

# Chiropractic Billing and Documentation

9/26/2024

**Closed Captioning:** *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

# Today's Presenters

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Attendees/providers are never permitted to record (tape record or any other method) our educational events. This applies to webinars, teleconferences, live events and any other type of National Government Services educational events.

# Objective

Provide a sampling of chiropractic billing concepts and guidelines to give you a better understanding of the Medicare Program, while helping to decrease your National Government Services claim submission billing errors.



# Agenda

- [Chiropractic Coverage Policy](#)
- [Medical Necessity](#)
- [Active Versus Maintenance Treatment](#)
- [Documentation Guidelines](#)
- [Coding Guidelines](#)
- [Administrative Simplification Compliance Act](#)
- [Significant Facts for Successful Chiropractic Billing](#)
- [NGSConnex](#)
- [Resources](#)

# Chiropractic Coverage Policy

# LCD L33613 – Coverage Document (RETIRED)

## SIA A52853 – Supplemental Instructions (RETIRED)

- Medical Policy Article (A57889) for Chiropractic Services
  - [Local Coverage Article for Chiropractic Services – Medical Policy Article](#)
  - Coverage and Coding information
  - CPT codes
- [Medicare Coverage Database – Overview](#)

# CMS Medicare Coverage Database

**MCD**  
Medicare Coverage Database

[Search](#) [Reports](#) [Downloads](#)

[Home](#) [Help](#) [Settings](#) [Archive](#) [API](#)

## Welcome to the **MCD** Search

**Start your search...**

chiropractic      Massachusetts      🔍

[Search entire database for complete results, in Massachusetts 🔍](#)

Articles in Massachusetts ?

A57889 - Chiropractic Services – Medical Policy Article [NGS]      [Analyses](#)  
[Comment](#)

12/14/2023 Ch... Updates

08/01/2023 **Notice:** Coverage API

Need more help? Visit [medicare.gov](#) for beneficiary-specific information or



# Chiropractic Services – Medical Policy Article (A57889)

## Contents

Contractor Information

Article Information

General Information

Article ID

Article Title

Article Type

Original Effective Date

Revision Effective Date

Revision Ending Date

Retirement Date

Article Guidance

Article Text

Coding Information

CPT/HCPCS

Article

## Chiropractic Services – Medical Policy Article

A57889

Expand All | Collapse All



### ! NOT AN LCD REFERENCE ARTICLE

This article is not in direct support of an LCD. [Learn more](#)

## Contractor Information

## Article Information

### General Information

#### Article ID

A57889

#### Article Title

Chiropractic Services – Medical Policy Article

#### Article Type

### AMA CPT / ADA CDT / AHA NUBC Copyright Statement

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Fee schedules, relative value units, conversion factors and/or related components not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense



# Chiropractic Services

The screenshot displays the National Government Services website interface. At the top, the navigation bar includes links for HOME, EDUCATION (highlighted with a red box), RESOURCES, EVENTS, ENROLLMENT, and APPS. A search icon is located on the right. Below the navigation bar, the 'Education' section is visible, featuring a 'SPECIALTIES' heading. A dropdown menu is open under 'EDUCATION', listing various resources such as 'Help And FAQs', 'Medicare Arcade', 'Medicare Topics', 'News', 'Self-Service Pulse', 'Manuals and Guides', 'Medicare Monthly Review', 'Medicare University', 'POE Advisory Group', and 'Specialties' (indicated by a red arrow). Below the dropdown, a grid of specialty tiles is shown, including 'Ambulance', 'Anesthesia', 'Cardiac', 'Chiropractic Services' (highlighted with a red box), 'Dental', and 'Durable Medical Equipment, Prosthetics, Orthotics and...'. The 'national government SERVICES' logo is in the top left corner of the page content.

# Chiropractic Services

The screenshot shows the National Government Services website. The top navigation bar includes links for HOME, EDUCATION (highlighted with a yellow underline), RESOURCES, EVENTS, ENROLLMENT, and APPS. A search icon is located on the right. Below the navigation bar, the breadcrumb trail reads "Education > Specialties". The main heading is "CHIROPRACTIC SERVICES".

