR NAME_____________________

I hereby certify that I have been informed of the usual fees for the examination, testing and treatment that have been recommended. I am unable to pay those fees at this time without substantial financial hardship and peril. I have no expectation of being able to recover those expenses from any third party or insurance benefit.

To enable me to obtain the recommended services Dr_____________________
and I have agreed to a special payment arrangement under which I will pay $________ each visit.

It is my responsibility to make these payments without any need for periodic bills or other reminders of payments due.

Patient Signature ___________________________ Witness Signature ___________________________

Print Name ___________________________ Print Name ___________________________
According to the Office of the Inspector General, 94% of claims submitted by chiropractors are missing required elements in the documentation with a detailed breakdown as follows:

<table>
<thead>
<tr>
<th>Element</th>
<th>Percentage of Documentation Errors by Chiropractors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation:</td>
<td>Improper PART or missing 34%</td>
</tr>
<tr>
<td>Diagnosis:</td>
<td>Improper or missing 33% (29% no diagnosis 4% no subluxation)</td>
</tr>
<tr>
<td>Treatment plan:</td>
<td>Insufficient 83% (missing goals and objective measures)</td>
</tr>
<tr>
<td>Medical necessity:</td>
<td>Not shown or miscoded 67%</td>
</tr>
<tr>
<td>Contraindications:</td>
<td>Not checked 66%</td>
</tr>
</tbody>
</table>

Rumor: If you are a non-participating provider (non-par), you do not have to worry about billing Medicare.

Truth: Being non-par does not exempt you from having to bill Medicare. ALL Medicare-covered services must be billed to Medicare or the provider could face penalties.

Rumor: If you are a non-par provider, you will never be audited or have claims reviewed.

Truth: Any Medicare claim submitted can be audited/reviewed despite provider status. The status of the physician does not affect the probability of this occurring.

Rumor: Non-par providers do not have the same documentation requirements as par providers.

Truth: Chiropractic care has documentation requirements to show medical necessity. The participation status of the provider is irrelevant.

Rumor: You can ‘opt out’ of Medicare.

Truth: Opting out is NOT an option for Doctors of Chiropractic. If you treat Medicare patients, you must register as ‘participating’ or ‘non-participating’. If you don’t want to deal with Medicare, then don’t treat Medicare patients. It is illegal to treat Medicare patients and not submit a claim.
## California
### 2011 Chiropractic Fee Schedule

**Locality 03** - Marin, Napa, Solano

**Locality 05** - San Francisco

**Locality 06** - San Mateo

**Locality 07** - Alameda, Contra Costa

**Locality 09** - Santa Clara

**Locality 99** - Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Nevada, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Joaquin, Santa Cruz, Shasta, Sierra, Siskiyou, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba

<table>
<thead>
<tr>
<th>LOC</th>
<th>PROCEDURE</th>
<th>PAR AMT</th>
<th>NON PAR AMOUNT</th>
<th>LIMITING CHARGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>98940</td>
<td>$28.05</td>
<td>$26.65</td>
<td>$30.65</td>
</tr>
<tr>
<td>3</td>
<td>98941</td>
<td>$38.24</td>
<td>$36.33</td>
<td>$41.78</td>
</tr>
<tr>
<td>3</td>
<td>98942</td>
<td>$49.26</td>
<td>$46.80</td>
<td>$53.82</td>
</tr>
<tr>
<td>5</td>
<td>98940</td>
<td>$29.84</td>
<td>$28.35</td>
<td>$32.60</td>
</tr>
<tr>
<td>5</td>
<td>98941</td>
<td>$40.56</td>
<td>$38.53</td>
<td>$44.31</td>
</tr>
<tr>
<td>5</td>
<td>98942</td>
<td>$52.15</td>
<td>$49.54</td>
<td>$56.97</td>
</tr>
<tr>
<td>6</td>
<td>98940</td>
<td>$29.91</td>
<td>$28.41</td>
<td>$32.67</td>
</tr>
<tr>
<td>6</td>
<td>98941</td>
<td>$40.65</td>
<td>$38.62</td>
<td>$44.41</td>
</tr>
<tr>
<td>6</td>
<td>98942</td>
<td>$52.28</td>
<td>$49.67</td>
<td>$57.12</td>
</tr>
<tr>
<td>7</td>
<td>98940</td>
<td>$28.38</td>
<td>$26.96</td>
<td>$31.00</td>
</tr>
<tr>
<td>7</td>
<td>98941</td>
<td>$38.72</td>
<td>$36.78</td>
<td>$42.30</td>
</tr>
<tr>
<td>7</td>
<td>98942</td>
<td>$49.87</td>
<td>$47.38</td>
<td>$54.49</td>
</tr>
<tr>
<td>9</td>
<td>98940</td>
<td>$28.98</td>
<td>$27.53</td>
<td>$31.66</td>
</tr>
<tr>
<td>9</td>
<td>98941</td>
<td>$39.52</td>
<td>$37.54</td>
<td>$43.17</td>
</tr>
<tr>
<td>9</td>
<td>98942</td>
<td>$50.92</td>
<td>$48.37</td>
<td>$55.63</td>
</tr>
<tr>
<td>99</td>
<td>98940</td>
<td>$25.81</td>
<td>$24.52</td>
<td>$28.20</td>
</tr>
<tr>
<td>99</td>
<td>98941</td>
<td>$35.46</td>
<td>$33.69</td>
<td>$38.74</td>
</tr>
<tr>
<td>99</td>
<td>98942</td>
<td>$45.77</td>
<td>$43.48</td>
<td>$50.00</td>
</tr>
<tr>
<td>LOC</td>
<td>PROCEDURE</td>
<td>PAR AMT</td>
<td>NON PAR AMOUNT</td>
<td>LIMITING CHARGE</td>
</tr>
<tr>
<td>-----</td>
<td>-----------</td>
<td>---------</td>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>17</td>
<td>98940</td>
<td>27.74</td>
<td>26.35</td>
<td>30.30</td>
</tr>
<tr>
<td>17</td>
<td>98941</td>
<td>37.98</td>
<td>36.08</td>
<td>41.49</td>
</tr>
<tr>
<td>17</td>
<td>98942</td>
<td>48.85</td>
<td>46.41</td>
<td>53.37</td>
</tr>
<tr>
<td>18</td>
<td>98940</td>
<td>27.59</td>
<td>26.21</td>
<td>30.14</td>
</tr>
<tr>
<td>18</td>
<td>98941</td>
<td>37.83</td>
<td>35.94</td>
<td>41.33</td>
</tr>
<tr>
<td>18</td>
<td>98942</td>
<td>48.70</td>
<td>46.27</td>
<td>53.21</td>
</tr>
<tr>
<td>26</td>
<td>98940</td>
<td>28.09</td>
<td>26.69</td>
<td>30.69</td>
</tr>
<tr>
<td>26</td>
<td>98941</td>
<td>38.47</td>
<td>36.55</td>
<td>42.03</td>
</tr>
<tr>
<td>26</td>
<td>98942</td>
<td>49.46</td>
<td>46.99</td>
<td>54.04</td>
</tr>
<tr>
<td>99</td>
<td>98940</td>
<td>25.81</td>
<td>24.52</td>
<td>28.20</td>
</tr>
<tr>
<td>99</td>
<td>98941</td>
<td>35.46</td>
<td>33.69</td>
<td>38.74</td>
</tr>
<tr>
<td>99</td>
<td>98942</td>
<td>45.77</td>
<td>43.43</td>
<td>50.00</td>
</tr>
</tbody>
</table>
CALIFORNIA ADVANCED MEDICARE 2011

