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## LATEST INSURANCE ISSUES

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### TOPICS INCLUDED

I highly suggest you print this document, and keep it in your insurance manual or files for future references and easier viewing.

- LMTs Hiring Chiropractors or Doctors as Medical Directors
- Proprietorship by a person other than licensed Chiropractic physicians
- The Latest Reasons For Insurance Rejections
  - A. Disclosure Form
  - B. Sign-In Log
  - C. Modifier Numbers
  - D. Codes 97124 and 97140
  - E. Prescription
  
- Gift Certificate Law Effective June 28, 2007
- Health Care Provider Identification / Patient Notice
- Newest 1500 Insurance Claim Forms
- National Provider Identification (NPI) Numbers
- NEW PIP FEE SCHEDULE
  - A. Setting Fees
  - B. Example #1
  - C. Example #2
  - D. Things to Think About
  - E. Time of Service Fees
  - F. Posting Fees
  - G. Balance Billing
- We Cannot Bill Medicare
- Disclaimer
- Final Message (Stay Tuned)

### **ABOUT LMTS HIRING CHIROPRACTORS or MDs TO WORK AS EMPLOYEES OR MEDICAL DIRECTORS AT MASSAGE ESTABLISHMENTS or SPAS**

Seems as though lately, throughout the country, massage therapists are trying to do or be more than what their scope of practice and licensure allows.

I've received many questions in the last year about how massage therapists may be able to hire Chiropractors as "Medical Directors" of their massage establishments. They want to know how they should pay them to provide services to "their" patients and how the doctors should be listed, if at all, on their (the massage therapist's) corporation papers.

What happened to Massage Therapists working in their own establishments, working under physician's prescriptions or just working for doctors as employees (or as an independent contractor when applicable)? So many people now seem to be trying to conjure up seemingly borderline relationships.

Often Massage Therapists seem to forget or have not yet realized how fortunate we really are. We are one of the very few groups of health care practitioners who can work independently in a multitude of settings, including by physician's prescriptions/referrals whereby we may direct bill and be reimbursed by many types of insurance cases. So many people in the health care profession cannot do this. We need to continue to view insurance billing as a privilege.

The more we try to push the limits (*beyond our scope of practice*) the quicker we will drive ourselves right into the ditch. As new laws are implemented, we will see that it is best we stick close to our scope of practice before our freedoms are restricted.

### **Proprietorship by a person other than licensed Chiropractic physicians**

**As of July 1<sup>st</sup> 2008**, whether or not a previous written or oral contract has been established, a Chiropractor will not be allowed to be a medical director of a Massage Establishment and Massage Therapists cannot hire a Chiropractor as an employee.

I believe the following information taken from the Florida Board of Chiropractic Medicine, written by Salvatore D. LaRusso, D.C., Chairman will answer your questions about hiring Chiropractors.

Effective July 1, 2008 no person other than a sole proprietorship, group practice, partnership, or corporation that is wholly owned by one or more Chiropractic Physicians licensed under chapter 460, F.S. or by the spouse, parent, child or sibling of that Chiropractic Physician may employ a Chiropractic Physician or engage a Chiropractic Physician as an independent contractor to provide services authorized by chapter 460.

#### **Exceptions for the above are:**

- A practice owned by a physician or physicians licensed under chapter 460, 458, 459, or 461
- Those facilities owned directly or indirectly by an entity licensed or registered by the state under Chapter 395
- A public or private university or college
- An entity exempt from federal taxation
- An entity owned by a corporation the stock of which is publicly traded
- A clinic licensed under part X of Chapter 400 and provides health care services by physicians licensed under 458, 459, and 460
- A state licensed insurer

### **THE LATEST REASONS FOR INSURANCE REJECTIONS:**

#### **DISCLOSURE FORM:**

This Official Form must indicate to the patient, every procedure and modality including initial visit fees that will be submitted to the insurer for patients' first visit.

