The Healthcare Medicine Institute presents

Acupuncture Insurance Billing #1

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Table of Contents

Acupuncture Insurance Billing #1 4
- ICD-10-CM Diagnosis Codes 4
  - Cervicalgia 6
  - Laterality 6
  - Lumbago 7
  - Headaches and Migraines 7
  - Useful ICD-10-CM Codes 8
- Phone Call For Insurance Verification 10
  - Basic Call Questions 10
- CPT Basics 12
  - CPT (Current Procedural Technology) Codes 12
  - Acupuncture CPT Codes 12
  - Re-Insertion 13
  - CPT General Information 13
  - Additional Codes 15
  - Physical Medicine Codes 16
  - EM - Evaluation and Management Services 17
  - New Patient EM Codes 18
    - 99201 Evaluation/Management - Limited 18
    - 99202 Evaluation/Management - Expanded 18
    - 99203 Evaluation/Management - Detailed 18
  - Established Patient EM Codes 18
    - 99211 Evaluation/Management - Limited 18
    - 99212 Evaluation/Management - Expanded 19
    - 99213 Evaluation/Management - Detailed 19
  - SOAP Notes 19
- The New 1500 Health Insurance Claim Form 21
  - Special Instructions - Technical Details 21
    - Multipage For A Patient 21
    - Address 21
    - Item 1a 21
    - Item 6 22
    - Superbills 24
    - Federal and State Laws & Regulations 24

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Acupuncture Insurance Billing #1

ICD-10-CM Diagnosis Codes

New diagnosis codes were originally developed by the World Health Organization (WHO) and are called the International Statistical Classfication of Diseases and Related Health Problems, 10th Revision (ICD-10). The United States has developed a clinical modification of the ICD-10 called the ICD-10-CM (International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Clinical Modification).

Use of ICD-10-CM acupuncture insurance billing diagnosis codes are mandatory beginning October 2015. This system is very different from the old ICD-9 diagnosis codes. The National Center for Health Statistics (HCHS), the Centers for Disease Control (CDC) and the Centers for Medicare & Medicaid Services (CMS) play important roles in developing, maintaining and updating the ICD-10-CM diagnosis codes. Modifications to the codes and related forms over time are part of this process.

The CMS has a downloadable list of all ICD-10-CM billing codes. The CMS file labeled “tabular list” is a downloadable PDF and is the file that contains a quick and easy reference guide to all of the ICD-10 the codes. The link below takes you to ICD-10-CM files but first asks the user to accept the agreement. The PDF file becomes available after accepting the terms. For the complete up-to-date list, visit:

http://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx

This article lists some of the most common ICD-10-CM codes you will need in the acupuncture clinic. These codes may change over time because it is a relatively new system. We have primarily selected codes related to pain in our samples.

Pain codes are usually reimbursed by insurance companies. Other commonly accepted diagnoses include nausea due to chemotherapy and

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morning sickness and codes for the treatment of temporomandibular dental related disorders. General internal medicine conditions such as lupus, IBS, infertility, etc... are often rejected. The new ICD-10-CM code set does not change this restriction. It is up to individual health insurance providers to determine the diagnosis codes that are deemed reimbursable for licensed acupuncturists.

The old ICD-9-CM diagnosis codes ranged from 3-5 characters. There are specific conventions developed to determine whether a 3, 4 or 5 digit code is reimbursable in the old ICD-9 system. The new ICD-10-CM system consists of 3-7 characters. The first character is a letter, the second character is a number and characters 3-7 are either letters or numbers. The decimal place is after the first three characters. Example: M65.352 is the diagnosis code for “Trigger finger, left little finger.” An “X” may appear in a diagnosis code. The “X” is a placeholder sometimes used between designating characters.

There is ambiguity on whether some 3, 4 and 5 digit codes are acceptable in lieu of more lengthy 6 and 7 digit codes. Let’s take a look at how to make sure there is more certainty in the process. We start by looking a why certain codes are more commonly reimbursed than others.