**Part B Medicare Coverage of Chiropractic Services**

- Introduction to Chiropractic Services
- Chiropractic Coverage**
- Maintenance Care for Chiropractic Services
- Medical Review Audits
- Comprehensive Error Rate Testing Program
- Modifiers
- Advance Beneficiary Notice of Noncoverage Liability

## Medicare Coverage of Chiropractic Services

### Chiropractic Coverage

Medicare pays chiropractors for spinal manipulation CPT codes 98940–98942, when these services are reasonably and medically necessary and meet all Medicare coverage guidelines as set forth in the CMS IOMs.

- 98940: CMT; spinal, 1–2 regions
- 98941: CMT; spinal, 3–4 regions
- 98942: CMT; spinal 5 regions
- 98943: CMT; extraspinal, 1 or more regions

**Note:** CPT code 98943, CMT, extraspinal, one or more regions, is **not** a Medicare benefit.

# CMS Internet-Only Manual

- [CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240](#)
  - Guidelines given to us from CMS
  - LCD cannot contradict IOMs
  - NCD

# Internet-Only Manuals

The Internet-only Manuals (IOMs) are a replica of the Agency's official record copy. They are CMS' program issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives. The CMS program components, providers, contractors, Medicare Advantage organizations and state survey agencies use the IOMs to administer CMS programs. They are also a good source of Medicare and Medicaid information for the general public.


Showing 1-10 of 25 entries

Show entries: 10 per page

<u>Publication #</u> <input type="checkbox"/>	<u>Title</u> <input type="checkbox"/>
<a href="#">100</a>	Introduction
<a href="#">100-01</a>	Medicare General Information, Eligibility and Entitlement Manual
<a href="#">100-02</a>	Medicare Benefit Policy Manual

# MLN Matters® Articles

- CRs put into simple language
  - [MLN Matters® Articles – CMS website](#)



**MLN Matters®** Number: SE1603      **Related Change Request (CR) #:** N/A

**Related CR Release Date:** N/A      **Effective Date:** N/A

**Related CR Transmittal #:** N/A      **Implementation Date:** N/A

**Educational Resources to Assist Chiropractors with Medicare Billing**

**Provider Types Affected**

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This Special Edition (SE) MLN Matters® article is intended for Chiropractors submitting claims to Medicare Administrative Contractors (MACs) for chiropractic services provided

# Medical Necessity

# Medicare Coverage

- Medical Necessity
  - Title XVIII of the Social Security Act, Section 1862 (a)(1)(A). This section allows coverage and payment for only those services considered medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.



# Medical Necessity

- Medical necessity
  - Assures services to Medicare patients are reasonable and necessary for diagnosis or treatment of illness or injury
- Remittance remark code
  - CO-50 Medical Necessity Denial

# Medical Necessity Denials

- Some services are only covered in some instances
- Example: chiropractic manipulation
  - Only covered for a diagnosis listed in LCD
  - Any other diagnosis will be denied as not medically necessary

# Medicare Coverage

- Medical Necessity
  - Patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment
  - The manipulative services rendered must have a direct therapeutic relationship to patient's condition and provide reasonable expectation of recovery or improvement of function
  - The patient must have a subluxation of the spine as demonstrated by X-ray/physical exam

# Active Versus Maintenance Treatment

# Active/Corrective Treatment

- Goal driven
- Treatment plan
- Individualized
- Usually short term
- Measurable progress towards goals

# Active Treatment

- Reasonable expectation of improvement
- Not always recovery
- Not always complete return to prior level of function

# Acute Subluxation

- A patient's condition is considered acute when the patient is being treated for a new injury, identified by X-ray or physical exam as specified above
- The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition

# Chronic Subluxation

- A patient's condition is considered chronic when it is not expected to improve/resolve with further treatment, but where the continued therapy can be expected to result in some functional improvement
- Once the clinical status has remained stable for a given condition, further manipulative treatment is considered maintenance therapy and is not covered



# Acute Exacerbation

- Temporary but marked deterioration of patient's condition that is causing significant interference with activities of daily living due to an acute flare-up of the previously treated condition
- Patient's clinical record must specify the date of occurrence, nature of the onset, or other pertinent factors that would support the medical necessity of treatment
- As with an acute injury, treatment should result in improvement or arrest of the deterioration within a reasonable period of time