FILING A MEDICARE CLAIM

1. All claims to Medicare must be sent within one year from the date of service. If claim is denied you have 120 days to respond from the date of the denial.
2. Medicare deductible $162
3. Diagnoses: Subluxation must be the primary code

ICD-9 Codes for reporting subluxation Palmetto:

739.0 Occiptiocervical Region
739.1 Cervical Region
739.2 Thoracic Region
739.3 Lumbar Region
739.4 Sacral Region
739.5 Pelvic Region

4. Secondary Diagnosis must support the primary

The patient must have a significant health problem in the form of a neuromusculoskeletal condition (Secondary diagnosis) necessitating treatment. The manual manipulative treatment must have a direct therapeutic relationship to the patient’s condition and provide reasonable expectation of recovery or improvement of function (Palmetto Chiropractic Billing Guide). In addition Medicare has identified “complicating factor” diagnoses. These conditions, by themselves, would normally not be considered a need for care but when another injury or disease is superimposed it will cause regression or retard recovery of an acute or chronic condition.
Secondary ICD-9-CM Codes

Category I - ICD-9-CM Diagnosis (diagnoses that generally require short term treatment):

307.81 TENSION HEADACHE
718.48 CONTRACTURE OF JOINT OF OTHER SPECIFIED SITES
721.0 CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY
721.2 THORACIC SPONDYLOSIS WITHOUT MYELOPATHY
721.3 LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY
721.6 ANKYLOSING VERTEBRAL HYPEROSTOSIS
721.90 SPONDYLOSIS OF UNSPECIFIED SITE WITHOUT MYELOPATHY
721.91 SPONDYLOSIS OF UNSPECIFIED SITE WITH MYELOPATHY
723.1 CERVICALGIA
724.1 PAIN IN THORACIC SPINE
724.2 LUMBAGO
724.5 BACKACHE UNSPECIFIED
784.0 HEADACHE

Category II - ICD-9-Cm Diagnosis (diagnoses that generally require moderate term treatment):

353.0 BRACHIAL PLEXUS LESIONS
353.1 LUMBOSACRAL PLEXUS LESIONS
353.2 CERVICAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.3 THORACIC ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.4 LUMBOSACRAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.8 OTHER NERVE ROOT AND PLEXUS DISORDERS
719.48 PAIN IN JOINT INVOLVING OTHER SPECIFIED SITES
720.1 SPINAL ENTHESOPATHY
722.91 OTHER AND UNSPECIFIED DISC DISORDER OF CERVICAL REGION
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>722.92</td>
<td>OTHER AND UNSPECIFIED DISC DISORDER OF THORACIC REGION</td>
</tr>
<tr>
<td>722.93</td>
<td>OTHER AND UNSPECIFIED DISC DISORDER OF LUMBAR REGION</td>
</tr>
<tr>
<td>723.0</td>
<td>SPINAL STENOSIS IN CERVICAL REGION</td>
</tr>
<tr>
<td>723.2</td>
<td>CERVICOCRANIAL SYNDROME</td>
</tr>
<tr>
<td>723.3</td>
<td>CERVICOBRAHIAL SYNDROME (DIFFUSE)</td>
</tr>
<tr>
<td>723.4</td>
<td>BRACHIAL NEURITIS OR RADICULITIS NOS</td>
</tr>
<tr>
<td>723.5</td>
<td>TORTICOLLIS UNSPECIFIED</td>
</tr>
<tr>
<td>724.01</td>
<td>SPINAL STENOSIS OF THORACIC REGION</td>
</tr>
<tr>
<td>724.02</td>
<td>SPINAL STENOSIS, LUMBAR REGION, WITHOUT NEUROGENIC CLAUDICATION</td>
</tr>
<tr>
<td>724.03</td>
<td>SPINAL STENOSIS, LUMBAR REGION, WITH NEUROGENIC CLAUDICATION</td>
</tr>
<tr>
<td>724.4</td>
<td>THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED</td>
</tr>
<tr>
<td>724.6</td>
<td>DISORDERS OF SACRUM</td>
</tr>
<tr>
<td>724.79</td>
<td>OTHER DISORDERS OF COCCYX</td>
</tr>
<tr>
<td>724.8</td>
<td>OTHER SYMPTOMS REFERABLE TO BACK</td>
</tr>
<tr>
<td>729.1</td>
<td>MYALGIA AND MYOSITIS UNSPECIFIED</td>
</tr>
<tr>
<td>729.4</td>
<td>FASCIITIS UNSPECIFIED</td>
</tr>
<tr>
<td>738.4</td>
<td>ACQUIRED SPONDYLOLISTHESIS</td>
</tr>
<tr>
<td>756.12</td>
<td>SPONDYLOLISTHESIS CONGENITAL</td>
</tr>
<tr>
<td>846.0</td>
<td>LUMBOSACRAL (JOINT) (LIGAMENT) SPRAIN</td>
</tr>
<tr>
<td>846.1</td>
<td>SACROILIAC (LIGAMENT) SPRAIN</td>
</tr>
<tr>
<td>846.2</td>
<td>SACROSPINATUS (LIGAMENT) SPRAIN</td>
</tr>
<tr>
<td>846.3</td>
<td>SACROTUBEROUS (LIGAMENT) SPRAIN</td>
</tr>
<tr>
<td>846.8</td>
<td>OTHER SPECIFIED SITES OF SACROILIAC REGION SPRAIN</td>
</tr>
<tr>
<td>847.0</td>
<td>NECK SPRAIN</td>
</tr>
<tr>
<td>847.1</td>
<td>THORACIC SPRAIN</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>847.2</td>
<td>LUMBAR SPRAIN</td>
</tr>
<tr>
<td>847.3</td>
<td>SPRAIN OF SACRUM</td>
</tr>
<tr>
<td>847.4</td>
<td>SPRAIN OF COCCYX</td>
</tr>
</tbody>
</table>

