INSURANCE COMMITTEE

Important Information for You to Know and Use

STATE BOARD OF CHIROPRACTIC

Licensure Processing Guides and Timelines

https://www.dos.pa.gov/ProfessionalLicensing/Pages/professional-licensing-guides.aspx

PALS online - Account Registration for Chiropractic Licensure

https://www.pals.pa.gov/#/page/register

Important Note: remember to apply for adjunctive license also if you want to perform physical medicine modalities – required by law If you want to get reimbursed by the insurance carriers.

Jurisprudence: The "Pennsylvania Chiropractic Law Examination" is no longer required. Instead, applicants complete a "Pennsylvania Chiropractic Legal Review" page. This page is included in the application and allows applicants to demonstrate to the Board that they are aware of the contents of the Rules and Regulations and Act.

8:30 - 4:00 pm (M-F)
Phone: (717) 783-7155
Fax: (717) 787-7769
email: ST-CHIROPRACTIC@PA.GOV

Mailing Address
State Board of Chiropractic
P.O. Box 2649
Harrisburg, PA 17105-2649

Physical Address
One Penn Center
2601 N. 3rd Street
Harrisburg, PA 17110

The National Provider Identifier (NPI)

How to apply for your NPI. The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Remember you need an NPI as a provider AND as a corporate entity (pc, llc, etc).

FAQ on applying for NPI in PA information - https://www.dhs.pa.gov/providers/FAQs/Pages/NPI-FAQ.aspx
The NPI Enumerator Call Center Telephone Number is 1-800-465-3203
First time user: https://nppes.cms.hhs.gov/IAWeb/register/startRegistration.do
https://nppes.cms.hhs.gov/IAWeb/login.do
To look up an NPI use this link - https://npiregistry.cms.hhs.gov

Data base for Insurance companies to 'look you up'
'One stop practice, provider, malpractice, credentials' etc etc etc so that insurance carriers can obtain your information:: here is the link to register and login regularly to update information and re-attest that all your information is correct - https://proview.caqh.org/Login/Index?ReturnUrl=%2f It will make your life a little easier except has to be reattested every few months.

Important note: Insurance carriers have a deadline for billing claims if you want to get reimbursed for services provided. Those timely requirements vary with each carrier.

Common Procedure Codes Used

99202 Initial examination 10-30 min time spent WITH guidelines of what was performed and decision making involved.
99203 Initial examination 30-45 min time spent WITH guidelines of what was performed and decision making involved.
99204 Initial examination 45-60+ time spent **NOTE:** red flag many times by carriers unless you can prove it was medically necessary and you truly spent the time necessary and decision making was an extensive process.

99212 - brief exam/reevaluation time and decision level based
99213 - brief exam/reevaluation time and decision level based
99214 - brief exam/reevaluation time and decision level based **NOTE:** red flag many times by carriers unless you can prove it was medically necessary and you truly spent the time necessary and decision making was an extensive process. Workers Compensation fee schedule does not allow for reevaluation codes.

98940 1-2 regions of spinal manipulation
98941 3-4 regions of spinal manipulation
98942 5+ regions of spinal manipulation **NOTE:** chronic use of this code will get you on a red flag status unless you can prove medical necessity

98943 – extremity, TMJ, Rib manipulation. Cannot bill for each body part manipulated. Can only be billed once per patient visit. NOT covered by Medicare. No need for modifier on this code.

97140 Manual Manipulation /myofascial release/ joint mobilization / to a separate and distinct region than spinal manipulation. Time based code minimum 8 min for private insurance based patients (8-15 minutes is 1 unit billed) (23-30 minutes is 2 units billed) (31-39 minutes is 3 units billed). Use 59 or XS modifier when also performing spinal manipulation and dx point (box 24 E to the region you provided the manual therapy to) **IMPORTANT NOTE**: For Workers Compensation cases in PA MUST BE BILLED AND DOCUMENTED for full 15 min increment.

97110 – Therapeutic exercise –Time based code minimum 8 minutes for private insurance-based patients with same time constraints for units. Must document in detail of what, how, how long, reps, sets were performed. **IMPORTANT NOTE:** For Workers Compensation BILLED AND DOCUMENTED per 15 min increments only. **VERY VERY VERY IMPORTANT NOTE:** unless you have licensed personnel present (DC, PT, MD) physically in front of the patient(s) (not overseeing from another room with door open) (Cannot be performed by non-licensed personnel such as personal trainer, staff, LMT. You may bill for group therapy if more than one patient is exercising under your gaze.