# Maintenance

- Preventive
- Promote health
- Prolong or enhance the quality of life
- Maintain/prevent deterioration
- Supportive
- Noncorrective
- No reasonable expectation of further clinical improvement
- May be beneficial
- May be necessary treatment
- Not covered by Medicare

# Contraindications

- Dynamic thrust is therapeutic force/maneuver delivered by the physician during manipulation in the anatomic region of involvement
- Contraindication adds significant risk of injury to the patient from dynamic thrust, but does not rule out the use of dynamic thrust
- The doctor must discuss this risk with the patient and record this in the chart
  - See LCD for contraindication listing

# Documentation Guidelines

# Medical Necessity Documentation

- Patient's medical record must contain documentation that fully supports medical necessity for services
- Documentation includes, but is not limited to, relevant medical history, physical examination and results of pertinent diagnostic tests or procedures

# Medical Necessity Documentation- Plan of Care

- Chiropractic care is focused on treatment goals outlined in the plan of care and should be individualized for each patient and include the following
  - Recommended level of care (duration/frequency of visits)
  - Specific treatment goals (with documentation of progress or lack thereof within the clinical records)
  - Objective measures to evaluate treatment effectiveness (with qualitative and/or quantitative measures)

# Medical Necessity Documentation

- Use of objective measures at beginning of treatment, during and/or after treatment is recommended to quantify progress and support justifications for continued treatment
- Treatment effectiveness must be assessed at appropriate intervals during subsequent visits (objective measurable goals)
- For patients who have not achieved the goals documented in the plan of care, the practitioner should conclude the episode of chiropractic care in the last visit by documenting the clinical factors that contributed to the inability to meet the stated goals in the treatment plan

# Documentation of Subluxation

- The precise level of subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine
- The level of spinal subluxation must bear a direct causal relationship to patient's symptoms, and symptoms must be directly related to level of subluxation that has been diagnosed



# Documentation of Subluxation

- X-ray
  - 12 months before/three months after
  - CT/MRI
- Physical exam
  - Pain/tenderness
  - Asymmetry/misalignment
  - ROM abnormality
  - Tissue, tone, texture and temperature changes
    - Must have two of the four mentioned above, one of these must be asymmetry or ROM abnormality

# Medical Necessity Documentation- Prolonged Treatment

- The need for an extensive, prolonged course of treatment must be clearly documented in the medical record
- Treatment should result in improvement or arrest of deterioration of subluxation within a reasonable and generally predictable period of time

# Documentation of History

- Patient's history should include the following
  - Symptoms causing patient to seek treatment
  - Family history, if relevant
  - Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history)
  - Mechanism of trauma
  - Quality and character of symptoms/problem
  - Onset, duration, intensity, frequency, location and radiation of symptoms
  - Aggravating or relieving factors, and
  - Prior interventions, treatments, medications, secondary complaints

# Documentation of Initial Visit

- All components of history
- Description of present illness
- Evaluation
- Diagnosis
- Treatment plan
- Date of initial treatment
- Signature

# Documentation of Subsequent Visits

- History (review chief complaint, changes)
- Physical exam (progress, presence/absence of subluxation)
- Documentation of treatment (given on day of treatment)
- Progress or lack of related to goals/plan of care
- D/C when no further progress (or give an ABN)

# Medicare Coverage

- Break down of key points
  - Significant health problem in the form of a neuro-musculoskeletal condition
  - Services have a direct therapeutic effect
  - Reasonable expectation of recovery or improvement of function
  - Subluxation

# Covered Services

- CPT/HCPCS codes
  - Chiropractic manipulative treatment
    - 98940 CMT; spinal, one to two regions
    - 98941 CMT; spinal, three to four regions
    - 98942 CMT; spinal, five regions
- Regions: cervical region (atlanto-occipital joint), thoracic region (costovertebral/ costotransverse joints), lumbar region, pelvic region (sacro-iliac joint) and sacral region