Insurance companies are rejecting the entire claim when the patient has not signed the form with the initial visit charges or any and all procedures or modalities performed on the very first treatment session.

Those of you who are billing insurance companies by now should know that if you are billing an auto accident case (PIP) in Florida, you must sign and have the patient sign the \* Disclosure Form.

The ORIGINAL Disclosure Form must be sent to the insurance company with the first claim on each patient. By the original they mean the one the patient and you signed, not a copy. Be sure you do keep a copy. To better insure that there are no questions as to whether or not the form is the original, you may want to be sure the information and signatures are written in BLUE ink.

**SIGN IN-LOG:** The patient must sign a sign-in log (kept in their file) for each following session. This form must list the modality and/or procedure you performed for which you will submit a claim.

**MODIFIER NUMBERS:**

State Farm has been returning unpaid claims indicating they need modifier numbers. We have NEVER needed to use a modifier number. It is customary for a Chiropractor to have to use Modifier 59 when billing 97140 or other code in conjunction to the chiropractic adjustment to indicate a "distinct service."

If you use a procedure (code) that is not likely in your scope of practice along with a code that is clearly within your scope of practice, you might also be asked for a Modifier number.

**CODES 97140 and 97124**

In checking, almost every case where I was asked for advice on rejected claims regarding modifiers, the massage therapist billed codes 97124 and 97140 during the same visit. If you are working more than 15 minutes (1 unit) of time, then be sure to bill one or the other codes all the way through the session.

While insurers state that these two procedures are one and the same, we all know that massage therapy and Manual Therapy Techniques (myofascial release) is a different procedure. Even the American Medical Association CPT Code Book lists and describes each code differently; still insurance companies software programs kick out claims when these codes are used together

(YES I KNOW, we always did it in the past). However, more and more, commercial insurance companies are following Medicare rules. Bottom line, do we want to be right or do we want to put the money in the bank?

**PRESCRIPTION:**

When you are billing 97140 be sure the physician has indicated on the prescription one of the following, "Myofascial Release, manual therapy techniques, or code 97140." IF the prescription reads, "Massage Therapy", then you must only bill the massage therapy code 97124. If you bill 97140, be sure to document what you did in each 15-minute segment of time you are charging for, maximum procedures, four units.

**GIFT CERTIFICATES:**

(Florida Statutes Sec. 501.95, added by Laws of 2007, Chapter 256, approved and effective June 28, 2007.)

**Sec. 501.95. Gift certificates and credit memos**

(1) As used in this section, the term:

(a) "Credit memo" means a certificate, card, stored value card, or similar instrument issued in exchange for returned merchandise when the certificate, card, or similar instrument is redeemable for merchandise, food, or services regardless of whether any cash may be paid to the owner of the certificate, card, or instrument as part of the redemption transaction.

(b) "Gift certificate" means a certificate, gift card, stored value card, or similar instrument issued in exchange for monetary consideration when the certificate, card, or similar instrument is redeemable for merchandise, food, or services regardless of whether any cash may be paid to the owner of the certificate, card, or instrument as part of the redemption transaction, but this term shall not include tickets as specified in s. 717.1355.

(2)(a) A gift certificate or credit memo sold or issued for consideration in this state may not have an expiration date, expiration period, or any type of post sale charge or fee imposed on the gift certificate or credit memo, including, but not limited to, service charges, dormancy fees, account maintenance fees, or cash-out fees.

However, a gift certificate may have an expiration date of not less than 3 years if it is provided as a charitable contribution when no consideration is given to the issuer by the consumer, or not less than 1 year if it is provided as a benefit pursuant to an employee-incentive program, consumer-loyalty program, or promotional program when no consideration is given to the issuer by the consumer, and the expiration date is prominently disclosed in writing to the consumer at the time it is provided. In

addition, a gift certificate may have an expiration date if it is provided as part of a larger package related to a convention, conference, vacation, or sporting or fine arts event having a limited duration so long as the majority of the value paid by the recipient is attributable to the convention, conference, vacation, or event. An issuer may honor a gift certificate that has expired on or before the effective date of this act.