**Category III - ICD-9-CM Diagnosis (diagnoses that may require long term treatment):**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>721.7</td>
<td>TRAUMATIC SPONDYLOPATHY</td>
</tr>
<tr>
<td>722.0</td>
<td>DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY</td>
</tr>
<tr>
<td>722.10</td>
<td>DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY</td>
</tr>
<tr>
<td>722.11</td>
<td>DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC WITHOUT MYELOPATHY</td>
</tr>
<tr>
<td>722.4</td>
<td>DEGENERATION OF CERVICAL INTERVERTEBRAL DISC</td>
</tr>
<tr>
<td>722.51</td>
<td>DEGENERATION OF THORACIC OR THORACOLUMBAR INTERVERTEBRAL DISC</td>
</tr>
<tr>
<td>722.52</td>
<td>DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC</td>
</tr>
<tr>
<td>722.6</td>
<td>DEGENERATION OF INTERVERTEBRAL DISC SITE UNSPECIFIED</td>
</tr>
<tr>
<td>722.81</td>
<td>POSTLAMINECTOMY SYNDROME OF CERVICAL REGION</td>
</tr>
<tr>
<td>722.82</td>
<td>POSTLAMINECTOMY SYNDROME OF THORACIC REGION</td>
</tr>
<tr>
<td>722.83</td>
<td>POSTLAMINECTOMY SYNDROME OF LUMBAR REGION</td>
</tr>
<tr>
<td>724.3</td>
<td>SCIATICA</td>
</tr>
</tbody>
</table>

Use of any code as a secondary other than the listed codes here will result in an automatic denial for chiropractic services for Medical necessity.
MEDICARE MODIFIERS

-AT

All chiropractic claims submitted to Medicare must have the modifier AT appended to the manipulation code (98940- AT) to indicate that services are deemed by the provider as medically necessary. If you do not add this modifier, your care will automatically be considered maintenance and will be denied. The use of the AT does not guarantee that Medicare will automatically consider care as medically necessary.

-GY

All services other than spinal manipulation when billed to Medicare should have modifier GY. (99213-GY, 97124-GY).

Chiropractic physicians are not required to bill Medicare for excluded services unless billing for a denial to submit to a secondary carrier.

-GX

This modifier may be added to an excluded service to indicate the patient has signed a waiver understanding that the services are not covered by Medicare and their responsibility. This modifier may be used in lieu of GY when a waiver was signed.

Using modifier GY or GX will afford the same response from Medicare – patient responsibility for those specific services.

-GP Modifier

GP is appended to physical medicine services when part of a physical therapy plan of care. This is not a requirement when physical medicine services are done by a chiropractor.
When it is determined that manipulation will be or is likely to be denied the patient must be informed prior to receiving the service, by having the patient sign and read the Advanced Beneficiary Notice (ABN. Once this has been done those services should be billed with the Modifier GA (98941-GA) which indicates that the form has been signed and is on file in the patient’s chart. If Medicare denies for medical necessity this modifier will ensure patient responsibility is given on the EOB so that the secondary insurance or patient will be liable for payment.

The GA modifier is necessary to ensure patient responsibility on the explanation of benefits (EOB) and allow payment by the secondary insurance. Without patient responsibility on the EOB the secondary insurance will deny reimbursement and the patient may not be billed for that service.

What if the doctor believes it is medically necessary but not sure Medicare will allow the amount of services

Often the provider may determine that care is medically necessary but may feel Medicare may not. In that instance the provider would have the patient sign an ABN and would bill the CMT code with both modifiers. 98940 ATGA This cannot be done as a blanket for all dates but likely only a few dates when the provider is unsure of what Medicare may decide.
ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn’t pay for (D) spinal manipulative therapy, 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) spinal manipulative therapy below.

<table>
<thead>
<tr>
<th>(D) Spinal Manipulation</th>
<th>(E) Reason Medicare May Not Pay:</th>
<th>(F) Estimated Cost:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal Manipulative therapy beginning on January 15, 2011 and extending to February 15, 2011 at 2 visits per week.</td>
<td>Medicare generally considers treatments above 18 for this diagnosis as maintenance.</td>
<td>$37.07 per visit For a total of 8 visits $296.56</td>
</tr>
</tbody>
</table>

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) spinal manipulative therapy 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) spinal manipulative therapy 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) spinal manipulative therapy 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) spinal manipulative therapy listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature: 

(J) Date:

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 09380566. 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 (03/08) 

Form Approved OMB 49-938-0566
5. Claim form must be completed and conform to Medicare standards
   (not the same format as a claim form for health insurance)

**BILLING AND APPEALS ADDRESSES**

<table>
<thead>
<tr>
<th>Claims</th>
<th>General Correspondence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palmetto GBA</td>
<td>Palmetto GBA</td>
</tr>
<tr>
<td>P.O. Box 1051</td>
<td>P.O. Box 1091</td>
</tr>
<tr>
<td>Augusta, GA 30903-1051</td>
<td>Augusta, GA 30903-1091</td>
</tr>
<tr>
<td></td>
<td>Fax: (803) 462-3912</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Review</th>
<th>Provider Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palmetto GBA</td>
<td>Palmetto GBA</td>
</tr>
<tr>
<td>P.O. Box 1476</td>
<td>P.O. Box 1667</td>
</tr>
<tr>
<td>Augusta, GA 30903-1476</td>
<td>Augusta, GA 30903-1508</td>
</tr>
<tr>
<td>Fax: (803) 462-3918</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Redeterminations</th>
<th>Physical Address for Fed Ex and similar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palmetto GBA</td>
<td>Palmetto GBA</td>
</tr>
<tr>
<td>P.O. Box 1252</td>
<td>2743 Perimeter Parkway</td>
</tr>
<tr>
<td>Augusta, GA 30903-1252</td>
<td>Building 200, 2\textsuperscript{nd} Floor</td>
</tr>
<tr>
<td>Fax: (803) 462-3914</td>
<td>Augusta, GA 30909</td>
</tr>
</tbody>
</table>

Department IVR (Interactive Voice Response) 9/2/08 866-931-3903 open 24 x 7

Customer Service Representatives 866-931-3901 and 931-3906
7 am – 5:00 pm (PST)

TTY (Teletypewriter – for the hearing impaired) 9/2/08 866-931-3902
7 am - 5 pm (PST)

Palmetto GBA EDI Technology Support Center (TSC) at (866) 749-4301
8 am – 5 pm (PST)

www.palmettogba.com
Examples of daily note for Medicare

Patient 1

Date of Service
S: Patient reports continued pain (5/10 VAS) in lower back with some ROM improvement.