# Diagnosis Codes

ICD-10-CM Codes	Description
M99.01	Segmental/somatic dysfunction cervical region
M99.02	Segmental/somatic dysfunction thoracic region
M99.03	Segmental/somatic dysfunction lumbar region
M99.04	Segmental/somatic dysfunction sacral region
M99.05	Segmental/somatic dysfunction pelvic region



# Medicare Coverage

- Coverage is specifically limited to treatment by means of manual manipulation i.e., by use of hands
- Manual devices may be used but no additional payment is available for use of the device

# Utilization Guidelines

- A chiropractic manipulation service for a beneficiary can only be reimbursed once per day
- The frequency and duration of chiropractic treatment must be medically necessary and based on the individual patient's condition and response to treatment
- Medical necessity determines visits/no set number of visits

# Noncovered Services

- The following services are considered noncovered services when ordered, performed, or interpreted by a chiropractor
  - Labs
  - Physical therapy (CPT 97140)
  - X-rays
  - Massage
    - Use the GY modifier when billing these services

# Coding Guidelines

# Coding Guidelines

- One diagnosis required on all claims
  - Precise level of the subluxation (region of spine) must be listed as the primary diagnosis
  - Resulting disorders (condition) are to be listed as secondary diagnosis in medical record
- Date of initial treatment/exacerbation of existing condition
  - Must be entered in Item 14 of the CMS-1500 claim form or the electronic equivalent

# Coding Guidelines

- If using an X-ray as documentation of the subluxation
  - The date of the X-ray (or existing MRI or CT scan) must be entered in Item 19 of the CMS-1500 claim form or the electronic equivalent
- Modifier AT (acute treatment) used for medically necessary manipulation

# Administrative Simplification Compliance Act

# ASCA Requirements for Paper Claim Submissions

- All Medicare claims are required to be submitted electronically, with limited exceptions
- Requirements
  - You must meet one of the ASCA exception criteria
    - Small practice – fewer than ten full-time employees (Part B)
    - No method for submitting claims electronically
    - Unusual circumstances
  - Complete the ASCA Waiver Request Form
  - Provide supporting documentation
  - [ASCA Requirements for Paper Claim Submissions](#)



# Significant Facts for Successful Chiropractic Billing

# Medical Record Documentation Requirements for Initial and Subsequent Visits (SE1601)

- Majority of denials due to insufficient documentation or other documentation errors
  - Indication of “pain” is insufficient
- Two ways the level of subluxation may be specified in the patient’s record
  - May refer either to the condition of the spinal joint involved or
  - Direction of position assumed by the particular bone named

# Medical Record Documentation Requirements for Initial and Subsequent Visits (SE1601)

- Examples of acceptable descriptive terms for the nature of the abnormalities
  - Off-centered
  - Misalignment
  - Malpositioning
  - Spacing - abnormal, altered, decreased, increased
  - Incomplete dislocation
  - Rotation
  - Listhesis - antero, postero, retro, lateral, spondylo
  - Motion - limited, lost, restricted, flexion, extension, hypermobility, hypomotility, aberrant

# Medical Record Documentation Requirements for Initial and Subsequent Visits (SE1601)

- Treatment Plan
  - Recommended level of care (duration and frequency of visits)
  - Specific treatment goals
  - Objective measures to evaluate treatment effectiveness
- Date of the initial treatment
- Patient's medical record
  - Validate all the information on the face of the claim, including the patient's reported diagnosis, physician work (CPT code), and modifiers
  - Verify that all Medicare benefits and medical necessity requirements were met
- MLN Matters® [SE1601 Revised: Medicare Coverage for Chiropractic Services - Medical Record Documentation Requirements for Initial and Subsequent Visits](#)

# Use of the AT Modifier for Chiropractic Billing (SE1602)

- Active treatment (AT) modifier
  - Not used if maintenance therapy is being performed
- Acute and chronic subluxation may be covered as long as there is active treatment which is well documented and improvement is expected
- MLN Matters® [SE1602 Revised: Use of the AT modifier for Chiropractic Billing](#)

# Educational Resources to Assist Chiropractors with Medicare Billing (SE1603)

- Article provides the correct resources providers should be accessing to properly bill Medicare
  - Enrollment Information
  - Coverage, Documentation, and Billing
- MLN Matters® [SE1603 Revised: Educational Resources to Assist Chiropractors with Medicare Billing](#)