There are several insurance companies, including Cigna, that accept only a limited number of diagnoses. Currently, Cigna readily reimburses for neck pain, low back pain, nausea due to chemotherapy and nausea due to morning sickness. Anthem (Blue Cross-Blue Shield) tends to reimburse for a wider variety of diagnosis codes. However, their clinical utilization review guidelines published in 2013 stipulate:

> **Medically Necessary:**
> The use of acupuncture is considered **medically necessary** for treatment of nausea and vomiting associated with surgery, chemotherapy, or pregnancy provided the individual does not have either of the following*:*
>
> - Pacemaker; or
> - Automatic implantable cardioverter-defibrillator (AICD).
>
> The use of acupuncture is considered **medically necessary** for treatment of painful chronic osteoarthritis of the knee or of the hip, if all of the following criteria are met:

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•Radiographic evidence of osteoarthritis; and
•Absence of **ALL** of the following:
 Other metabolic, inflammatory, or infectious causes of arthritis; and
 Pacemaker or AICD; and
 No plans for total joint replacement; and
•Pain significantly affecting daily activity and function.

Not Medically Necessary:

Acupuncture for any other indication, including but not limited to, the treatment of pain other than specified above, is considered **not medically necessary.**

Anthem guidelines stipulating "not medically necessary" partially explain why some pain related diagnosis codes are rejected. That said, most pain codes are reimbursed by Anthem whereas Cigna tends to adhere to strict and narrow guidelines.

Cervicalgia

Neck pain, cervicalgia, is the first place to start. Most insurance carriers will not reject the use of cervicalgia as a diagnostic specification. The new cervicalgia ICD-10-CM code is M54.2, a simple 4 character alphanumeric code. There is no extra digit ambiguity in this case. Sciatica is another story. The basic ICD-10-CM sciatica code is M54.3. The M54.3 code might be denied because there are five character versions of this code:

M54.30 Sciatica, unspecified side
M54.31 Sciatica, right side
M54.32 Sciatica, left side

Laterality

This is an example of a new feature in the ICD-10-CM system. Laterality may be specified. In this instance, the 5th character designates an unspecific side with a 0, right with a 1 and left with a 2. It is probable that a five character code is going to cause less problems than the four character code. It is less likely to be rejected and sent back for re-billing. In this case, an M54.3 is less likely to be accepted than an M54.30. The greater the specificity, the greater the likelihood of reimbursement. Some carriers may ask for laterality to be specified. In this case, either the right sided M54.31 or left sided M54.32 code will be required.

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Lumbago

Low back pain is perhaps one of the most universally accepted of all diagnoses. Low back pain is M54.5 and includes loin pain and lumbago NOS. The NOS indication means “Not Otherwise Specified” and refers to the generality of the unspecified disorder. Lumbago NOS is understood as generalized low back pain, unspecified. The M54.5 low back pain code excludes low back strain, which is an S39.012 ICD-10 code.

All of these codes can be easily found in the downloadable “tabular list” document from the CMS. The download is free. It is searchable because it is in the PDF format. In addition, expect updates over time to this list.

Headaches and Migraines

Acupuncturists are often reimbursed for the treatment of headaches. The R51 Headache ICD-10-CM code includes facial pain NOS but excludes atypical face pain (G50.1), migraine and trigeminal neuralgia (G50.0). R51 is only three digits but may be acceptable to many carriers for a headache NOS diagnosis. The migraine code (G43) requires extra character specificity and excludes headache NOS (R51) and lower half migraine (G44.00). The following are a few of the common migraine ICD-10-CM codes:

G43.009 Migraine without aura, not intractable, NOS
G43.109 Migraine with aura, not intractable, NOS
G43.409 Hemiplegic migraine, not intractable, NOS
G43.709 Chronic migraine without aura, not intractable, NOS
G43.909 Migraine NOS

The list for migraines is quite lengthy but a few codes should meet most office needs. The above selection fits the needs of many acupuncture offices. It is expected that most carriers will continue to reimburse for the treatment of headaches and migraines. However, non-pain codes for conditions commonly treated at acupuncture clinics such as G47.00 (insomnia NOS) may get rejected.

