CSS | STRATEGIES 10.07

Opening Minds, Hands, & Hearts

Chiropractic Success Systems™
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GENERAL ANNOUNCEMENTS

- As usual there are no public seminars this fall. The next series will begin in late January in the San Jose California area.
- If you or your team needs immediate training, we will come to you! Just give us a call at (831) 438-0861.
- Look for *Cash Practice or Insurance Practice? That is the Question* in the November 5, 2007 issue of *Dynamic Chiropractic*.
- If your State Association is looking for an event speaker, I am available for a limited number of engagements each year. If you are interested please contact me at (831) 438-0861.

MEDICARE

- Diagnosis: CMS will now accept 8 diagnoses per claim. The initial four will continue to be listed in box #21 on the new CMS-1500 (08/05) form and the additional four will be listed in box #19.
- Box 24I: This box must contain "1C" in the shaded portion for all chiropractic services. Without it your claims could be denied.
- PTAN: When verifying benefits some contractors are now asking for a PTAN (Provider Transaction Access Number). This number was previously referred to as the PIN or Legacy Number.
- 2008 Fees Increase: Expect a 5% increase.

GENERAL INSURANCE

- CMT & 97140 ON SAME DAY:

CPT has stated for some time now that Chiropractic Manipulative Treatments which are rendered to the same region of the body as Manual Therapy is considered bundled and therefore not reimbursable.

When billing for services you are to list in box #24e (the "diagnosis pointer" box) which diagnosis pertains to the service on each line. For example if diagnosis 1 is a cervical condition, 2 is a thoracic condition, 3 is for a lumbar condition, and 4 is for a pelvic condition and you performed a 98940 (CMT 1-2 spinal regions) because you adjusted the cervical and lumbar regions you would have "1" and "3" appear in the diagnosis pointer box for that line of service.

If you performed a manual therapy to the thoracic and pelvic regions you would have "2" and "4" appear in the diagnosis pointer box for that line of service.

Too often we're not using our software correctly and box #24e indicates "1 2 3 4" for each line of service. More and more frequently carriers are asking for copies of treatment notes when these codes appear on a claim form for the same date of service. If they review your notes and determine that you have performed both services to the same body part they may be correct in denying one of the services. When this occurs you may not bill the patient for the denied service as it is considered "bundled".

If you are using box #24E correctly, one solution might be to have the patient return on a separate day for one of the services. Keep in mind that if their policy has a limit on the number of visits allowed per year this may be a concern.

- Orthotic Modifiers: It has recently come to my attention that some carriers are requiring the use of the HCPCS modifiers when billing for orthotics. Many of the HCPCS codes used for billing orthotics state the code will be used for "each" impression.

If a patient receives a pair of orthotics (one for the left foot and the one for the right foot) you need to bill each foot separately. The right foot would have the appropriate HCPCS code with a "RT" modifier and the left foot would have the appropriate HCPCS code with at "LT" modifier.

- BLUE SHIELD OF CALIFORNIA

As of 7/1/07 they have changed their provider allowances and in addition they have now tiring reimbursement for physical medicine and rehabilitation codes 97001 through 97804. The last time I checked I was told it is 100% for the procedure with the highest RV, 85% for the second and 40% for the third and any other additional codes the range of procedures codes.

PRACTICE TIP-

- SUPER BILLS REVISITED

If you are having your health insurance patients pay you in full at the time of service and providing them with a "super bill" to send to their carrier, do them a favor and give them a completed CMS-1500 (08/05) form. Just remember to leave box #13 blank (unless you want payment to come directly to your office).

When the patient submits their claims on the properly completed CMS-1500 (08/05) form they receive faster reimbursement and patients look forward to receiving their checks! Better yet, if you have electronic billing capabilities submit the claim for them. This is quick, easy, and cost effective.