# Limited Coverage for Services Ordered or Furnished by a Chiropractor

- X-rays or other diagnostic/therapeutic services furnished or ordered by a chiropractor are considered statutorily excluded services
  - Beneficiary would be responsible for any charges incurred
  - Use modifier GY

# Billing Medicare for Therapy Services

- Noncovered “always therapy” services must be submitted according to the therapy guidelines along with one of the therapy modifiers
  - GN - Service delivered under an outpatient speech-language pathology plan of care
  - GO - Service delivered under an outpatient occupational therapy plan of care
  - GP - Service delivered under an outpatient physical therapy plan of care
- Claims submitted without an appropriate modifier will be returned to provider
- Claims will be appropriately denied as noncovered only with a valid modifier
- [Annual Therapy Update](#)
- [Chiropractors Billing Medicare for Therapy Services](#)



# Timely Claims Filing Requirement

- Claims not submitted timely are provider-liable
  - Beneficiary cannot be charged
- For claims submitted with spanned dates of service, the line item “From” date will be used to determine the date of service and filing timeliness
- If a line item “From” date is not timely, but the “To” date is timely, the line item will be split and deny the untimely services

# Submitting Duplicate Claims

- May delay payment
  - Resubmitting your claim prior to receiving a determination is considered an inappropriate billing practice
  - Increases administrative costs to the Medicare Program and the provider
- Could cause you to be identified as an abusive biller; or may result in an investigation for fraud if a pattern of duplicate billing is identified

# Unprocessable

- Information is
  - Invalid
  - Missing
  - Insufficient
  - Incomplete
- Claims will be rejected
- Must submit a new claim
- No appeal rights granted

# Unprocessable

- Methods for rejection
  - Remittance advice shows an MA130
  - Additional remark codes used to identify the error
- Paper claims are screened
  - Form letter sent back indicating the error
- Electronic claims
  - Fail initial edits

# JK Contact Information

- IVR: 877-869-6504
- Provider Contact Center: 866-837-0241
- EDI Helpdesk: 888-379-9132
- Provider Enrollment: 888-379-3807
- Correspondence
  - National Government Services, Inc.  
P.O. Box 6189  
Indianapolis, IN 46206-6189

# J6 Contact Information

- IVR: 877-908-9499
- Provider Contact Center: 866-234-7340
- EDI Helpdesk: 888-379-9132
- Provider Enrollment: 877-908-8476
- Correspondence
  - National Government Services, Inc.  
Attn: Written Inquiries  
P.O. Box 6475  
Indianapolis, IN 46206-6475

# Fee Schedules

The screenshot shows the National Government Services website navigation and a grid of service categories. The navigation bar includes the logo, 'HOME', 'EDUCATION', 'RESOURCES', 'EVENTS', 'ENROLLMENT', 'APPS', and a search icon. The grid contains six categories:

- Medical Policies/LCDs**: Find LCDs and related billing and coding articles
- Enrollment**: Getting started, after you enroll, and revalidating your enrollment
- Fee Schedules**: Code pricing search, payment systems, limits, and fee schedule lookup (highlighted with a red border)
- Claims and Appeals**: Learn about claims, top errors, fees, MBI and appeals
- Overpayments**: Repayment schedules, and post-pay adjustment
- Medicare Compliance**: Medical Review, Prior Authorization, Fraud & Abuse, CERT, and more

# Fee Schedule Lookup Page

Select a Fee Schedule: \*

Medicare Physician Fee Schedule Pricing

Result Type: \*

Full Fee Schedule

Specific To Fee Code

Date of Service: \*

02/29/2024

Procedure Code: \*

98941

Region: \*

Connecticut

Search



# Claims and Appeals

The screenshot displays the National Government Services website interface. At the top, the navigation bar includes the logo, 'HOME', 'EDUCATION', 'RESOURCES' (highlighted with a red box), 'EVENTS', 'ENROLLMENT', and 'APPS'. A search icon is located on the right. Below the navigation bar, a 'Resources' section features a large blue banner with the text 'CLAIMS AND A'. A dropdown menu is open under 'RESOURCES', listing various resource categories. The 'Claims and Appeals' option is highlighted with a red box. Below the dropdown, a grid of six white boxes contains the following text: 'CMS 1500 Claim Form', 'Fee Schedule Lookup', 'Medicare Beneficiary Identifier (MBI)', 'Medicare Secondary Payer (MSP)', 'NGSConnex', and 'Top Claim Errors'.