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Useful ICD-10-CM Codes

M54.2 Cervicalgia
M76.50 Patellar tendinitis, unspecified knee
M76.51 Patellar tendinitis, right knee
M76.52 Patellar tendinitis, left knee
M05.33 Rheumatoid arthritis
M16.10 Unilateral primary osteoarthritis, unspecified hip
M54.40 Lumbago with sciatica, unspecified side
M54.41 Lumbago with sciatica, right side
M54.42 Lumbago with sciatica, left side
M54.6 Pain in the thoracic spine
M54.5 Lower Back Pain
M54.30 Sciatica, unspecified side
M54.31 Sciatica, right side
M54.32 Sciatica, left side
M54.9 Dorsalgia, unspecified (backache NOS, back pain NOS)
H57.1 Eye Pain
R10.2 Pelvic and perineal pain
R07.0 Throat pain
K08.8 Tooth pain
F45.42 Pain disorder exclusively related to psychological factors
R51 Headache NOS
G43.009 Migraine without aura, not intractable, NOS
G43.109 Migraine with aura, not intractable, NOS
G43.409 Hemiplegic migraine, not intractable, NOS
G43.709 Chronic migraine without aura, not intractable, NOS
G43.909 Migraine NOS
G44.019 Cluster headache syndrome NOS
M75.20 Bicipital tendinitis, unspecified shoulder
S43.429 Sprain of unspecified rotator cuff capsule
M75.00 Adhesive capsulitis, unspecified shoulder (frozen shoulder)
M77.20 Periarthritis, unspecified wrist
G56.00 Carpal tunnel syndrome, unspecified upper limb
M72.2 Plantar fascial fibromatosis (plantar fasciitis)
M79.7 Fibromyalgia
M54.1 Brachial radiculitis NOS
M54.1 Lumbosacral radiculitis NOS
M79.601 Pain in right arm

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M79.602 Pain in left arm
M79.603 Pain in arm, unspecified
M79.604 Pain in right leg
M79.605 Pain in left leg
M79.606 Pain in leg, unspecified
M79.609 Pain in unspecified limb
M79.643 Pain in unspecified hand
M79.646 Pain in unspecified finger(s)
M79.673 Pain in unspecified foot
M79.676 Pain in unspecified toe(s)
M77.10 Lateral epicondylitis, unspecified elbow (tennis elbow)

Non-specific codes regarding laterality such as M79.643 (pain in unspecified hand) may be adequate. However, time will tell whether or not the codes must specify left or right. Pain in the left hand is M79.642 and pain in the right hand is M79.641.

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Phone Call For Insurance Verification

A phone call is often necessary to determine insurance reimbursement amounts and restrictions. A patient member ID number, patient name, patient date of birth and possibly the group number is required. The ID number is normally written on the patient's insurance verfication card. If you don't have the ID number you may be able to use the name, date of birth and social security number instead. The practitioner's name, physical address and the NPI and/or Tax ID number are required.

Be prepared to wait on-hold. Identify insurance company call centers that have quick links to a live operator. For example, some carriers allow the caller to press 0 to get an operator. Others force the user to sift through a phone tree of selections every time. A speakerphone or wireless headset is recommended.

Determine whether or not you are in-network or out-of-network and be sure to specify network membership status when confirming benefits. If unsure, get both in and out-of-network parameters.

Basic Call Questions

Remember to get the name or ID number of the carrier's operator and document the date. After getting all of the information, *get the call reference number.* At the beginning of the call, provide a call-back number to be used in the event of the call being prematurely disconnected.

General Opening Question
Is there acupuncture coverage for licensed acupuncturists?

Deductible
How much is the deductible and how much of it has been met?
Has the deductible been met?
Is there a maximum amount towards each visit applied to the deductible?

Payments
What is the co-pay?
What percentage does the insurance pay?

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What is the dollar maximum paid per visit?
Is the reimbursement paid based on the usual, customary and reasonable reimbursement (UCR) determination by the carrier?
What dollar amount is the UCR maximum per visit?
After the UCR amount is met, what percentage is paid on the remainder?