O: Lumbar paraspinal muscle rigidity and tenderness unchanged. Hypomobility and tenderness L3, 4, 5

A: No changes since last but overall improving

P: CMT to L3, 4, 5 per treatment plan. Patient is mildly improved and will continue with treatment protocol. Instructed on home stretches for hamstrings and knee to chest. Return in 3 days.

Dr Signature

Patient 2

S: Pt states LBP better by 2/3 and easier to get in/out car and sitting. Patient sleeping better. VAS now 5/10 was 8/10 prior to last visit.

O: L/S flexion 60°/90°. SLR + @50° bilaterally with decreased pain. Muscle spasm +2 lumbar spine, Motion palpation fixation at L4/5 and left SI on internal and external rotation

A: Decreasing per treatment plan

P: CMT: Lumbar 4-5, Left SI
Therapy 8 min US-EMS combo lumbar spine and SI joints bilaterally
Next appointment Friday

Dr Signature
Patient: John Adams  DOB: 3-7-1930  Date: 1-3-2011

**S:** Pain level today 6/10  
General pain level 6/10

Review of chief complaint (include changes from last visit)

**Neck pain bilaterally but less intense**

Pain is -Less intense overall & improves markedly post treatment. Still stiffer in the AM but as he warms up it ↓

**ADL changes- ROM is much better he can turn his head to back up his car and sleep more comfortably**

**O:** Exam of spine region involved in diagnosis

**P:** Tenderness C2, 3, 4 spinous

**A:**

**R:** Cervical flexion hypomobility C2, 3, 4

**T:**

**ROM** Cervical - Flex- 55/90  Ext 50/75 LRot 70/90 RRot 60/70 LLB 60/80 RLB 50/80

ROM smoother and less halting but + for end point pain

**Muscle spasm/tenderness & other palpatory findings**

2+ spasm and tenderness cervical paraspinal muscles. Pt notes more intense R side

**Ortho Tests**

**Compression 2+ pain radiating to left shoulder**

**Other**

**A:** Assessment of change since last visit & overall treatment effectiveness

**Pt is responding as expected**

Subluxation Dx: 739.1

Secondary Dx: 720.1

**P:** Treatment performed

Spinal manipulation (indicate specific vertebrae) **Diversified manipulation C2, 3, 4**

Physical medicine

**Massage cervical paraspinal muscles 17 minutes**

Changes to treatment plan, if any **Continue 2x week for 2 weeks increase home stretches 2x day**

Dr. Signature  Dr James Chiropractor
- **Ranges of Motion**
  - AROM or PROM: Degrees of motion

- **Motion Palpation:**
  - Fixed
  - Hypomobile
  - Normal
  - Hypermobile

**Grading Muscle Tenderness**
- +1 Tenderness with no grimace
- +2 Tenderness with grimace
- +3 Tenderness with flinch (Jump Sign)
- +4 Superficial causes withdrawal

**Grading Muscle Spasm**
- +1 Increased tone but no change in motion
- +2 Spasm with changes in motion (Halting)
- +3 Spasm that restricts and changes motion
- +4 Spasm with complete restriction (Splinting)

**Orthopedic Testing**
- Correlate to diagnosis
  - Do not fall into the trap of multiple testing that does not fit the diagnoses

- Reference Measurements
  - SLR + @ 40 degrees with moderate pain at L4-5 and R SI joint
  - Foraminal compression + bilaterally with moderate pain and tingling to right hand
**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 –

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
<td>TO FUNCTION</td>
<td>COMPLETELY ABLE</td>
</tr>
</tbody>
</table>

Patient Name __________________________ Date __________

Score _____ [50] Benchmark = 5 _____

55
LOW BACK PAIN AND DISABILITY QUESTIONNAIRE
(Roland-Morris)

NAME_________________________ DATE__________________________

AGE_______ SCORE________________

When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

1. □ I stay at home most of the time because of my back.
2. □ I walk more slowly than usual because of my back.
3. □ Because of my back, I am not doing any jobs that I usually do around the house.
4. □ Because of my back, I use a handrail to get upstairs.
5. □ Because of my back, I lie down to rest more often.
6. □ Because of my back, I have to hold onto something to get out of an easy chair.
7. □ Because of my back, I try to get other people to do things for me.
8. □ I get dressed more slowly than usual because of my back.
9. □ I stand up only for short periods of time because of my back.
10. □ Because of my back, I try not to bend or kneel down.
11. □ I find it difficult to get out of a chair because of my back.
12. □ My back or leg is painful almost all of the time.
13. □ I find it difficult to turn over in bed because of my back.
14. □ I have trouble putting on my socks (or stockings) because of pain in my back.
15. □ I sleep less well because of my back.
16. □ I avoid heavy jobs around the house because of my back.
17. □ Because of back pain, I am more irritable and bad tempered with people than usual.
18. □ Because of my back, I go upstairs more slowly than usual.

# The Lower Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.

**Today, do you or would you have any difficulty at all with:**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Extreme Difficulty or Unable to Perform Activity</th>
<th>Quite a Bit of Difficulty</th>
<th>Moderate Difficulty</th>
<th>A Little Bit of Difficulty</th>
<th>No Difficulty</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Any of your usual work, housework, or school activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Your usual hobbies, recreational or sporting activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Getting into or out of the bath.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Walking between rooms.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Putting on your shoes or socks.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Squatting.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Lifting an object, like a bag of groceries from the floor.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Performing light activities around your home.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. Performing heavy activities around your home.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. Getting into or out of a car.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. Walking 2 blocks.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. Walking a mile.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. Going up or down 10 stairs (about 1 flight of stairs).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. Standing for 1 hour.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. Sitting for 1 hour.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. Running on even ground.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. Running on uneven ground.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. Making sharp turns while running fast.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. Hopping.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. Rolling over in bed.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**Column Totals:**

Minimum Level of Detectable Change (90% Confidence): 9 points

**SCORE: _____ / 80**

Please submit the sum of responses to ASH

SCORING METHOD FOR LOWER EXTREMITY FUNCTIONAL SCALE

The Lower Extremity Functional Scale (LEFS) is an easily administered and scored functional outcome tool. It can be utilized for lower extremity conditions and is sensitive enough for a wide range of functional disability levels. It can and should be used on the initial visit and subsequently on a 2-4 week basis to measure patient's progress. The tool has a sufficient measure of reliability, variability, and sensitivity to change for determining minimally clinically important score differences, on a test to re-test basis.

Scoring

LEFS is scored by adding of all responses (one answer per section) and compared to a total possible score of 80.

\[
(Score = \frac{\text{sum of responses}}{80}) \times 100
\]

Error + / - 5 points; therefore test score is within 5 points of a patient's "true" score.