(b) Paragraph (a) does not apply to a gift certificate or credit memo sold or issued by a financial institution, as defined in s. 655.005, or by a money transmitter, as defined in s. 560.103, if the gift certificate or credit memo is redeemable by multiple unaffiliated merchants.

### **PROVIDING PATIENT NOTICE: (Health Care Provider Identification)**

**BILL #1.** HB 587-Relating to Health Care Practitioners/Licensees: **All health care licensees** must provide notice to patients of what type of license the health care provider has (e.g., Medical Doctor, Dentist, ARNP, Physician Assistant, Dentist, etc):

- A name tag meets the requirement,
- An oral notice to patient meets the requirement,
- Advertisement must include this notice as well,
- Exemptions apply under Chapter 394, 395, and 400 facilities, and
- Boards may promulgate rules to further define compliance with the statute.

### **NEWEST 1500 CLAIM FORMS:**

The new 1500 Insurance Claim Forms must now be used. These forms will have boxes for NPI Numbers.

### **NPI NUMBERS:**

National Provider Identification Numbers are now available to every health care practitioner including Massage Therapists. It is free and follows you as your own personal number forever. To apply for yours go to: <https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.instructions>

### **PIP FEE SCHEDULE CHANGES. Effective January 2008**

#### **HOW THE NEWLY REQUIRED FEE SCHEDULE AFFECTS YOU**

TWO EXAMPLES of billing under the new rules of the 200% of the 2007 Medicare Fee Schedule: Insurer will pay only 80% of your full charge no matter what that is so long as it's not over the new 2007 Medicare Based Fee Schedule rules. The 20% Co-Pay balance is due by patient.

**EXAMPLE #1:** CPT CODE: 97124: Massage Therapy, (kneading, effleurage, petrissage, tapotement)

#### **Using Code 97124: Massage Therapy**

You would be able to bill at 200% of the 2007 Medicare base, which equates to \$45.48. Of that billed \$45.48, you would be reimbursed at 80% or \$36.38. You are then responsible for balance billing the 20% (\$9.10) co-pay to the patient. *I know, I can hear you now saying, "there is no way we can make it on this low amount of reimbursement."* However, the above figure is for one unit or 15 minutes of time. Most LMTs work in excess of this and are allowed to bill 4 units of this procedure when treatment is prescribed as medically necessary and with complete and proper documentation. That being the case; 1 hour (4 units) of Massage Therapy (97124) billed at \$45.48 per unit or \$181.92, which will be reimbursed at 80% by insurer & would bring you \$145.54. Remember the 20% co-pay balance of \$36.38 still due from the patient. Not as bad as you thought it would be is it?

**EXAMPLE #2: CPT CODE: 97140: Manual Therapy Techniques:** (Including manual traction, myofascial release, manual lymphatic drainage)

Using Code 97140: Manual Therapy Techniques.

You would be able to bill at 200% of the Medicare base, which equates to \$53.00. Of that billed \$53.00 you would be reimbursed at 80% or \$42.40. You are then responsible for billing the 20% co-pay of your billed amount (\$10.60) to the patient. This example is for 1 unit of time.

That being the case; 1 hour (4 units) of Manual Therapy Techniques (97140) billed at \$53.00 per unit equals \$212.00, reimbursed at 80% by insurer would bring you \$169.60, with the 20% co-pay balance of \$42.40 still being due from the patient.

You would bill the insurer your full charge no matter what price you set for your “medically, prescribed fees” (*not to exceed the 200% of the Medicare Fee Schedule*). Insurer will calculate and reimburse at the 80% level. It is your responsibility to bill the patient for the 20% co-pay balance.