97014/G0283 - electrical muscle stimulation, not a timed base code and can only be billed one time per visit no matter the areas. **IMPORTANT NOTE:** For State Farm utilize G0283 code for electrical muscle stimulation, other carriers will make the switch internally if you bill 97014. United Healthcare also insists on G0283 but you must append a GP modifier.

97012 – mechanical traction (some use this code for spinal decompression therapy however that would be incorrect as most carriers want you to use 97039) – A traction based procedure. Not a time based code, bill one time per visit no matter how many regions are treated. If providing mechanical traction as well as manual therapy it is necessary to append 59 or XS and your documentation must clearly show that traction (either mechanical or manual) was not provided under the 97140.

97035 – Attended Ultrasound - Time based code minimum 8 min for private insurance based patients (8-15 minutes is 1 unit billed)(16-24 minutes is 2 units billed)(25-44 minutes is 3 units billed). Must document in detail of what, how, how long, reps, sets was performed. IMPORTANT NOTE: For Workers Compensation in PA you must bill and document full 15 minutes.

Clearinghouse for billing insurance electronic claims (only suggestions)

TRIZETTO PROVIDER SOLUTIONS OFFICE
501 North Broadway
Suite #300
St. Louis, MO 63102
800-556-2231
https://www.trizettoprovider.com/who-we-serve/payers/clearinghouse

OFFICE ALLY
www.officeally.com

CAQH
https://www.caqh.org/solutions/clearinghouse-faqs

AVAILITY
https://www.availity.com/

QUESTIONS TO ASK

THE PATIENT

For Insurance Patients:

·Patient registered Name with their insurance
·Date of birth
·If they are the primary insurance holder (or policy thru significant other)
·If significant other is the policy holder, will need their full name and date of birth.
·Their Home address
·Insurance company name
·Insurance company provider services number (usually on the card)
·Insurance company address if available on the card

Always remember that the insurance policy is the patient's policy, it is their responsibility to obtain the benefits that their policy allows and any restrictions they may have. Always inform the patient of that when they call as well as when they come into the office and do not take responsibility for their insurance restrictions.

QUALIFYING INSURANCE

·Copay
·Co-insurance
·Deductible
·Claims address
·Effective date of coverage
·Submitted clean claims turn around time (usually 45days for private pay carriers) WC and Auto accident cases (usually 30 days)
·Claims fax number (ask if you can fax the claims with notes if required)
·Any Third Party Administrators (TPA) requirements
·Any limitations of allowed services before authorization is required. Example: 8 visits allowed before authorization is required to continue treatment
·Is there a dollar amount limitation per person and family
·How many visits are allowed per year and when does the year start? And have they used any visits for the year yet.
·Is there authorization requirement for patient visit from day one, if so, how many allowed without authorization
·Is it a self funded plan
·Is there an authorization requirement for an MRI or a CAT scan?
·Is there a referral requirement, especially for HMO policy.

ADDITIONAL QUESTIONS FOR AUTO ACCIDENT CASES (NO FAULT (NF)

·Date of accident
·Attorney if retained
·Initial complaint of injury, any complaints that started after
·Are you the patient the insured?
·IMPORTANT NOTE: In Pennsylvania, the treatment for medical claims under auto accidents must be treated through the patient's policy and not the opposite party involved in the accident. If the patient is not the insured (meaning they do not have their own policy/or listed in the household they live in) you need to file a medical claim in the household they reside in and use that persons/households auto policy for medical claims. In the event that there is no household auto policy in effect at the time of the accident, then and only then can a medical claim be filed with the vehicle owners policy. This also means that they have to sign an affidavit that states that they are an uninsured passenger/driver in the vehicle that was involved in the accident. In short, the treatment must be rendered in the household auto policy unless there is no effective auto policy for that patient or the household.

NOTE: Act VI allows the carrier to send your bills and documentation out for a Peer Review. If you do not agree with the reviewer's decision you must ask for reconsideration or have an atty such as Jason Martin file in small claims court on your behalf.