Limits and Exclusions
Is there a limit on the amount reimbursed per year?
Is there a limit on the number of visits per year?
Are there any limits or exclusions on the policy?
Are there any limits on diagnoses? Please let me know what they are.
Are there limits on acupuncture when combined on the same day of service with other services such as physical therapy and chiropractic?

Authorization of Care
Is pre-authorization or a referral required and by whom?
Is there a utilization review process (UR) required?

陀 華
Hua Tou

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CPT Basics

Several years ago, there were two acupuncture billing codes. One code was used for electroacupuncture and the other for acupuncture. They have been replaced by four codes.

The 97810 code is for the application of acupuncture. Technically, it is for the application of one or more acupuncture needles during the initial phase of an acupuncture treatment wherein the acupuncturist has "personal one-on-one contact with the patient." The next code, 97811 is for each additional 15 minutes of acupuncture during that same treatment period. However, the code stipulates that there is a "re-insertion of needles" for it to be allowed.

CPT (Current Procedural Technology) Codes

CPT billing codes for acupuncture procedures are not affected by the change to ICD-10-CM diagnosis codes. CPT® codes are a registered trademark of the AMA (American Medical Association). CPT codes are a number assigned to a procedure and are used in the billing process to determine reimbursement quantities. The CMS writes in their ***FAQs: ICD-10 Transition Basics*** publication, "The switch to ICD-10 does not affect CPT coding for outpatient procedures."

Acupuncture CPT Codes

CPT Code: 97810
Acupuncture, one or more needles, without electrical stimulation, initial 15 minutes.

CPT Code: 97811
Acupuncture, one or more needles, without electrical stimulation, each additional 15 minutes. With re-insertion.

CPT Code: 97813
Acupuncture, one or more needles, with electrical stimulation, initial 15 minutes.

CPT Code: 97814

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Acupuncture, one or more needles, with electrical stimulation, each additional 15 minutes. With re-insertion.

Re-Insertion

There has been a concern in the acupuncture community over the term "re-insertion" since it may imply taking a needle out and putting it back in again. That would be a violation of clean needle technique and several state laws. A simple case of poor semantics is probably the core issue.

Either additional acupuncture needles must be added to the patient after the first 15 minutes for the 97811 code to be used or re-insertion may imply the use of acupuncture techniques such as Setting the Mountain on Fire, Penetrating Heaven's Coolness and other procedures that involve lifting and thrusting of the needles. If the latter is true, then the code may not acknowledge the Dragon and Tiger Fighting technique and other procedures based on twirling the needle. Clarification would be helpful in the CPT system. Some insurance carriers have clarified their positions by stating that the timed nature of acupuncture codes is most important and the issue of re-insertion is not important.

The next two codes are similar to the manual acupuncture codes only they account for the additional time and effort in the application of electroacupuncture. The 97813 code is for the first 15 minutes of electroacupuncture and the 97814 code is for the next 15 minutes of electroacupuncture, again with "re-insertion" as a requirement.

CPT General Information

Today, there are insurance carriers that will only pay the first CPT code and will ignore any additional timed codes. Other carriers pay a percentage of each code billed. Sometimes weight is given to the first code. In some

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cases, carriers will pay the entire amount billed. This is a difficult situation for licensed acupuncturists because CPT reimbursements are not only different between carriers but also between policies provided by the same carrier. This is one reason why acupuncturists often choose to hire professional billing services or medical coding employees.

A review of your EOBs (Explanation of Benefits) that are received with your reimbursement payments from the insurance carriers will let you know the exact mechanism each policy employs. An EOB form is a statement sent by a health insurance company to covered individuals and/or providers explaining what medical treatments and/or services were paid for. Paper EOBs are being phased out. Over time, expect the entire process to become electronic.

Be sure to pay attention to your EOBs. They flag unpaid services, underpaid codes, deductibles, objections, rejections, full payments, partial payments and requests for more information by the carrier necessary for payment. Verifying insurance coverage by telephone may yield inaccurate information that is passed along to patients. For example, a carrier may mistakingly note that a patient has acupuncture coverage when they do not.