national government SERVICES

HOME EDUCATION RESOURCES EVENTS ENROLLMENT APPS

Resources

CLAIMS AND A

VIEW ALL RESOURCES

Claims and Appeals

Contact Us

EDI Enrollment

EDI Solutions

Forms

Medical Policies/LCDs

Medicare Compliance

NGSConnex

Overpayments

Production Alerts

Tools & Calculators

CMS 1500 Claim Form

Fee Schedule Lookup

Medicare Beneficiary Identifier (MBI)

Medicare Secondary Payer (MSP)

NGSConnex

Top Claim Errors

# About Appeals

**national government SERVICES** HOME EDUCATION ▾ RESOURCES ▾ EVENTS ENROLLMENT APPS ▾

Resources > Claims and Appeals

## ABOUT APPEALS

About Appeals

Reopening versus Redetermination

Who May File an Appeal?

**Levels of Appeals and Time Limits for Filing**

MSP Overpayments

Initiate Part B Reopenings or Non-MSP Overpayment Adjustments in NGSConnex

What Documents are Needed

Submit an Appeal Electronically with NGSConnex

Submit an Appeal Electronically via esMD

Get Help Submitting a Appeal Hard Copy

### Levels of Appeals and Time Limits for Filing

#### Five Levels of Appeals: Overview

#### Level One – Redetermination

- Time Limit for Filing a Redetermination - 120 days from date of receipt of the initial determination notice
- Amount in Controversy - No minimum (none)

#### Level Two - Reconsideration (QIC)

- Time Limit for Filing a Reconsideration - 180 days from date of receipt of the redetermination decision
- Amount in Controversy - No minimum (none)

#### Level Three - Administrative Law

#### Helpful Resources

[Log Into NGSConnex](#)

[Appeals Timeline Calculator](#)

[YouTube Video: Holistic Approach to Avoiding Administrative Burden](#)

Form(s) you'll need:

[Appeal Forms](#)

# Reopening versus Redetermination

The screenshot shows the National Government Services website. The navigation bar includes links for HOME, EDUCATION, RESOURCES (highlighted), EVENTS, ENROLLMENT, and APPS. A search icon is in the top right. The breadcrumb trail is Resources > Claims and Appeals. The main heading is 'ABOUT APPEALS'. A sidebar on the left contains a list of links, with 'Reopening versus Redetermination' highlighted by a red box. The main content area features the title 'Reopening versus Redetermination', an introductory paragraph, a bulleted list of definitions, a paragraph about electronic submission, and a paragraph about the guide's purpose. A table at the bottom compares reopening and redetermination. A 'Helpful Resources' sidebar on the right lists links like 'Log Into NGSConnex' and 'Appeals Timeline Calculator'.

**Reopening versus Redetermination**

Understanding your next steps are very important for quick reimbursement and providers are required to know the difference between a reopening or a redetermination.

- **A reopening** is a reprocessing of a claim to fix minor mistakes.
- **A redetermination** is an examination of a claim that includes analysis of documentation.

Providers are encouraged to register for NGSConnex. Providers who are registered to use NGSConnex, should use this option to submit reopening requests electronically.

This guide distinguishes the differences between a reopening and redetermination. Please review and share this information with anyone in your organization who can benefit from this guide.