ADDITIONAL QUESTION WORKERS COMPENSATION CASE

·Date of injury
·Attorney if retained
·Body part reported and on the report (NOTE: stick with body part reported for treatment to patient UNLESS you can validate medical necessity of other body part referring pain)(Note: Will need help from attorney to file a formal injunction to include that body part in the injury – which means there will be a hearing to deny or accept the additional injury at which time will determine if you can treat and bill the 'new or additional' body part as part of WC claim.
·Was the patient given a panel of providers when injury was reported
·Who the injury was reported and title of their position
·Insurance adjusters name, claims address, fax number, nurse case manager if available

Important note – in order for you to treat a WC patient

1. 90 days must have passed after date of injury unless you are listed as one of the panel of providers
2. If you are not on the panel and 90 days from date of injury has not passed – permission to treat from employer is required (also a good way to ask if you can be placed on the panel as a collaborative provider for their employees now and future
3. If the employee was NOT given a list of the panel providers when injury was reported. (Might need help from counsel as the employer/carrier in many cases will tell you medical claims will NOT be paid for/covered). This will be a good way to establish a professional working relationship with a good mutually beneficial/professional relationship with a WC attorney firm.

NOTE: an IME (Independent Medical Exam) is the right of the insurance carrier to send the patient to validate treatment. A URO (Utilization Review Organization) allows the carrier to send your documentation and bills to another DC for his/her opinion as to medical necessity. Therefore it is imperative that you document and provide care that is effective and according to medical standards to avoid denials of claims submitted for nonpayment. In the event that claims are denied after a URO you still have the right to dispute the denial and possibly will need assistance from legal counsel. Jason Martin, ESQ is an excellent resource of the Pennsylvania Chiropractic Association to help you in this process.

For WC Remember you have to file a LIBC 9 form every month with the carrier so that in the event that you have to file a fee review petition they don't have a reason to deny your claims. Here is the link to the LIBC9 form - https://www.dli.pa.gov/Businesses/Compensation/WC/claims/wcais/Documents/wcais forms/LIBC-9 print.pdf

The below link replaced some of the carriers such as personal choice, keystone HPE, independence administrators that were through NAVINET in the past https://www.pearprovider.com/group/pear/home

For Highmark, Capital BC, Horizon BCBS, Anthem benefits and claims use below site https://navinet.navimedix.com/plan-central/highmark-blue-shield

For Aetna use https://www.availity.com/

E-check – this link allows to Receive payments electronically if you have registered to receive the checks deposited into your office bank account. Many carriers use this company to receive ETF deposits. (Highmark, some secondary carriers, Meritain (aetna) and Trustmark) https://my.echecks.com/welcome

You can also have electronic payments sent through provider payments.com or ECHO

Medicare:
Covered services: Medicare only pays for chiropractic manipulation. The procedure codes to use are 98940AT, 98941AT, 98942AT. The ICD 10 coding must be a subluxation code on the first line followed by a pointer that pertains to the area of complaint. The more specific the secondary pointer code the better your chances of having less problems and issues for billed services. Example M99.01 and second line M53.1. Another example M99.03 and second line M54.42. Another example M99.01, S13.4XXA, line 3 M99.03 with line 4 as S33.5XXA. You may collect deductibles and copay up front if you'd like but most patients have a secondary or supplemental policy that Medicare will automatically send to them for reimbursement to you. Please note - Some 'old grandfathered employer secondary insurance plans' cover physical medicine modalities, but almost none do these days. You're required to bill Medicare for covered services (manipulation) If at any time you suspect Medicare will not pay for the spinal manipulation you must append a GA modifier to the 9894X so that Medicare makes the patient responsible. GA modifier means you have a valid signed ABN on file. You do not have to bill Medicare for non covered services (maintenance, etc.) unless the patient asks you to.
(ABN information, form and instructions below)

A Medicare provided ABN form needs to be signed by the patient, If you feel the patient has reached maximum medical improvement you can have the patient sign the ABN form advising the patient that services might not be covered as Medicare guidelines states maintenance is not a covered service. Definition of maintenance for the most part states that you need a consecutive care of treatment plan to resolve an issue in a standard of care protocol. If the ABN form is signed it gives you the benefit allowing you to collect the payment from the patient if Medicare denies the service.
Instructions taken from www.CMS.gov below.