The EOB is the most accurate way to verify a carrier's exact coverage. It is important to communicate with your patient if there is a discrepancy between the phone verification information and the EOB reality if you have shared the phone verification information. The phone information sets up expectations and may cause a rift between the practitioner and the patient when there are discrepancies between payments and initial verification of coverage.

Let's look at an example of a $75 office visit. If one performs a 45 minute acupuncture visit and divides their standard fee into thirds for each portion of the visit and bills 97810 at $25 and bills two 97811 codes at $25 each, the insurance carrier may only recognise the first code and will pay according to a $25 cost per visit. On the other hand, some carriers will pay based on the total amount billed, a $75 acupuncture visit.

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If an acupuncturist bills $50 for the initial 15 minutes and $12.50 twice with the next two 15 minute codes, the acupuncturist runs into similar difficulties. Some insurance carriers will discount reimbursement for the first 15 minutes because of the addition of extra codes. Ultimately, it is the first 15 minutes that is weighted most heavily for reimbursement by the CPT system and that is where the bulk of the fee is best placed in most scenarios.

Insurance is regulated on a state-by-state basis. Many states allow for discount to patients who are underinsured or are non-insured. Other states allow discounts for other reasons including hardship and for payment at the time of service. For example, a 97810 can be billed at $85.00 and a 97811 can be billed at $35.00. Total billing to an insurance carrier in this example for a 45 minute treatment (97810, 97811, 97811) is $155.00. Many states allow patients that are underinsured or paying cash at the time of the office visit to pay a discounted rate adjusted downward from the $155.00.

Additional Codes

Acupuncture codes are timed CPT codes. As a result, more than one 97811 or 97814 code can be added to the initial 15 minute timed codes of 97810 and 97814 respectively. For example: 97813, 97814 and another 97814 can be billed if the service is 45 minutes or greater and meets the parameters of the codes. Some carriers limit the amount of codes that may be submitted per visit.

Additional billing codes such as evaluation and management (EM) and physical medicine codes may be added in some cases. Evaluation and management of a patient is built-in to the timed acupuncture CPT codes. However, additional evaluation and management of the patient over and above a reasonable and customary expectation may be billed with an EM code in addition to acupuncture codes. However, SOAP notes must document this additional work. Be prepared for EM codes to be rejected by carriers and sent back with a request for the attachment of SOAP notes to justify the billing.

Another issue encountered by acupuncturists is that some insurance carriers will pay the EM code but not the acupuncture codes when billed

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together. The acupuncturist must then formally object and re-bill. As a result, many acupuncturists choose to not add EM codes. EM codes are never added on a regular basis and are only for special cases of extended evaluation and management over and above a reasonable expectation.

Physical Medicine Codes

A trouble encountered by licensed acupuncturists is underpayment when adding physiotherapy CPT codes. Legally, acupuncturists are allowed to use these codes but insurance companies may wind up paying for these codes and ignoring the acupuncture codes entirely. These codes include 97110 for therapeutic exercises, 97112 for neuromuscular reeducation, 97114 for functional activities, 97540 for training of activities of daily living, 97610 for soft tissue mobilization, etc.…

An example would be the application of tui-na, shiatsu or another form of massage that is billed with the 97610 code, soft tissue mobilization. One would expect that adding additional time for the application of massage would yield a higher reimbursement rate. Unfortunately, some insurance carriers either ignore the physiotherapy code(s) and pay the acupuncture codes or ignore the acupuncture codes and pay the physiotherapy codes.

The carrier may also reduce the patient’s annual allotment of physical therapy appointments by one visit because a physiotherapy code was used. This reduction will appear on the patient’s EOB (Explanation Of Benefits) paperwork that is mailed directly to the patient. This may lead to uncomfortable communication issues wherein the patient may become irate towards the licensed acupuncturist because of the actions of the carrier.

The most important concept here and with all insurance billing is to ensure that a third party, the insurance carrier, does not come between the medical practitioner and the patient.

In some cases insurance carriers will pay for all of the services rendered and billed. Some premium insurance plans continue to reimburse providers based on the actual services rendered. Patients with these plans tend to be in high technology jobs or are union members.