Minimum detectable change (MDC) is 9 points; or, a change of more than 9 points on the LEFS represents a true change in the patient's level of function.
**Tinetti Assessment Tool: Balance**

<table>
<thead>
<tr>
<th>Task</th>
<th>Description of Balance</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Sitting balance:</strong></td>
<td>Leans or slides in chair</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Steady, safe</td>
<td>1</td>
</tr>
<tr>
<td><strong>2. Arises:</strong></td>
<td>Unable without help</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Able, uses arms to help</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Able without using arms</td>
<td>2</td>
</tr>
<tr>
<td><strong>3. Attempts to arise:</strong></td>
<td>Unable without help</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Able, requires &gt;1 attempt</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Able to arise, 1 attempt</td>
<td>2</td>
</tr>
<tr>
<td><strong>4. Immediate standing balance</strong> (first five seconds):</td>
<td>Unsteady (swaggers, moves feet, trunk sway)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Steady but uses walker or other support</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Steady without walker or other support</td>
<td>2</td>
</tr>
<tr>
<td><strong>5. Standing balance</strong></td>
<td>Unsteady</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Steady but wide stance (medial heels &gt;4 in. apart) and uses cane or other support</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Narrow stance without support</td>
<td>2</td>
</tr>
<tr>
<td><strong>6. Nudged</strong></td>
<td>(subject at maximum position with feet as close together as possible, examiner pushes lightly on subject's sternum with palm of hand 3 times):</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Begins to fall</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Staggers, grabs, catches self</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Steady</td>
<td></td>
</tr>
<tr>
<td><strong>7. Eyes Closed</strong></td>
<td>(at maximum position No. 6)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Unsteady</td>
<td>1</td>
</tr>
<tr>
<td><strong>8. Turning 360 degrees</strong></td>
<td>Discontinuous Steps</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Continuous</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Unsteady (grabs, stagers)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Steady</td>
<td>1</td>
</tr>
<tr>
<td><strong>9. Sitting down</strong></td>
<td>Unsafe (misjudges distance, falls into chair)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Uses arms or not a smooth motion</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Safe, smooth motion</td>
<td>2</td>
</tr>
</tbody>
</table>

**Balance Score:** 16/16

*Source: The Journal of the American Geriatric Society by Carole Lewis Ph.D, PT*
Functional Capacity Examination

Patients need clear goals to change behavior. All insurance payers also want to see a clearly expressed goal of care. Alongside identification of activity intolerances from functional questionnaires (e.g. Oswestry), examination of physical capacity deficits provides objective, quantifiable data from which realistic end points or goals of care can be established.

When to Perform Physical Capacity Tests - The Indications

When should a physical capacity evaluation be performed? As soon as the patient is out of the acute pain phase. In fact, this is when the goal of care transitions from pain relief to functional restoration and these tests are important for establishing such goals clearly. These give clear documentation of functional performance and will allow easy documentation of progress and necessity of care.

How to Perform Physical Capacity Tests

1. Repetitive Squat

Patient position: The patient stands with feet shoulder-width apart.

Technique: The patient squats until thighs are horizontal and returns to upright position. Each repetition rate is 1/2-3 seconds. Repeat to maximum.

Observe: Count number of repetitions (max. 50).

The normative data for dynamic squatting endurance is segregated by age, sex and occupation are in the table below.

<table>
<thead>
<tr>
<th>Age</th>
<th>MALES (n=242)</th>
<th>FEMALES (n=233)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Blue Collar</td>
<td>White Collar</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>SD</td>
</tr>
<tr>
<td>35-39</td>
<td>39</td>
<td>13</td>
</tr>
<tr>
<td>40-44</td>
<td>34</td>
<td>14</td>
</tr>
<tr>
<td>45-49</td>
<td>30</td>
<td>12</td>
</tr>
<tr>
<td>50-54</td>
<td>28</td>
<td>14</td>
</tr>
<tr>
<td>35-54</td>
<td>33</td>
<td>14</td>
</tr>
</tbody>
</table>

X = AVERAGE
SD = Standard deviation
Note: The last row represents the average of all the ages (35-54).
2. Repetitive Sit-up

Patient position: The patient is supine, knees flexed 90 and ankles fixed.

Technique: Patient sits up until touching the thenar-hand to patella, and curls back down to the supine position.

Observe: Count number of repetitions (max. 50).

The normative data for dynamic trunk flexor endurance segregated by age, sex and occupation are in table below.

<table>
<thead>
<tr>
<th>AGE</th>
<th>MALES (n=243)</th>
<th>FEMALES (n=233)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Blue Collar</td>
<td>White Collar</td>
</tr>
<tr>
<td></td>
<td>x  SD</td>
<td>x  SD</td>
</tr>
<tr>
<td>35-39</td>
<td>29 13</td>
<td>35 13</td>
</tr>
<tr>
<td>40-44</td>
<td>22 11</td>
<td>34 12</td>
</tr>
<tr>
<td>45-49</td>
<td>19 11</td>
<td>33 15</td>
</tr>
<tr>
<td>50-54</td>
<td>17 13</td>
<td>36 16</td>
</tr>
<tr>
<td>35-54</td>
<td>23 13</td>
<td>35 13</td>
</tr>
</tbody>
</table>

X = AVERAGE  
SD = Standard deviation  
Note: The last row represents the average of all the ages (35-54)
3. Static Back Endurance Test

Dr. Position: The doctor is at the side of the table holding the patient’s ankles (strap is ideal). Alternatively, a Roman chair type of device can be used.

Patient position: The patient is prone with the inguinal region at the end of the table; arms at sides, ankles fixed and holding horizontal position.

Technique: The patient maintains the horizontal position as long as possible.

Observe: Time the duration the position can be held (max. 240 seconds).

Normals:

<table>
<thead>
<tr>
<th>Table III: Static back endurance test (sec).</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>35-39</td>
</tr>
<tr>
<td>40-44</td>
</tr>
<tr>
<td>45-49</td>
</tr>
<tr>
<td>50-54</td>
</tr>
<tr>
<td>35-54</td>
</tr>
</tbody>
</table>

X = AVERAGE
SD = Standard deviation
Note: The last row represents the average of all the ages (35-54)
4. One Leg Stand Normative Data \textsuperscript{8-11}

Dr. Position: The doctor is near the patient.

Patient position: The patient is standing on one leg; nonsupport leg is bent 60 degrees at the hip and 90 degrees at the knee so that the ankle is at the height of the support leg's knee.

Technique: The patient maintains the position as long as possible.

Observe: Time the duration the position can be held, i.e., until the patient moves the support foot, puts other foot down, or reaches out to grasp with the hand(s).

