Medicare Coding and Billing

- The CMS-1500 form (or its electronic equivalent) is how we communicate with our local Part B Medicare Administrative Contractor the services we have performed and why we performed them.You are talking to a computer and all that it knows is what you tell it through the numbers that you put on the 1500 Form.
- There are two code sets that are used to communicate information to the MAC.
    - ICD-9-CM codes.
    - PT codes.ICD-9-CM stands for International Classification of Disease, 9th edition, Clinical Modification.
- We covered diagnosis in another webinar.
- CPT® stands for Current Procedural Terminology®
- The CPT® Code Set is owned by the American Medical Association.
- This is why there is a delay in the implementation of the ICD-10 codes.
- The ICD-10 codes are used both for diagnosis and procedures coding.
- The procedure codes that chiropractors use to bill covered procedures to Medicare are:
    - 98940
    - 98941
    - 98942Remember that the only Medicare covered procedure for chiropractors is the adjustment.
- The only reason to bill any other procedure would be at the request of the patient and then only if they have a secondary insurance that would require a denial from Medicare before they paid for the service.

Modifiers

- With all of the coding options available, sometimes there is no code to fit the situation.
- When that happens it is time to use a modifier.
- Some modifiers are specific to Medicare and some can be used with all insurance.
    - AT = Active Treatment
    - GA = Waiver of Liability Statement Issued as Required by Payer Policy
    - GY = Noncovered Service
    - GZ = Used when service is expected to be denied and no ABN is on file. Use of this modifier results in an automatic audit.It is allowable to use up to four modifiers on the same code.
- Medicare carriers and MACs are required to accept two modifiers.
- When using multiple modifiers, the first one takes precedence.
- For example; when you have a signed ABN form on file and you are still under active treatment, you should use AT,GA as the modifier.

AT Modifier

- "For Medicare purposes, a chiropractor **must** place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However the presence of an AT modifier may not in all instances indicate that the service is reasonable and necessary. As always, contractors may deny if appropriate after medical review."
- The AT modifier must be on all active treatment services for correction of acute and chronic subluxations.
- If you have a signed ABN on file but are still in active treatment, use the AT,GA modifier combination in that order.
- **Do Not** use the AT modifier for care that is maintenance in nature.**GA Modifier**
- The GA code signifies the "Waiver of Liability Statement Issued as Required by Payer Policy."
- The GA modifier **does not** signify that the care is maintenance.
- If you place the GA modifier on a code you **must** have a signed ABN form in the file.
- It is appropriate to report the GA modifier when the beneficiary refuses to sign the ABN.For chiropractors, the –AT modifier (which signifies that the patient is under active treatment and that improvement is expected) is only used with the procedure codes 98940, 98941 and 98942.
- With the new changes in effect, the –GA modifier can only be used with procedure codes 98940, 98941 and 98942.

GY Modifier

- The GY modifier is used to indicate that a service is not covered by Medicare
- Use the GY modifier when a patient's secondary insurance needs a rejection by Medicare before they will pay for a service

GZ Modifier

- The GZ modifier is used when you expect Medicare to deny the service and you do not have an ABN form signed.
- Use this modifier when you forgot the ABN.
- Expect an audit if you use this modifier

Q6 Modifier

- Services provided by a Locum Tenens physician
- Use this modifier when you have another doctor filling in for you.
- A Locum Tenens doctor can fill in for 60 days.

The CMS 1500 Form

Note: Get a copy of the CMS 1500 form from your stock to follow along

- Now that we know what codes and modifiers to use, lets look at how to use them
- Services are billed to Medicare using the CMS 1500 claim form or the electronic equivalent.The CMS 1500 form will be replaced in the future.
- The replacement form will have more spaces for diagnoses.
- The recommended timeline is to have insurers able to accept the new form by June 1, 2013 with the current form discontinued by October 1, 2013.This is the CMS 1500 form.
- Commonly called the 1500 form.
- It is printed in red because it is read by an Optical Character Recognition (OCR) scanner
- Electronic Health records require the same information that the 1500 form does.
- The top part of the form is for the patient information and the insured's information (if it is different from the patient's.The bottom part of the form is for the claim information.
- This is where you submit the charges.

Patient Section

- **Item 1 -** Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box.
- **Item 1a -** Enter the patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer. This is a required field.
- **Item 2 -** Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card. This is a required field.
- **Item 3 -** Enter the patient's 8-digit birth date (MM | DD | CCYY) and sex.
- **Item 4 -** If there is insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.
- How to Determine the Correct MSP Type Below is a list of some questions your office may want to ask:
    - Is the beneficiary covered by a Group Health Plan (GHP) through his or her current or former employment?
    - Is the beneficiary covered by a GHP through his or her spouse or other family member's current or former employment?Is the beneficiary receiving Workers' Compensation (WC) benefits?
    - Is the beneficiary filing a claim with a no-fault insurance or liability insurance?
    - Is the beneficiary being treated for an injury or illness for which another party has been found responsible?
- **Item 5** - Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.