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EM - Evaluation and Management Services

The standard manual and electroacupuncture billing codes 97810 and 97813 include the time an acupuncturists takes to evaluate and manage patient care. If extra time is taken, some practitioners choose to bill for the extra evaluation and management of the patient with an extra code, an EM code. A modifier to the EM code of “-25” on the 1500 form is necessary to indicate services that are in addition to the evaluation and management services built-in to the standard acupuncture codes. The -25 signifies that the extra evaluation and management is separate from the treatment reflected in the acupuncture codes.

If you bill EM codes with acupuncture codes there is a possibility of only being paid for the EM code and not the acupuncture code therefore earning less. You may need to re-bill to get the acupuncture code reimbursed. If you have already billed and have been paid for acupuncture codes on a given day of service, it is acceptable to re-bill for the EM code for that same day of service if you have discovered that your services rise to the level of the additional code.

EM codes require extended chart notes to justify the extra evaluation and management of the patient. EM codes are not billed with every visit but are exceptional cases wherein extra time was needed for evaluation and management. The carrier may request submission of chart notes prior to reimbursement of EM codes for licensed acupuncturists.

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New Patient EM Codes

This applies to patients that have not bee seen within the last three years or a completely new patient

99201 *Evaluation/Management - Limited*

History and Exam:	problem-focused
Medical Decision Complexity:	straightforward
Presenting Problem/Severity:	self-limited or minor

This code usually involves an extra 10 minutes of face-to-face time with the patient.

99202 *Evaluation/Management - Expanded*

History and Exam:	expanded problem-focused
Medical Decision Complexity:	straightforward
Presenting Problem/Severity:	low to moderate

This code usually involves an extra 20 minutes of face-to-face time with the patient.

99203 *Evaluation/Management - Detailed*

History and Exam:	detailed
Medical Decision Complexity:	low
Presenting Problem/Severity:	moderate

This code usually involves an extra 30 minutes of face-to-face time with the patient.

99204, 99205

The 99204 code involves increased severity and usually involves an extra 45 minutes. The 99205 is the maximum complexity and usually involves an extra 60 minutes.

Established Patient EM Codes

99211 *Evaluation/Management - Limited*

History and Exam:	minimal

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Medical Decision Complexity: minimal
Presenting Problem/Severity: minimal

This code usually involves an extra 5 minutes of face-to-face time with the patient.

99212 Evaluation/Management - Expanded

History and Exam: problem-focused
Medical Decision Complexity: straightforward
Presenting Problem/Severity: self-limited or minor

This code usually involves an extra 10 minutes of face-to-face time with the patient.

99213 Evaluation/Management - Detailed

History and Exam: expanded problem-focused
Medical Decision Complexity: low
Presenting Problem/Severity: low to moderate

This code usually involves an extra 15 minutes of face-to-face time with the patient.

99214, 99215

The 99214 code involves increased severity and usually involves an extra 25 minutes. The 99215 is the maximum complexity and usually involves an extra 40 minutes.

SOAP Notes

SOAP is an abbreviation for: subjective, objective, assessment, plan.

The S in SOAP is for the subjective portion of the chart notes. This includes information that the patient verbally relays to the acupuncturist. This may include the frequency, intensity and duration of a complaint. The patient history is included in this section. Technically, this information is not considered factual data.

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The O in SOAP is for objective. This is considered factual data. Objectives are observations made directly by the acupuncturist or other medical professional. This includes a variety of information including test results. Blood pressure, weight, clinical observations, range of motion and other signs are noted here. The objectives may also include clinical observations concerning a patient's psychological state.

The A is for assessment. This is the diagnosis section. This may include a differential diagnosis according to Traditional Chinese Medicine (TCM) principles and a biomedical diagnosis. Some insurance carriers will not reimburse for acupuncturist services unless a biomedical diagnosis is made and a corresponding CPT code is assigned in the billing information. If a diagnosis cannot be made, a list of possible diagnoses may be included in this section. Evaluation of diagnostic tests and need for referral may be discussed in this section.