<table>
<thead>
<tr>
<th>AGE (years)</th>
<th>EYES OPEN (seconds)</th>
<th>EYES CLOSED (seconds)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-59</td>
<td>29-30</td>
<td>21-28.8</td>
</tr>
<tr>
<td>60-69</td>
<td>22.5</td>
<td>10</td>
</tr>
<tr>
<td>70-79</td>
<td>14.2</td>
<td>4.3</td>
</tr>
</tbody>
</table>

5. Horizontal Side Bridge Endurance \textsuperscript{12}

Dr. Position: The doctor is near the patient.

Patient position: The patient is side lying, supported on forearm and crossed ankles.

Technique: The patient raises up on forearm and ankles until pelvis and trunk are nearly horizontal.

Observe: Time the duration the position can be held until the patient's pelvis returns to the floor.

Normative data

In this study, data was only gathered on young healthy subjects, 75 (31 men, 44 women).

Even though this study did not cover a broad range of different age groups, the ratios between side bridge and flexor or extensor tests are of most interest. Men could sustain the "side bridge" for 65 percent of the extensor time and 99 percent of the flexion time; the women could sustain the "side bridge" for only 39 percent
Functional Capacity Examination

of the extensor time and 79 percent of the flexion time. The tests proved to be reliable, with reliability coefficients of > 0.97 for the repeated tests on five consecutive days and again eight weeks later.

<table>
<thead>
<tr>
<th>Task</th>
<th>Mean</th>
<th>SD</th>
<th>Ratio</th>
<th>Mean</th>
<th>SD</th>
<th>Ratio</th>
<th>Mean</th>
<th>SD</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extensor</td>
<td>146</td>
<td>51</td>
<td>1.0</td>
<td>189</td>
<td>60</td>
<td>1.0</td>
<td>177</td>
<td>60</td>
<td>1.0</td>
</tr>
<tr>
<td>Flexor</td>
<td>144</td>
<td>76</td>
<td>0.99</td>
<td>149</td>
<td>99</td>
<td>0.79</td>
<td>147</td>
<td>90</td>
<td>0.86</td>
</tr>
<tr>
<td>Side Bridge, Rt</td>
<td>94</td>
<td>34</td>
<td>0.64</td>
<td>72</td>
<td>31</td>
<td>0.38</td>
<td>81</td>
<td>34</td>
<td>0.47</td>
</tr>
<tr>
<td>Side Bridge, Lt</td>
<td>97</td>
<td>35</td>
<td>0.66</td>
<td>77</td>
<td>35</td>
<td>0.40</td>
<td>85</td>
<td>36</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Cervical Spine Strength

Patient position: Supine

Technique: Patient flexes chin towards sternal notch and the lifts head off table one inch and holds head for as long a possible.

Observe: Record each of the following in seconds

a. Initial shaking of head and neck
b. Dropping of the head

Normative data:

a. Point of shaking: 39 seconds
b. Dropping of head: 100 seconds
PERSONAL INJURY FLOW SHEET

Med Pay

Patient

Driver

Vehicle owner

Excess Med Pay

Health insurance must be billed first and the med pay acts as a secondary. Contracted provider write offs are taken by the Med Pay carrier as it is equivalent to patient. Therefore Med Pay is only liable for the patient is liable for under the PPO contract.

ASHN
Blue Cross & Blue Shield

Aetna
CIGNA

Insurance Code 491. The rating plan of a motor vehicle liability insurer shall not provide for an increase in the premium if based upon an accident in which the insured is not at fault, in any manner, as determined by either the accident report or the insurer. In the event the insurer determines that its insured is at fault contrary to an accident report’s specific finding that the insured is not at fault, the insurer shall reach its conclusion only after an investigation.

Attorney Med Pay “Jumpers”

Attorney intercepts med pay payment from the doctor

Doctor

Attorney

Rescission of assignment- Does it work?

Verify who will receive payment prior to submitting bill to med pay
Attorney Lien Claims

Third Party and No Attorney

Third party lien and financial agreements – Patient is only responsible and liable party

No Insurance

If the patient has no insurance on their vehicle and were not at fault they will receive no award, only actual damages (Prop 213 Civil Code 3333.4), if the at fault party was insured. This means they only get their doctor billed paid and will have no award or remuneration for “pain and suffering”.

Prop 213 with an attorney
ATTORNEY NOT PAYING SETTLED CLAIM
(Send Certified Mail - Return Receipt requested)

Date

Casey Casemaker, Esq.
1900 Money Bucks Blvd.
Any City, USA 00000

Re: William Dunn
DOI:
Lien Amount $2,054.69

Dear Mr. Casemaker:

We have not received payment on the above noted patient, your client, and we understand the claim has been settled. Please see the attached lien which you previously signed and agreed to pay when the case settles. Our lien clearly states that you agree to pay the amount in full upon settlement.

The patient is fully aware that the lien agreement was an agreement for our office to wait for his claim to settle before the balance of his account became immediately due, in full, without regard to the amount or the result of his settlement.

We assume that you will honor your lien contract; but your delay is causing us concern. Accordingly, we demand that full and immediate payment of $$$$$$ (see copy of bill and report). I am sure you are familiar with the provisions of the Rules of Professional Conduct of the State Bar of California. The Bar charges you as a fiduciary for moneys collected in this case.

I expect this payment to be made within 72 hours. Should you not be able to meet this deadline or make satisfactory arrangements I will make a formal complaint about your fiduciary impropriety to the State Bar of California as well as file a law suit against you.

Of course we prefer to not resort to these methods and expect we can maintain the professional relationship established.

Sincerely yours,

Albert Longspine, D.C.
cc: patient
MEDICAL CONTROL

30 days if no MPN or predesignation

Medical Provider Networks Insurance may offer a panel of doctors (Medical Provider Network - MPN) when a panel is set up control remains with employer/insurance at all times.

www.firsthealth.com
www.caqh.org
www.scif.com
www.libertymutual.com

Pre-designation: An employee may pre-designate, with their employer, medical doctor or osteopath (LC4600) or a chiropractor or acupuncturist (LC4601) to treat them in the event of an industrial injury. This pre-designation must on file with the employer prior to the injury. For a doctor to be pre-designated they must have previously examined and directed care of the patient (LC4600 & 4601). Employers must at the time of hire, give the employee the opportunity to pre-designate and the employee has the right to change the pre-designation at any time. Employers who have HCO’s must yearly give written choice of pre-designation. Only employees who have group health insurance from their employer may pre-designate.

If an employee pre-designates a personal physician, chiropractor or acupuncturist, the employee may automatically, upon notice to the employer, seek treatment from that practitioner.