Reopening (Clerical Error)	Redetermination (Appeal - First level)
To correct a claim(s) determination resulting from	For partially paid or denied claim(s) resulting from more

# Contacting the Telephone Reopening Unit

- Part B TRU Line
  - J6: 877-867-3418
  - JK: 888-812-8905
    - Each state will have a different option
- When calling TRU, provide the following information
  - Beneficiary's name
  - Medicare Health Insurance Claim Number/MBI
  - Your full name (first and last name)
  - Your phone number
  - Provider's name (Name listed on the Medicare Remittance Advice)
  - PTAN
  - Date(s) of service in question
  - Item or service in question
  - Reason for request

# Telephone Reopening Unit (TRU)

- TRU reopenings may be done for
  - Adding/changing ordering/referring/supervising physician
  - Add/change rendering provider
  - Assignment of claims (contractor errors only)
  - CLIA certification denials
  - Duplicate denials
  - Fee schedule allowance update (contractor error only)
  - MBI corrections (contractor error only)
  - Medicare Advantage plan denials (clinical trial or hospice only)
  - MSP (Medicare now primary)
  - Modifier GV and GW
  - Patient paid amount (contractor error only)
  - POS Changes
- These items cannot be initiated in NGSConnex

# Additional Development Request (ADR)

- Claims selected for review
  - An ADR letter will be generated
    - Mailed to the “Pay To” or “Practice Location” address
  - Forward to the appropriate person in your organization as soon as possible
  - Submit the requested medical documentation
  - Respond in a timely manner
    - Recommended response within 35–40 days
    - [Additional Development/Documentation Request Timeline Calculator](#)
    - [Ways to Respond to ADRs](#)

# Record Requests Documentation Tips

- Documentation
  - Legible
  - Copy both sides
  - Signatures
  - Do not bind records together
  - Do not highlight records
  - Do not tab records
  - Make sure the ADR request matches the records sent

# Medical Documentation Signature Requirements

- Requires that services provided/ordered/certified be authenticated by the person responsible for the care of the beneficiary
- Handwritten or electronic signatures accepted
  - Stamped signatures are not acceptable
  - Credentials and the date of signing should be included
  - Signature must be legible
    - Consideration for illegible signatures will be given to a signature log or attestation statement
  - Claims not meeting the signature requirements will be denied
  - MLN<sup>®</sup> Fact Sheet [Complying With Medicare Signature Requirements ICN 905364](#)



NGSConnex

# What is NGSConnex

What is NGSConnex ^

**What is NGSConnex?**

Why Use NGSConnex ^

Why Use NGSConnex?

How to Register ^

How to Register

What to Expect After Registering

Email Verification Requirement

How to Use Multi-Factor Authentication

NGSConnex Security Requirements

Manage Your Account ^

Forgot User ID or Password

Account Suspension

Annual Security Training/Certifying Access

News ^

NGSConnex News

## What is NGSConnex?

NGSConnex is a free, secure, web-based application developed by National Government Services just for you! NGSConnex provides access to a wide array of self-service functions that save you time and money, such as:

- Obtain beneficiary eligibility information
- Query for your claims status
- Initiate and check the status of redetermination and reopening requests
- View your provider demographic information
- Query for your financial data
- Submit documents for an Additional Documentation Request
- Submit claims
- And More!

### Helpful Resources

[Log Into NGSConnex](#)

[NGSConnex User Guide](#)

#### NGSConnex Contact Info

866-837-0241

Select Option 2 for NGSConnex Portal access, administration, or site performance assistance.

**Hours of Operation\*:**  
Monday-Friday  
8:00 a.m.-4:00 p.m. ET

**\*Closed for training** on the 2nd and 4th Friday of the month  
12:00 p.m.-4:00 p.m. ET

# Hours of Availability

- NGSConnex is available 24/7
- Information obtained from the local system is only available
  - Monday–Friday: 7:00 a.m.–6:00 p.m. ET
  - Saturday: 7:00 a.m.–3:00 p.m. ET
- Not available during system upgrades or maintenance

# Resources

# Coverage and Billing Resources

- [CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15](#)
  - Section 30.5, “Chiropractor’s Services”
  - Section 240, “Chiropractic Services-General”
  - Section 240.1.1, “Manual Manipulation”
  - Section 240.1.2, “Subluxation May Be Demonstrated by X-ray or Physician’s Exam”
  - Section 240.1.3, “Necessity for Treatment”
  - Section 240.1.4, “Location of Subluxation”
  - Section 240.1.5, “Treatment Parameters”