Form Instructions
Advance Beneficiary Notice of Non-coverage (ABN) OMB Approval Number: 0938-0566
The ABN is a notice given to beneficiaries in Original Medicare to convey that Medicare is not likely to provide coverage in a specific case. "Notifiers" include:
• Physicians, providers (including institutional providers like outpatient hospitals), practitioners and suppliers paid under Part B (including independent laboratories);
• Hospice providers and religious non-medical health care institutions (RNHCIs) paid exclusively under Part A; and
• Home health agencies (HHAs) providing care under Part A or Part B.
All of the aforementioned healthcare providers and suppliers must complete the ABN as described below in order to transfer potential financial liability to the beneficiary, and deliver the notice prior to providing the items or services that are the subject of the notice.
Medicare inpatient hospitals and skilled nursing facilities (SNFs) use other approved notices for Part A items and services when notice is required in order to shift potential financial liability to the beneficiary; however, these facilities must use the ABN for Part B items and services.
The ABN must be reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. Employees or subcontractors of the notifier may deliver the ABN. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the notifier must retain a copy of the ABN delivered to the beneficiary on file.
The ABN may also be used to provide notification of financial liability for items or services that Medicare never covers. When the ABN is used in this way, it is not necessary for the beneficiary to choose an option box or sign the notice.
ABN Changes
The ABN is a formal information collection subject to approval by the Executive Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (PRA). As part of this process, the notice is subject to public comment and re-approval every 3 years. With the latest PRA submission, a change has been made to the ABN. In accordance with Title 18 of the Social Security Act, guidelines for Dual Eligible beneficiaries have been added to the ABN form instructions.

Completing the Notice

ABNs may be downloaded from the CMS website at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html . Instructions for completion of the form are set forth below:

ABNs must be reproduced on a single page. The page may be either letter or legal-size, with additional space allowed for each blank needing completion when a legal-size page is used.

There are 10 blanks for completion in this notice, labeled from (A) through (J). We recommend that notifiers remove the lettering labels from the blanks before issuing the ABN to beneficiaries. Blanks (A)-(F) and blank (H) may be completed prior to delivering the notice, as appropriate. Entries in the blanks may be typed or hand-written, but should be large enough (i.e., approximately 12-point font) to allow ease in reading. (Note that 10 point font can be used in blanks when detailed information must be given and is otherwise difficult to fit in the allowed space.) The notifier must also insert the blank (D) header information into all of the blanks labeled (D) within the Option Box section, Blank (G). One of the check boxes in the Option Box section, Blank (G), must be selected by the beneficiary or his/her representative. Blank (I) should be a cursive signature, with printed annotation if needed in order to be understood.

Header:

Blanks A-C, the header of the notice, must be completed by the notifier prior to delivering the ABN.

1. Blank (A) Notifier(s): Notifiers must place their name, address, and telephone number (including TTY number when needed) at the top of the notice. This information may be incorporated into a notifier's logo at the top of the notice by typing, hand-writing, pre- printing, using a label or other means.

If the billing and notifying entities are not the same, the name of more than one entity may be given in the Header as long as it is specified in the Additional Information (H) section who should be contacted for billing questions.

2. Blank (B) Patient Name: Notifiers must enter the first and last name of the beneficiary receiving the notice, and a middle initial should also be used if there is one on the beneficiary's Medicare card. The ABN will not be invalidated by a misspelling or missing initial, as long as the beneficiary or representative recognizes the name listed on the notice as that of the beneficiary.

3. Blank (C) Identification Number: Use of this field is optional. Notifiers may enter an identification number for the beneficiary that helps to link the notice with a related claim. The absence of an identification number does not invalidate the ABN. An internal filing number created by the notifier, such as a medical record number, may be used. Medicare numbers (HICNs), Medicare beneficiary identifiers (MBIs), or Social Security numbers should not appear on the notice.

Body:

4. Blank (D): The following descriptors may be used in the Blank (D) fields:

Item

Service Laboratory test Test

Procedure Care Equipment

• The notifier must list the specific names of the items or services believed to be non-covered in the column directly under the header of Blank (D).

• In the case of partial denials, notifiers must list in the column under Blank (D) the excess component(s) of the item or service for which denial is expected.

• For repetitive or continuous non-covered care, notifiers must specify the frequency and/or duration of the item or service.

• General descriptions of specifically grouped supplies are permitted in this column. For example, "wound care supplies" would be a sufficient description of a group of items used to provide this care. An itemized list of each supply is generally not required.

• When a reduction in service occurs, notifiers must provide enough additional information so that the beneficiary understands the nature of the reduction. For example, entering "wound care supplies decreased from weekly to monthly" would be appropriate to describe a decrease in frequency for this category of supplies; just writing "wound care supplies decreased" is insufficient.