- **Item 6 -** Check the appropriate box for patient's relationship to insured when item 4 is completed.
- **Item 7 -** Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4, 6, and 11 are completed.
- **Item 8 -** Check the appropriate box for the patient's marital status and whether employed or a student.
- **Item 9 -** Enter the last name, first name, and middle initial of the enrollee in a Medigap policy if it is different from that shown in item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank. **This field may be used in the future for supplemental insurance plans.**
- **NOTE:** Only participating physicians and suppliers are to complete item 9 and its subdivisions and only when the beneficiary wishes to assign his/her benefits under a MEDIGAP policy to the participating physician or supplier.
- Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for **all** Medicare patients.
- A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer.
- **Medigap -** Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in §1882(g)(1) of title XVIII of the Social Security Act (the Act) and the definition contained in the NAIC Model Regulation that is incorporated by reference to the statute.
    - It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits.
    - It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare.
    - It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.
- Do not list other supplemental coverage in item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.
- **Item 9a -** Enter the policy and/or group number of the Medigap insured preceded by MEDIGAP, MG, or MGAP.
- **NOTE:** Item 9d must be completed, even when the provider enters a policy and/or group number in item 9a.
- **Item 9b -** Enter the Medigap insured's 8-digit birth date (MM | DD | CCYY) and sex.

- **Item 9c -** Leave blank if a Medigap Payer ID is entered in item 9d. Otherwise, enter the claims processing address of the Medigap insurer.
- **Item 9d -** Enter the 9-digit PAYERID number of the Medigap insurer. If no PAYERID number exists, then enter the Medigap insurance program or plan name.
- **Items 10a through 10c -** Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. Enter the State postal code. Any item checked "YES" indicates there may be other insurance primary to Medicare. Identify primary insurance information in item 11.
- **Item 10d -** Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by MCD.
- **Item 11 -** THIS ITEM MUST BE COMPLETED, IT IS A REQUIRED FIELD. BY COMPLETING THIS ITEM, THE PHYSICIAN/SUPPLIER ACKNOWLEDGES HAVING MADE A GOOD FAITH EFFORT TO DETERMINE WHETHER MEDICARE IS THE PRIMARY OR SECONDARY PAYER.If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to items 11a - 11c. Items 4, 6, and 7 must also be completed.
- **NOTE:** Enter the appropriate information in item 11c if insurance primary to Medicare is indicated in item 11. If there is no insurance primary to Medicare, enter the word "NONE" and proceed to item 12.
- If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), enter the word "NONE" and proceed to item 11b.
- **Insurance Primary to Medicare -** Circumstances under which Medicare payment may be secondary to other insurance include:
    - Group Health Plan Coverage
        - Working Aged;
        - Disability (Large Group Health Plan); and
        - End Stage Renal Disease; No Fault and/or Other Liability; and
    - Work-Related Illness/Injury:
        - Workers' Compensation;
        - Black Lung; and
        - Veterans Benefits.
- **NOTE:** For a paper claim to be considered for Medicare secondary payer benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form.
- **Item 11a -** Enter the insured's 8-digit birth date (MM | DD | CCYY) and sex if different from item 3.
- **Item 11b -** Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) retirement date preceded by the word "RETIRED."
- **Item 11c -** Enter the 9-digit PAYERID number of the primary insurer. If no PAYERID number exists, then enter the **complete** primary payer's program or plan name.

- If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. This is required if there is insurance primary to Medicare that is indicated in item 11.
- **Item 11d -** Leave blank. Not required by Medicare.
- **Item 12 -** The patient or authorized representative must sign and enter either a 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or an alpha-numeric date (e.g., January 1, 1998) unless the signature is on file.
- In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with Chapter 1, "General Billing Requirements."
- If the patient is physically or mentally unable to sign, a representative specified in Chapter 1, "General Billing Requirements" may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by "by" the representative's name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless the patient or the patient's representative revokes this arrangement.
- **NOTE:** This can be "Signature on File" and/or a computer generated signature. The patient's signature authorizes release of medical information necessary to process the claim.
- It also authorizes payment of benefits to the provider of service or supplier when the provider of service or supplier accepts assignment on the claim.
- **Signature by Mark (X) -** When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.
- **Item 13 -** The patient's signature or the statement "signature on file" in this item authorizes payment of medical benefits to the physician or supplier. The patient or his/her authorized representative signs this item or the signature must be on file separately with the provider as an authorization.
- However, note that when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating physician or supplier, a patient's signature or a "signature on file" is not required in order for Medicare payment to be made directly to the physician or supplier. In addition, the signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions.

Claim Section

- **Item 14 -** Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy.
- For chiropractic services, enter an 8 digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date in item 19.
  Reminder: For date fields other than date of birth, all fields shall be one or the other format, 6-digit: (MM | DD | YY) or 8-digit: (MM | DD | CCYY).
- **Intermixing the two formats on the claim is not allowed.**
- **Item 15 -** Leave blank. Not required by Medicare.

