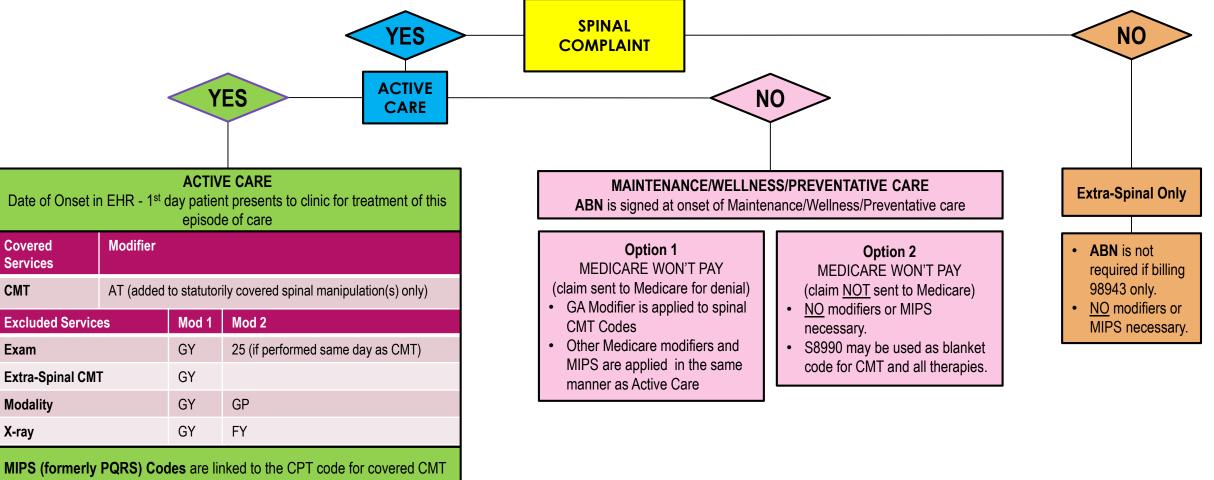
## **Medicare Modifier Flow**



- services. Most commonly used codes are:
- 1st OATS visit and each positive re-assessment:
- G8539 Functional outcome assessment documented as positive using a standardized tool and a care plan based on identified deficiencies on the date of functional outcome assessment.
- 2<sup>nd</sup> visit and each positive re-assessment:
- G8942 Functional outcomes assessment using a standardized tool is documented within the previous 30 days and care plan, based on identified deficiencies on the date of the functional outcome assessment. is documented.

Final visit if patient is asymptomatic:

**G8542** - Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required.

Billable CMT(s) must be Performed by a licensed DC. If a patient is seen 2 times in 1 day. 2<sup>nd</sup> visit is not billed to Medicare and pt cannot be charged.



- All determinations to issue an ABN and explanations of ABNs must be performed by a licensed DC.
- ABN is issued when: Item or service is statutorily covered by Medicare, but is not reimbursable in this instance because it
- is not medically necessary. (Ex: maintenance CMT)
- Use: **GZ modifier** "geez, I forgot the ABN" for instances when no ABN was signed. We cannot collect from patient or Medicare if used.

What are Statutorily Reimbursable Services?		
<b>Reimbursable Services</b>	Excluded Services	
98940	EVERYTHING ELSE	
98941		
98942		