• Please note that there are a total of 7 Blank (D) fields that the notifier must complete on the ABN. Notifiers are encouraged to populate all of the Blank (D) fields in advance when a general descriptor such as "Item(s)/Service(s)" is used. All Blank (D) fields must be completed on the ABN in order for the notice to be considered valid.

5. Blank (E) Reason Medicare May Not Pay: In the column under this header, notifiers must explain, in beneficiary friendly language, why they believe the items or services listed in the column under Blank (D) may not be covered by Medicare. Three commonly used reasons for non-coverage are:
“Medicare does not pay for this test for your condition.”
“Medicare does not pay for this test as often as this (denied as too frequent).” “Medicare does not pay for experimental or research use tests.”

To be a valid ABN, there must be at least one reason applicable to each item or service listed in the column under Blank (D). The same reason for non-coverage may be applied to multiple items in Blank (D) when appropriate.
6. Blank (F) Estimated Cost: Notifiers must complete the column under Blank (F) to ensure the beneficiary has all available information to make an informed decision about whether or not to obtain potentially non-covered services.
Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed under Blank (D). In general, we would expect that the estimate should be within $100 or 25% of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted.
Multiple items or services that are routinely grouped can be bundled into a single cost estimate. For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). An average daily cost estimate is also permissible for long term or complex projections. As noted above, providers may also pre-print a menu of items or services in the column under Blank (D) and include a cost estimate alongside each item or service. If a situation involves the possibility of additional tests or procedures (such as in laboratory reflex testing), and the costs associated with such tests cannot be reasonably estimated by the notifier at the time of ABN delivery, the notifier may enter the initial cost estimate and indicate the possibility of further testing. Finally, if for some reason the notifier is unable to provide a good faith estimate of projected costs at the time of ABN delivery, the notifier may indicate in the cost estimate area that no cost estimate is available. We would not expect either of these last two scenarios to be routine or frequent practices, but the beneficiary would have the option of signing the ABN and accepting liability in these situations.
7. Blank (G) Options: Blank (G) contains the following three options:
• OPTION 1. I want the (D) 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.
This option allows the beneficiary to receive the items and/or services at issue and requires the notifier to submit a claim to Medicare. This will result in a payment decision that can be appealed.

Suppliers and providers who don’t accept Medicare assignment may make modifications to Option 1 only as specified below under “H. Additional Information.”
* Special guidance for people who are dually enrolled in both Medicare and Medicaid, also known as dually eligible individuals (has a Qualified Medicare Beneficiary (QMB) Program and/or Medicaid coverage) ONLY:
Dually Eligible beneficiaries must be instructed to check Option Box 1 on the ABN in order for a claim to be submitted for Medicare adjudication.
Strike through Option Box 1 as provided below:
□ OPTION 1. I want the (D) 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.
These edits are required because the provider cannot bill the dual eligible beneficiary when the ABN is furnished. Providers must refrain from billing the beneficiary pending adjudication by both Medicare and Medicaid in light of federal law affecting coverage and billing of dual eligible beneficiaries. If Medicare denies a claim where an ABN was needed in order to transfer financial liability to the beneficiary, the claim may be crossed over to Medicaid or submitted by the provider for adjudication based on State Medicaid coverage and payment policy. Medicaid will issue a Remittance Advice based on this determination.

Once the claim is adjudicated by both Medicare and Medicaid, providers may only charge the patient in the following circumstances:

• If the beneficiary has QMB coverage without full Medicaid coverage, the ABN could allow the provider to shift financial liability to the beneficiary per Medicare policy.

• If the beneficiary has full Medicaid coverage and Medicaid denies the claim (or will not pay because the provider does not participate in Medicaid), the ABN could allow the provider to shift financial liability to the beneficiary per Medicare policy, subject to any state laws that limit beneficiary liability.

Note: These instructions should only be used when the ABN is used to transfer potential financial liability to the beneficiary and not in voluntary instances. More information on dual eligible beneficiaries may be found at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glan ce.pdf

• OPTION 2. I want the (D) 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.

This option allows the beneficiary to receive the non-covered items and/or services and pay for them out of pocket. No claim will be filed and Medicare will not be billed. Thus, there are no appeal rights associated with this option.

• OPTION 3. I don't want the (D) listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

This option means the beneficiary does not want the care in question. By checking this box, the beneficiary understands that no additional care will be provided; thus, there are no appeal rights associated with this option.

