Medicare Modifier Flow

SPINAL COMPLAINT

YES → **ACTIVE CARE**

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Date of Onset in EHR - 1st day patient presents to clinic for treatment of this episode of care

Covered Services	Modifier
CMT	AT (added to statutorily covered spinal manipulation(s) only)

Excluded Services	Mod 1	Mod 2
Exam	GY	25 (if performed same day as CMT)
Extra-Spinal CMT	GY	
Modality	GY	GP
X-ray	GY	FY

MIPS (formerly PQRS) Codes are linked to the CPT code for covered CMT 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.

2nd 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. 2nd visit is not billed to Medicare and pt cannot be charged.

ACTIVE CARE → **NO**

MAINTENANCE/WELLNESS/PREVENTATIVE CARE
ABN is signed at onset of Maintenance/Wellness/Preventative care

Option 1
MEDICARE WON'T PAY
(claim sent to Medicare for denial)

- GA Modifier is applied to spinal CMT Codes
- Other Medicare modifiers and MIPS are applied in the same manner as Active Care

Option 2
MEDICARE WON'T PAY
(claim NOT sent to Medicare)

- NO modifiers or MIPS necessary.
- S8990 may be used as blanket code for CMT and all therapies.

SPINAL COMPLAINT → **NO**

Extra-Spinal Only

- **ABN** is not required if billing 98943 only.
- NO modifiers or MIPS necessary.

ABN

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?

Reimbursable Services	Excluded Services
98940	EVERYTHING ELSE
98941	
98942	

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