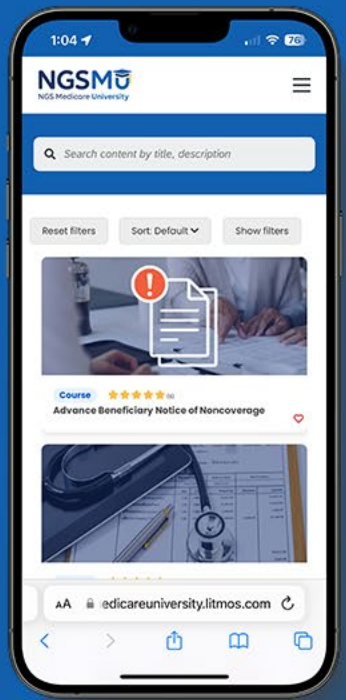
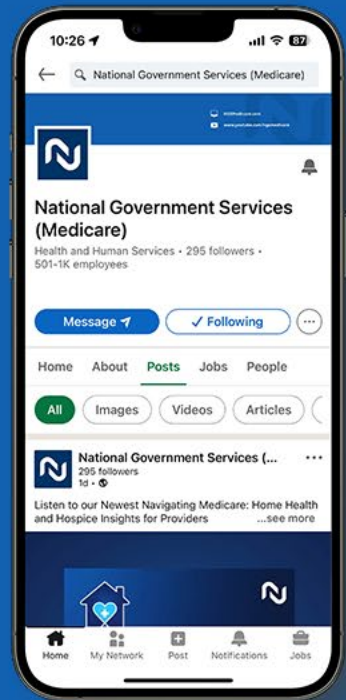
# Additional Resources

- MLN<sup>®</sup> Educational Tool [Medicare Documentation Checklist for Chiropractic Doctors](#)
- [Medicare Needs Better Controls to Prevent Fraud, Waste, and Abuse Related to Chiropractic Services](#)



# Questions?

Thank you!



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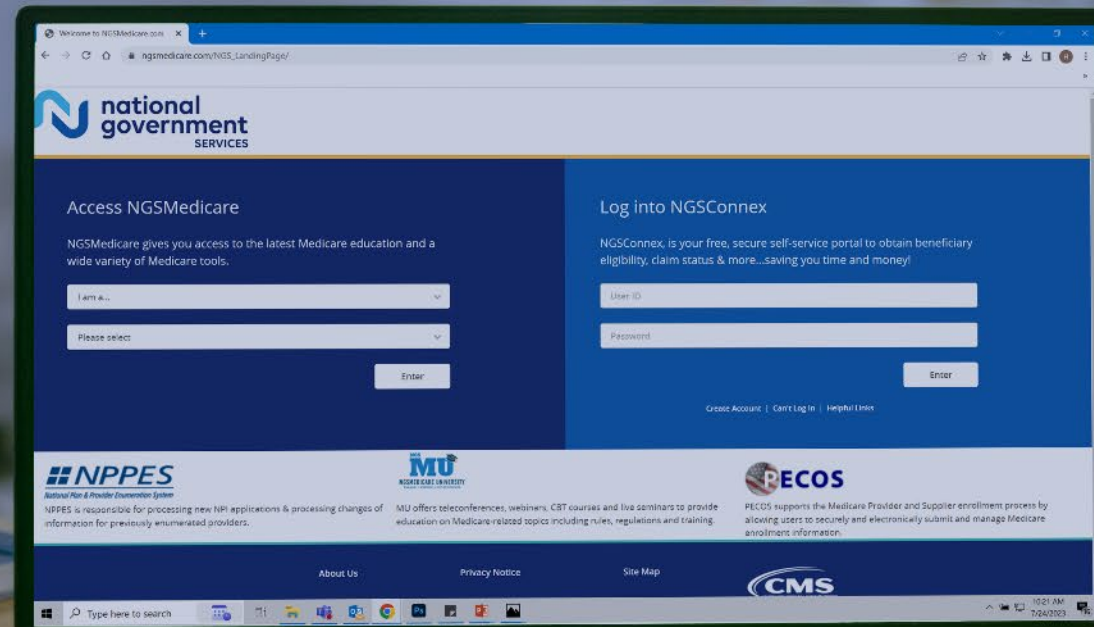
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