The beneficiary or his or her representative must choose only one of the three options listed in Blank (G). Unless otherwise instructed to do so according to the specific guidance provided in these instructions, the notifier must not decide for the beneficiary which of the 3 checkboxes to select. Pre-selection of an option by the notifier invalidates the notice. However, at the beneficiary's request, notifiers may enter the beneficiary's selection if he or she is physically unable to do so. In such cases, notifiers must annotate the notice accordingly.

If there are multiple items or services listed in Blank (D) and the beneficiary wants to receive some, but not all of the items or services, the notifier can accommodate this request by using more than one ABN. The notifier can furnish an additional ABN listing the items/services the beneficiary wishes to receive with the corresponding option.

If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: "beneficiary refused to choose an option."

8. Blank (H) Additional Information: Notifiers may use this space to provide additional clarification that they believe will be of use to beneficiaries. For example, notifiers may use this space to include:

• A statement advising the beneficiary to notify his or her provider about certain tests that were ordered, but not received;

• Information on other insurance coverage for beneficiaries, such as a Medigap policy, if applicable;

• An additional dated witness signature; or

• Other necessary annotations.

Annotations will be assumed to have been made on the same date as that appearing in Blank J, accompanying the signature. If annotations are made on different dates, those dates should be part of the annotations.

*Special guidance for non-participating suppliers and providers (those who don't accept Medicare assignment) ONLY: Strike the last sentence in the Option 1 paragraph with a single line so that it appears like this: If Medicare does pay, you will refund any payments I made to you, less co- pays or deductibles.

This single line strike can be included on ABNs printed specifically for issuance when unassigned items and services are furnished. Alternatively, the line can be hand-penned on an already printed ABN. The sentence must be stricken and can't be entirely concealed or deleted. There is no CMS requirement for suppliers or the beneficiary to place initials next to the stricken sentence or date the annotations when the notifier makes the changes to the ABN before issuing the notice to the beneficiary.

When this sentence is stricken, the supplier should include the following CMS- approved unassigned claim statement in the (H) Additional Information section:

"This supplier doesn't accept payment from Medicare for the item(s) listed in the table above. If I checked Option 1 above, I am responsible for paying the supplier's charge for the item(s) directly to the supplier. If Medicare does pay, Medicare will pay me the Medicare-approved amount for the item(s), and this payment to me may be less than the supplier's charge.

This statement can be included on ABNs printed for unassigned items and services, or it can be handwritten in a legible 10 point or larger font.
An ABN with the Option 1 sentence stricken must contain the CMS-approved unassigned claim statement as written above to be considered valid notice. Similarly, when the unassigned claim statement is included in the “Additional Information” section, the last sentence in Option 1 should be stricken.
Signature Box:
Once the beneficiary reviews and understands the information contained in the ABN, the Signature Box is to be completed by the beneficiary (or representative). This box cannot be completed in advance of the rest of the notice.
9. Blank (I) Signature: The beneficiary (or representative) must sign the notice to indicate that he or she has received the notice and understands its contents. If a representative signs on behalf of a beneficiary, he or she should write out “representative” in parentheses after his or her signature. The representative’s name should be clearly legible or noted in print.
10. Blank (J) Date: The beneficiary (or representative) must write the date he or she signed the ABN. If the beneficiary has physical difficulty with writing and requests assistance in completing this blank, the date may be inserted by the notifier.

Disclosure Statement: The disclosure statements in the footer of the notice are required to be included on the document. CMS will work with its contractors to ensure consistency when determining validity of the ABN in general. In addition, contractors will provide ongoing education to notifiers as needed to ensure proper notice delivery. Notifiers should contact the appropriate CMS regional office if they believe that a contractor inappropriately invalidated an ABN.

Link for form: https://www.cgsmedicare.com/jc/help/abn_form_tutorial.html (you MAY NOT advise patient on what and how to fill out as per guidelines of Medicare. You may inform of the three options available and explain what each means.

Questions regarding ABN : https://appeals.lmi.org/

Medicare does not cover, an examination consultation, maintenance care, extremity adjusting, Physical medicine modalities and therapeutic exercises. You may bill for the patient but will not be paid for by Medicare. You may collect for the services provided if you have advised the patient ahead of time that these services are not covered. Medicare does not pay for x-rays. The script has to come from their PCP. You may provide them a script for the x-rays, the x-ray facilities will perform them but Medicare will NOT cover it.