**Things to think about** when billing the “Medicare based fee schedule”

While you CAN bill the 200% of the Medicare Fee Schedule you are not required to bill that amount. Remember as I have always said, with billing comes responsibility and ramifications.

When you bill for your services you must bill the same fee for all “LIKE SERVICES”.

**“Medically prescribed” cases are an example of a specific “type of service”.**

Medically prescribed cases may require, but are not limited to, physician contact, extensive paperwork, extenuating circumstances such as additional education, insurance claim filing, attorney contact, increased extra face to face patient time, possibility of reductions, losses, time constraints such as dealing with delays and denials or possible court appearances etc.

**“Time of service” (TOS)** is another “type of service”. TOS cases are where they pay at the time of service. This type of service may be offered at a different or lower fee than your “medically related services”. It is my understanding that this TOS fee may be and should be offered to adjusters if they are willing to pay claims at TOS.

#### **POSTING FEES:**

While you are not legally required to post your fees, it is a good idea to have your fees posted in advance or to provide an alternative notification system for your clients/prospective clients which clearly explains your fee schedule. This will prevent untold problems, such as upset or angry clients, as well as possible loss of business down the road.

All clients should be aware of your fee schedule, because if you are charging a TOS fee and they later become involved in an accident where a physician prescribes therapy, they will already be aware that you have a fee schedule for your “medically prescribed services” or standard and related fees, different from your TOS fee they had been paying all along.

This issue has been the leading problem area I am constantly called upon for advice. Therapists become very upset when attorneys become involved and begin to argue with them over their fees because their clients complained of being overcharged when the case became a medical case (*where you had to wait for your money*) versus a TOS case. As a reminder, Federal Law indicates that no one can “set your fees for you” or tell you what you must charge; however, that said, insurance companies can tell you what they WILL pay, as in Workers’ Comp Fee Schedules.

*These problems occur all because the therapist did not notify clients of their fee schedule ahead of time . Early notification of fees is important to allow the patient to choose a provider based on service and fees. It is especially important if their co-pays amount to more than their ability to pay. At this new PIP Medicare based Fee Schedule their co-pay amounts can really add up when the physician prescribes your services 2-3 times a week as is often the case.*

**BALANCE BILLING:** Because you are legally responsible to bill patients the 20% co-pay amounts, you may want to consider this when setting your fees. If the co-pay amounts to more than the average auto accident victim can afford they may just consider going to someone whose fees may not be as high as yours.

**WE CANNOT BILL MEDICARE:** Even though Medicare Fee Schedule is incorporated in this new PIP No –FAULT law it does NOT mean that LMTs can bill for MEDICARE cases. We CANNOT!!

The fee schedule examples used above are based on the "2007 Medicare RBRVS Physicians Guide" using the Conversion Factor of 37.8975 and using the Relative Value Unit (RVU) established for each CPT CODE. A very special thanks to Lamar Mooneyham, DC, who assisted me in better understanding how to calculate Medicare Conversion Factors and RVUs to establish correct 2007 Medicare Fees and a very special thank you to Mr. Paul Lambert, FSMTA Legal Counsel for his generous support as always.

**DISCLAIMER:**

*I am not an attorney and am providing this information to you as the FSMTA Insurance Consultant and from research and knowledge I've obtained over the years. For legal information I urge you to refer to legal counsel.*

*Laws and Rules are changed before we can blink an eye. While I try to regularly stay on top of all issues there may come a time I just might not have it 100% accurate. If this is ever the case, please feel free to correct me on any issue at anytime.*

**FINAL MESSAGE:** Stay tuned because more changes are on the horizon. I will keep you posted. If you wish to be on my "MASSAGE INSURANCE UPDATE" E-list please go to my website (below) and click on the SIGN UP link on the top toolbar.

\* For Forms, Codes, Insurance Guidelines, Rules and Laws please refer to your Manipulate Your Future Manual or take my CE Courses on Insurance Billing Procedures and Marketing Strategies.

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