

THE MEDICARE CLAIM

This is a continuation of a series of articles on Medicare, Medicare documentation, and related issues. The Office of the Inspector General (OIG) issued a report on June 21, 2005 concerning the inadequacy of chiropractic Medicare documentation. The purpose of these articles is to familiarize the profession with the specific concerns that were raised in that report and the areas of which Doctors of Chiropractic need to be especially cognizant.

Many people are not aware that Medicare is the largest health payer in the country (as well as being the largest purchaser of managed care). Currently supplying coverage for over 43 million Americans, and growing with the aging of the baby boomer population, the impact it has in the health arena obviously cannot be denied.

Our purpose, with these articles, is to increase general understanding of the Medicare program. The first article addressed common myths prevalent within the profession. This second article pertains to billing Medicare claims. Although not specifically addressed in the OIG report, it is still a major source of error within the profession and contributes to the problems we face within the Medicare system.

A large portion of our Medicare issues stem, quite simply, from filing claims improperly. It is crucial for our profession that all services not only be properly documented, but properly represented on the claims.

Tips for Correctly Completing a Medicare Claim

Adapted from "Medicare Made Simple," as presented by Susan McClelland, BS, CCA, FICC (h.c.) for the Association of Chiropractic Colleges; May 3, 2007.

For detailed information on filing Medicare claims, please visit http://nucc.org/images/stories/PDF/claim_form_manual_v4-0_7-08.pdf. Also, please note that these are national instructions. Billing instructions can vary slightly from contractor to contractor, so be sure to check the claim/billing instructions found on YOUR contractor's web site.

Following is a list of some of the more problematic items found on chiropractic claims:

Box 1a: Reproduce the HICN as found on the patient's Medicare card. This is normally a series of 9 numbers followed by a letter. This series of characters should be reproduced exactly on the form, without using spaces or hyphens.

Box 2: Reproduce the patient's name exactly as found on the Medicare card. Include the middle initial only if shown on the card.

Box 11: Insert the word "NONE," if Medicare is primary, or enter the primary insurance policy or group number. You must check to see if anything is primary to Medicare (e.g., PI, WC, other health insurance).

Box 14: Insert the date of first treatment for this course of care (please note that may NOT be the first time they were in your office).

Box 17/17a: Insert the referring/ordering physician's name and NPI if the claim contains diagnostic or consultation codes (e.g., x-ray).

Box 19: X-ray date, if used to identify subluxation. Additional information may be required here, dependent on contractor.

Box 24E: Diagnosis pointer. Only put one number in this column (i.e., 1, 2, 3, OR 4)!

Box 24F: Charges (may not be more than the Limiting Charge, if this is a non-par provider not accepting assignment).

Box 24J: Individual provider NPI, if group or corporation. Please note this can vary with contractor.

Box 32: Physical address of where services were rendered (cannot be a post office box).

Box 21 (ICD-9): Item #1 MUST be a 739.* code, unless specified otherwise by your contractor. Secondary NMS codes must be from the approved list provided by your contractor.

Box 24D (CPT): Spinal CMT (98940/98941/98942) is the only covered service under Medicare. All other codes/services are non-covered. Don't forget to use the correct modifier. In addition, remember that supervised EMS should be coded as G0283 instead of 97014. This will allow for the proper denial code.

Modifiers: Don't forget them!

The five modifiers most commonly used in chiropractic care are:

- -GY : non-covered service (required)
- -GA: properly delivered ABN on file (required for covered services)
- -GZ: you should have given an ABN but, for some reason, did not (optional)
- -GP: therapy service
- -AT: active care (acute and chronic) spinal CMT