Note: you have to attest and reapply for Medicare every 5 even if nothing has changed.

Medicare – 877-235-8073
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier :
AARP Medicare Advantage – PO Box 31362 Salt Lake City, UT 84100. 800-643-4845
Cigna Alliance Medicare – PO Box 981706 El Paso, TX 79998
Cigna Medicare Supplement – PO Box 30010 Austin, TX 78755-3010 866-459-4272
Humana – PO Box 14601 Lexington, KY 40512-4601 800-457-4708
Keystone 65 Basic HMO – PO Box 211184 Eagan MN 55121 800-645-3965
Keystone HP 65 Complete – PO Box 69353 Harrisburg PA 17106-9353
Personal Choice 65 PPO – PO Box 211184, Eagan MN 55121

Keystone Health Plan East:
Used to require a referral from your primary care physician, that has changed over the last year or so (this is being produced June 2022)

Medicare advantage plan does NOT require a referral from their primary care physician for treatment. There is a requirement for referral for regular Keystone Health plan East. Unfortunately Keystone HPE does NOT cover physical medicine modalities and many times they will apply it as out of network benefits and yet not pay for the services provided for physical medicine by a Chiropractor. So to be on the safe end examination, consultation, chiropractic manipulation, extremity manipulation are the only covered services by keystone HPE. NOTE - Keystone Medicare advantage plan – this does not apply to and always follows Medicare guidelines, which means ONLY manipulation is covered and that does not include extremity manipulation, you are welcome to charge the patient provided you have advised them prior to services offered.

KHPE Follow policy parameters and billing guidelines

Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 898815 Camp Hill, PA 17089-8815. 800-275-2583

Aetna
Aetna policies in almost all cases covers examination consultation, chiropractic manipulation and physical medicine modalities. Do not bill more than four units/codes per visit as chances of denial will be greater. It is suggested to get the maximum reimbursement that your hierarchy of codes billed should be the highest paid cpt codes to the lowest paid codes. As always be specific in your diagnosis codes to allow coverage and reimbursement without issues.

Important note: 97140 XS - Can be billed if performed on a separate and distinct body part compared to the chiropractic manipulation. An XS is required for call 97140 codes billed. It is highly recommended that your notes be specific and concise because in many cases they will request your records if 97140 is billed. It has been our experience that they will deny 97140 and you will have to appeal it regardless, so it is again highly suggested that you document accordingly that the procedure was performed at a separate and distinct region.

Important note: It is our suggestion and recommendation that if you have a contract with an insurance carrier as a participating in network provider for any carrier and you decide to have that patient as an out-of-pocket paying patient that you have them sign the form that releases you from liability and gives you the legal backing that the patient has agreed to receiving these procedures and pay out of pocket and not thru their insurance carrier (usually happens to minimize their cost which many times is greater thru insurance).

Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 981106 El Paso, Tx 79998-1106. 888-632-3862

Meritain Health PO Box 853921, Richardson, TX 75085-3921

To search for benefits and claims for Aetna you can visit the below site:
https://apps.availity.com/availity/web/public.elegant.login

For authorization to continue care if the patient’s policy requires authorization for treatments, You can use this link for submitting information as well as receiving authorizations or denials.
https://www.radmd.com/RadMD/Common/UserMenu.aspx (At present this is ONLY for Aetna)
If you are in Network with Aetna and also with a third part administrator such as American Specialty Health Network (ASHN) - and if their plan requires a third-party administrator (ie ASHN) use below link. Important note - You’re not required to be in network with ASHN to bill and get reimbursed for ALL services provided, meaning you can be in network with Aetna and not with ASHN. Your reimbursement is higher (bill directly to Aetna) and less paperwork for authorization requirements if you are NOT in network for ASHN. If you are in network with ASHN - You are required to send all billing through ASHN website and will only get reimbursed $27 (98940) or $28 (98941) for manipulation, plus $10 for only one physical medicine modality. Important note: This information is only as an educational purpose and not advising you to be in or out of network with Aetna or ASHN. Here is the TPA link for authorization and claims submission for ASHN
https://ashlink.com/ASH/site/authentication/login.aspx?ReturnUrl=%2fASH

Highmark
(IMPORTANT NOTE: any blue cross/blue shield policy that's is out of state as well as Federal Employee Plan must still be submitted to PA local Highmark claims office

Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 890062 Camp Hill, PA 17089-0062. 866-975-7290 (Federal – 866-763-3608) (Other alternate number for Highmark BCBS Policies 866-731-8080)

Independence Administrators
Follow policy parameters and billing guidelines

Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 21974 Eagan, MN 55121

Independence Blue Cross
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 211184 Eden, MN 55121.