Use predesignation as way to inquire about MPN. If accepted by the employer then there is no MPN and consequently direct access. If returned because of an MPN immediately inquire about membership.
NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer’s insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

Your Chiropractor or Acupuncturist’s Information:

(name of chiropractor or acupuncturist)

(street address, city, state, zip code)

(telephone number)

Employee Name (please print):

Employee’s address:

Employee’s Signature __________________________ Date: ____________________
AUTHORIZATION OF TREATMENT (All care must be pre-authorized)

A report that has a treatment plan (DFR, PR2, narrative, or specific written request) is a request for care.

Request for care should follow the ACOEM or other accepted treatment guidelines for scope, intensity, and duration. Workers' compensation places a premium on
1. Return to work
2. Active care
3. Functional improvement

UTILIZATION REVIEW

LC 4610 Insurer has no more than 14 days to respond to requests for non emergency claims. Should they fail to respond does not indicate automatic authorization. Medical necessity is the deciding factor. If you take the claim without authorization it may require you file a lien to be paid.

If not responded to timely file a UR Complaint form (form and instructions on seminar CD)

REPORTING

Primary Treating Physician

First report of injury Form DLSR 5021 within 5 days of exam. (No fee)

PR2 Supplemental report every 45 days or change of condition. (99081 $11.69)

PR4 Final permanent and stationary report completed when patient has reached P&S. (99080-17 $37.98 page 1 and $23.37 for each page after)

Secondary Treating Physician

No formal report is required. The secondary doctor is to report in the manner prescribed by the primary doctor (referring doctor); generally it is a short narrative report. You may bill with the PR2 code and while many carriers will pay there is no law requiring payment
Manual Therapy & Manipulation: §9792.24.2. Chronic Pain Medical Treatment Guidelines
- Recommended for chronic pain if caused by musculoskeletal conditions.
- The intended goal or effect... is the achievement of positive... measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities.

Low back: Manual Therapy & Manipulation: §9792.24.2. Chronic Pain Treatment Guidelines
- Recommended as an option.
- Therapeutic care
  - Trial of 6 visits over 2 weeks, with functional improvement, up to 18 visits over 6-8 weeks.
- Elective/maintenance care
  - Not medically necessary.
- Recurrences/flare-ups
  - Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months.

- Not recommended.

- Not recommended.

- Not recommended.
- Knee: §9792.24.2. Chronic Pain Medical Treatment Guidelines: Part
  - Not recommended.

Manual therapy & manipulation: §9792.24.2. Chronic Pain Treatment Guidelines
- Time to produce effect:
  - 4 to 6 treatments
- Frequency:
  - 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition.
  - Treatment may continue at 1 treatment per week for the next 6 weeks.
- Maximum duration:
  - 8 weeks.
  - At week 8, patients should be reevaluated.
  - Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1
Chronic Pain Conservative Care California MTUS

treatment every other week until the patient has reached plateau and maintenance treatments have been determined.

- Extended durations of care beyond what is considered “maximum” may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis.
- Treatment beyond 4-6 visits should be documented with objective improvement in function.
- Palliative care should be reevaluated and documented at each treatment session.

- **Number of Visits:**
  - If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits.

- **Active Treatment versus Passive Modalities:**
  - Manipulation is a passive treatment, but many chiropractors also perform active treatments, and these recommendations are covered under Physical therapy (PT), as well as Education and Exercise.
  - The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes.
  - Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases.

- Payors may want to consider this option for patients showing continuing improvement, based on documentation at two points during the course of therapy, allowing 24 visits in total, especially if the documentation of improvement has shown that the patient has achieved or maintained RTW.

**Massage therapy:** §9792.24.2. Chronic Pain Medical Treatment Guidelines

- Recommended as an option as indicated below.
- This treatment should be an adjunct to other recommended treatment (e.g. exercise)
- should be limited to 4-6 visits in most cases.
- Massage is a passive intervention and treatment dependence should be avoided.
- The strongest evidence for benefits of massage is for stress and anxiety reduction
- Massage is an effective adjunct treatment to relieve acute postoperative pain in patients who had major surgery

**Physical Medicine:** §9792.24.2. Chronic Pain Medical Treatment Guidelines

- Recommended.
- Passive therapy
  - those treatment modalities that do not require energy expenditure on the part of the patient
  - can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries

HJ Ross Seminars and Network 2011
can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process.

- Active therapy
  - based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort.
  - requires an internal effort by the individual to complete a specific exercise or task.
  - may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s).
  - instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels.
  - Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices.
  - The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)

**Physical Medicine Guidelines:** §9792.24.2. Chronic Pain Medical Treatment Guidelines
- Allow for
  - fading of treatment frequency (from up to 3 visits per week to 1 or less) plus
  - active self-directed home Physical Medicine.
- **Myalgia and myositis, unspecified** (ICD9 729.1):
  - 9-10 visits over 8 weeks
- **Neuralgia, neuritis, and radiculitis, unspecified** (ICD9 729.2)
  - 8-10 visits over 4 weeks
- **Reflex sympathetic dystrophy (CRPS)** (ICD9 337.2):
  - 24 visits over 16 weeks

**Ultrasound, therapeutic:** §9792.24.2. Chronic Pain Medical Treatment Guidelines
- Not recommended.
- There is little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain or a range of musculoskeletal injuries or for promoting soft tissue healing.
Exercise: §9792.24.2. Chronic Pain Medical Treatment Guidelines

- Recommended.
- There is strong evidence that exercise programs, including aerobic conditioning and strengthening are superior to treatment programs that do not include exercise.
- A therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated.

Such programs should emphasize education, independence, and the importance of an on-going exercise regime.

Yoga: §9792.24.2. Chronic Pain Medical Treatment Guidelines

- Recommended as an option only for select, highly motivated patients.
- There is considerable evidence of efficacy for mind-body therapies such as yoga in the treatment of chronic pain.
- Since outcomes from this therapy are very dependent on a highly motivated patient, we recommend approval where requested by a specific patient, but not adoption for use by any patient.