The P in SOAP is for plan. This is the determination of what type of treatment is to be rendered. This may include acupuncture points, herbal medicines, work restrictions and dietary recommendations. The plan may have both short term and long term goals for patient health.

SOAP notes may include abbreviations to assist in quick documentation of clinical findings. For example, *eap* is an abbreviation of electroacupuncture. Importantly, SOAP notes are legally confidential documents. Patient privacy laws apply. This includes the maintenance, storage and proper disposal of records.

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The New 1500 Health Insurance Claim Form

Submission of insurance claims with the new ICD-10-CM codes requires the use of a new billing form. The new form was developed by the National Uniform Claim Committee (NUCC) in cooperation with the American Medical Association (AMA). The “1500” form is often referred to as the “HCFA 1500” or “CMS-1500” form. Included is the most recent example of the 1500 form at the time of writing this course material. However, this form may be modified over time. If your billing software is current or you order 1500 forms from a reputable medical supplier, they will have the most recent approved form for use.

The use of paper forms such as the CMS/HCFA 1500 will eventually be phased out in favor of electronic billing. Medical billing software packages should supply ICD-10-CM billing code updates and stay current with electronic billing standards. If your biling software does not accommodate the new layout of the 1500 form or does not use the new ICD-10-CM codes, it will not be fully functional for medical billing to insurance carriers or for the generation of superbills.

Special Instructions - Technical Details

A recent version of the 1500 form is included in this course. There are a few particularities worth reviewing when filling out a 1500 form.

Multipage For A Patient

When submitting multipage insurance claims, the diagnosis codes on the first page must be repeated on all subsequent pages for a given patient.

Address

The NUCC advises to NOT use punctuation including commas, periods and other symbols in the address line. Example:

Correct: 321 E Mulberry Lane 999
Incorrect: 123 E. Mulberry Lane, #999

Item 1a

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For item “1a. INSURED’s I.D. Number” enter the insured’s ID number on their health insurance card. For worker’s compensation cases, enter the employee ID number. For property and casualty claims, enter either the Federal Tax ID or Social Security number of the insured.

Item 6

For item “6. PATIENT RELATIONSHIP TO INSURED” there are check boxes for Self, Spouse, Child, Other. If the patient is a dependent and has a unique Member Identification Number required by the carrier to be used on the form, then check Self. ‘Other’ refers to patients other than one’s self, spouse or child and may be a ward, a dependent specified in the insured’s policy, an employee, etc.…

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

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

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. 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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. b.

33. BILLING PROVIDER INFO & PH # ( ) a. b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-1197 FORM 1500 (02-12)

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SAMPLE

Superbills

ICD-10 codes are the new standard for 1500 forms and superbills. Superbills are forms used by medical practitioners that may be given to patients so that they can be reimbursed for office visits and medical procedures. Patients can submit superbills directly to the carrier.

Superbills usually include:

Patient's name, address and phone
Additional identifying information (i.e., Social Security Number)
Medical practitioner's name, address
Medical practitioner's license number, NPI number, tax ID number
Medical practitioner's diagnoses for the patient (ICD-10-CM)
Treatment(s) rendered to the patient and Cost of the treatment (CPT)
Amount paid by the patient
A release authorization statement
Patient's signature
Medical practitioner's signature

Federal and State Laws & Regulations

The federal passage of the PPACA (Patient Protection and Affordable Care Act) required each state to pass legislation mandating minimum standards for health insurance policies. In some states, this has led to the adoption of acupuncture as a reimbursable service. In California and Maryland for example, acupuncture health insurance coverage is mandated to all of its citizens with small group and individual health insurance plans. The new state laws determine the specifics of healthcare coverage. In California, for example, the number of visits per year may no longer be capped for patients with individual plans or small group plans. These changes take effect when new policies are written and old policies are renewed.

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Follow the links. Courses can be downloaded to multiple locations, quizzes can be taken (and re-taken if needed) and certificates of completion can be saved and printed.

Note: First, select the Quiz button. Next, it changes to the Take Test button. This changes to a get Certificate button once you have passed the test.

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