Personal Choice 65 PPO
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 211184 Eagan, MN 55121.

Capital Blue Cross
Follow policy parameters and billing guidelines

Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 890062 Camp Hill, PA 17089-0062. (Note same as Highmark) 800-547-3627

Freedom Blue PPO
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 890173 Camp Hill, PA 17089-0173. 800-550-8722

FEP BCBS
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 898854 Camp Hill, PA 17089. 800-779-6945

United Healthcare Claims
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 740800 Atlanta, GA 30374-0800 877-842-3210

UPMC
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 2999 Pittsburgh, PA 15230

Allstate
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 660626 Dallas, TX 75266. 713-277-9433 Fax: 866-447-4293

Ameriprise
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 19018 Green Bay, 54307-9018 800-872-5246 Fax: 888-269-8408

Encompass
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 2873 Clinton, IA 52733. 908-429-7362 Fax: 608-373-7386

Erie Insurance
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 4286 Bethlehem, PA 18018. 844-479-3555 Fax: 610-974-7355

Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 2013 Mechanicsburg, PA, 17055 800-382-1304 Fax: 800-545-0408

Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 605 Murryville, PA 15668 724-325-7933 Fax: 800-553-5504

ERIE WARRENDALE - Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – 301 Commonwealth Drive, Warrendale PA 15086Fax: 724-772-7700

ERIE FAMILY OF INSURANCE CO - Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 10832 Clearwater, FL 33757

Farmers
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 268994 Oklahoma City, OK 73126-8994 856-437-2708 Fax: 877-217-1389

ESIS
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 6561 Scranton, PA 18505-6561 877-512-3768 Fax: 800-408-4131

Assurane
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 2869, Clinton IA 52733-2869 631-404-4312

Gallagher Bassett Services
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 2934 Clinton, IA 52733 856-780-3030 Fax: 856-778-7490

Geico
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 9505 Fredericksburg, VA 22403 540-286-9202 Fax: 703-738-2188
www.Geico.com/b2b - for Claims Verification

Hartford Mutual Insurance
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – 200 N Main St, Bel Air MD 21014 800-638-3669

Inservco Insurance Services
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 3899 Harrisburg, PA 17105-3899 800-356-0438 Fax: 866-356-0438

Liberty Insurance Co
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – 111 Presidential Blvd, Bala Cynwyd PA 19004 610-664-6380 Fax: 610-664-2134

Liberty Mutual
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 5014 Scranton, PA 18505 866-548-5127 Fax: 888-268-8840

Metlife Auto & Home
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 6040 Scranton, PA 18505 800-854-6011 Fax: 866-947-0184

Mutual of Omaha
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – 3316 Farnam St, Omaha NE 68175 877-617-5587

Nationwide
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 26005 Daphne, AL 36526-5005 717-657-6772 Fax: 877-590-8188

Ohio Casualty
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 515097 Los Angeles, CA 90051 800-332-3226 Fax: 888-268-8840

Progressive Claims
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 2930 Clinton, IA 52733 407-618-8779 Fax: 877-213-7258

Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 512926 Los Angeles, CA 90051 412-702-9104 Fax: 877-213-7258

Sedgwick
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 14516 Lexington, KY 40512-4156 304-348-9641 Fax: 866-828-8550

StateFarm Claims
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 52250 Phoenix, AZ 85072-2250 844-292-8615 Fax: 855-666-0964

Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 106170 Atlanta GA 30348-6170 844-292-8615 Fax: 844-218-1140

Travelers
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 660626 Dallas, TX 75266. 713-277-9433 Fax: 866-447-4293

Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – PO Box 4614 Buffalo, NY 14210 610-736-2474

Zurich American Insurance Company
Claims address as of 11/8/2022 (may change/might have changed) confirm with carrier – 1171 S Cameron St, Harrisburg, PA 17104800-482-2383 Fax: 717-705-1629

DISCLAIMER – PLEASE NOTE – The above claims address, phone numbers, fax numbers, website links are strictly for your reference. The PCA member must do their own due diligence in checking the information as this information is subject to change without our notice. PCA will do everything we can to keep up to date information & on the ongoing changes.The above information may differ from region to regions of the state.