Functional improvement measures: §9792.24.2. Chronic Pain Medical Treatment Guidelines

- Recommended.
- The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. It should include the following categories:
  - Work Functions and/or Activities of Daily Living, Self Report of Disability (e.g., walking, driving, keyboard or lifting tolerance, Oswestry, pain scales, etc): Objective measures of the patient’s functional performance in the clinic (e.g., able to lift 10 lbs floor to waist x 5 repetitions) are preferred, but this may include self-report of functional tolerance and can document the patient self-assessment of functional status through the use of questionnaires, pain scales, etc (Oswestry, DASH, VAS, etc.)
  - Physical Impairments (e.g., joint ROM, muscle flexibility, strength, or endurance deficits): Include objective measures of exam findings. ROM should be in documented in degrees.
  - Approach to Self-Care and Education Reduced Reliance on Other Treatments, Modalities, or Medications: This includes the provider’s assessment of the patient compliance with a home program and motivation. The provider should also indicate a progression of care with increased active interventions (vs. passive interventions) and reduction in frequency of treatment over course of care. For chronic pain, also consider return to normal quality of life, e.g., go to work/volunteer each day; normal daily activities each day; have a social life outside of work; take an active part in family life. (Cowan, 2008)
Requirements for Extending Care of Chronic Complaints

- “Functional improvement” § 9792.20. Medical Treatment Utilization Schedule—Definitions
  - either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the E & M visit
  - AND a reduction in the dependency on continued medical treatment
- Functional improvement measures: §9792.24.2. Chronic Pain Treatment Guidelines:
  Recommended. The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement or maintenance of function that would otherwise deteriorate. It should include the following categories:
  - Work Functions and/or Activities of Daily Living, Self Report of Disability: Objective measures of functional performance in the clinic (e.g., able to lift 10 lbs floor to waist x 5 repetitions) preferred, but may include assessment of functional status through the use of questionnaires, pain scales (Oswestry, VAS, etc.)
  - Physical impairments (e.g., joint ROM, muscle flexibility, strength, or endurance deficits): Include objective measures of exam findings. ROM in degrees.
  - Approach to Self-Care and Education Reduced Reliance on Other Treatments, Modalities, or Medications: This includes
    - assessment of patient compliance with a home program and motivation
    - progression of care with increased active interventions (vs. passive interventions)
    - reduction in frequency of treatment over course of care
    - For chronic pain: return to normal quality of life, e.g. work/volunteer each day; normal daily activities each day; social life outside of work: active part in family life.
- Exercise: §9792.24.2. Chronic Pain Medical Treatment Guidelines
  - A therapeutic exercise program should be initiated at the start of any treatment or rehab program, unless exercise is contraindicated. Such programs should emphasize education, independence, and the importance of an on-going exercise regime.
TREATMENT LIMITATIONS

California workers compensation OMFS physical medicine ground rules limit care per day to 2 procedures (hands on and/or attended services- this includes acupuncture needling) or 60 minutes of procedures along with 2 modalities (unattended), per visit without prior authorization. If treatment consists of modalities only, the limit is two per visit. Any services that are beyond these parameters must be additionally preauthorized.

Examinations and re-examinations are allowed on initial visit and subsequently every 45 days or change of condition (same parameters as the reporting regulation).

Chiropractic treatment is limited to 24 for injuries on or after 1-1-2004. Injuries prior have no limitation. Care may be extended by authorization.

BILLING/FEES

Billing may be submitted on an itemized statement or CMS 1500. Payment is made in accordance with the Official Medical Fee Schedule. All billing should be accompanied by a report. If fees charged are in excess of the Official Medical Fee Schedule you must include an explanation and itemization for the excess charge (CCR 9792.5).

PAYMENT

Reimbursement is based on the physical medicine ground rules. The highest valued procedure is paid at 100%, the second highest valued service is paid at 75%, the third service is paid at 50%, and the fourth service is paid at 25%. This process of payment is referred to as the "cascade".

Payment is to be made within 45 working days after receipt of each separate, itemized billing, together with any reports. If the carrier is contesting, denying, or considers the billing incomplete they must, within 30 working days, provide notice of such denial or claim is to be paid in 45 working days. If payment is not made nor a denial received in a timely fashion the fees shall be increased by 15% (penalty) and 10% annual interest on the unpaid amount. (LC4603.2)
Key Topics

Workers’ Compensation
* Treatment guidelines for chiropractic and physical medicine
* How to work (and get paid for) treating future med patients
* Updated fee schedule and codes

Health Insurance
* Diagnoses that demonstrate increased need for care
* Definitions and documentation for diagnosis and CPT codes
* The correct use of CPT codes and modifiers
* How to code and be paid for:
  Additional time for exams
  Review of records
  Phone call and E mail evaluations
  Physical medicine services
  House calls and after hours treatment
  Unusual or complicated chiropractic manipulation

Medicare
* Proper billing and documentation to pre-empt an audit
* Primary and secondary diagnoses requirements for your state
* Why claims are often denied after visit #12
* Secondary’s: How to bill and what they do and do not pay for
* Electronic billing requirements

Personal Injury
* 4 steps to ensure getting PI cases paid in full
* Med Pay, excess med pay, P.I.P., and how to GET PAID 100%
* How to handle an attorney lien claim
* When and how to use Liens and Letters of Protection
* Learn the rules of negotiating with an attorney
* Claims settlement: How the process impacts you

Managed Care
* Advantages and disadvantages of being a member
* Why you should or should not join
* Which are pro-chiropractic and anti-chiropractic
* Working with managed care forms and authorization process
* Obtaining additional care—know what they want

Documentation
* Audit proofing your claims
* Rules and protocols of chiropractic documentation
* Use and implementation of outcome assessment forms
* Demonstrating/documenting the medical necessity of services

* Up to 8 CEUs depending on state jurisdiction
Dates & Locations

Saturday 9/10/11  Bloomington, MN
Northwestern Health Sciences University
2501 W 84th Street, Bloomington, MN  55431
800-888-4777

Saturday 9/24/11  Orange County CA
Hilton Orange County/Costa Mesa
3050 Bristol St, Costa Mesa, CA 92626
714-540-7000

Saturday 10/8/11  Seattle, WA
Doubletree Suites Seattle Airport
16500 Southcenter Parkway, Seattle, WA 98188
206-575-8220

Saturday 10/15/11  San Jose, CA
Doubletree Hotel San Jose
2050 Gateway Place, San Jose, CA 95110
408-437-2126

Saturday 11/5/11  Whittier, CA
Southern California University of Health Sciences
16200 E. Amber Valley Drive, Whittier, CA 90604
800-562-3335

Saturday 11/5/11  Newark, NJ
Hilton Newark Airport
1170 Spring Street, Elizabeth, NJ 07201
908-351-9556

Saturday 11/19/11  Denver, CO
Hilton Garden Inn Denver/Cherry Creek
600 S. Colorado Blvd, Denver, CO 80246
303-654-9800

Saturday 12/3/11  Dallas, TX
TBA
TBA
TBA

***Seminar Time: 8am to 5pm***

Hurry, Register Now!
Space is limited!

Pricing:
Super Early Bird Special
$199*
*Must register 45 days in advance

Early Bird Special $245*
*Must register 21 days in advance

Advanced Registration $275
At the door $310
Additional Staff (No CEUs) $75

www.hjrosscompany.com

Register at www.hjrosscompany.com
(800) 562-3335