- **Item 16 -** If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is unable to work.
- An entry in this field may indicate employment related insurance coverage.
- **Item 17 -** Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.
- All physicians who order services or refer Medicare beneficiaries must report this data.
- When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician.
- The term "physician" when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to:
- 5. A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation).
- 1861(s) The term "medical and other health services" means any of the following items or services:
- physicians' services;
- (2)(A) services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills (or would have been so included but for the application of section 1847B);
- **Referring physician** - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
- **Ordering physician** - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.
- Chiropractors can only order or refer for services directly related to manual manipulation to the spine to correct subluxation.
- For all other services you must send the patient back to their MD or DO for evaluation.
- **Referral**: Turning the patient's care over to another doctor.
- **Request for Consult**: Requesting another doctor evaluate the patient and render an opinion and return the patient to you for continued care.
- **Item 17a –** Leave blank.

- **Item 17b Form CMS-1500 –** Enter the NPI of the referring/ordering physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data.
- **Item 18 -** Enter either an 8-digit (MM | DD | CCYY) or a 6-digit (MM | DD | YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
- **Item 19** - Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation).
- By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, is on file, along with the appropriate x-ray and all are available for carrier review.
- **Item 20 -** Complete this item when billing for diagnostic tests subject to the anti-markup payment limitation.
- Chiropractors will not use this box
- **Item 21 -** Enter the patient's diagnosis /condition. All physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order.
- **Item 22 -** Leave blank. Not required by Medicare.
- **Item 23 -** Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval.
- **Item 24 -** The six service lines in section 24 have been divided horizontally to accommodate submission of supplemental information to support the billed service.
- **Item 24A -** Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service, or supply.
- **Item 24B -** Enter the appropriate place of service code(s) from the list provided in section 10.5. Identify the location, using a place of service code, for each item used or service performed. This is a required field. Examples of place of service codes are:
    - 11 Office
    - 12 Home
    - 21 Inpatient Hospital
    - 22 Outpatient Hospital
    - 23 Emergency Room-Hospital
    - 26 Military Treatment Facility
    - 31 Skilled Nursing Facility
- **Item 24C -** Medicare providers are not required to complete this item.
- **Item 24D -** Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code.
- When applicable, show HCPCS code modifiers with the HCPCS code.
- The Form CMS-1500 has the ability to capture up to four modifiers.

- Enter the specific procedure code without a narrative description.
- This is a required field.
- **Item 24E -** Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis.
- Enter only one reference number per line item.
- When multiple services are performed, enter the primary reference number for each service, either a 1, or a 2, or a 3, or a 4.
- This is a required field.
- If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.
- **Item 24F-** Enter the charge for each listed service.
- **Item 24G -** Enter the number of days or units.
- If only one service is performed, the numeral 1 must be entered.
- **Item 24H** - Leave blank. Not required by Medicare.
- **Item 24I -** Enter the ID qualifier 1C in the shaded portion.
  Item 24J - Enter the rendering provider's NPI number in the lower unshaded portion.
- **Item 25 -** Enter the provider of service or supplier Federal Tax ID (Employer Identification Number or Social Security Number) and check the appropriate check box.
- Reimbursement of claims submitted without tax identification information will/may be delayed.
- **Item 26 -** Enter the patient's account number assigned by the provider's of service or supplier's accounting system.
- This field is optional to assist the provider in patient identification.
- **Item 27 -** Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits.
- **Item 28 -** Enter total charges for the services (i.e., total of all charges in item 24f).
- **Item 30 -** Leave blank. Not required by Medicare.
- **Item 31 -** Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alpha-numeric date (e.g., January 1, 1998) the form was signed.
    - **NOTE:** This is a required field, however the claim can be processed if the following is true.
    - If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or
    - If any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS(I certify that the statements on the reverse apply to this bill and are made a part thereof.)
- **Item 32 –** Effective January 1, 2011, for claims processed on or after January 1, 2011, submission of the location where the service was rendered will be required for all POS codes.

- **Item 32a -** If required by Medicare claims processing policy, enter the NPI of the service facility.
- **Item 32b -** Effective May 23, 2008, Item 32b is not to be reported.
- **Item 33 -** Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. This is a required field.
- **Item 33a -** Enter the NPI of the billing provider or group. This is a required field.
- **Item 33b -** Effective May 23, 2008, Item 33b is not to be reported.

The Back of the CMS 1500 Form

- Refer to the back of the CMS 1500 form.
- It contains notices to the physician and to the patient.BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.
- NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties**.**REFERS TO GOVERNMENT PROGRAMS ONLY
- MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete.
- In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. The next section is a statement about Black Lung.
- **SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)** I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.
- SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
- (I certify that the statements on the reverse apply to this bill and are made a part thereof.) This is how doctors fall prey to the False Claims Act.
- When you file a claim with the AT modifier and your records do not substantiate medical necessity, you have made a false statement to a government agency.No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).
- NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

- **NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION**
- This section is essentially a HIPAA notice to patients about how their information will be collected and used.
- **MEDICAID PAYMENTS (PROVIDER CERTIFICATION)**
- This section relates directly to Medicaid claims.

- Completing the CMS 1500 form is key to getting paid, but it also requires attention to detail to avoid reviews and other difficulties.