

Instructor Materials

Index

Instructor Materials

INSTRUCTOR MATERIALS pp. 3 - 29

Section includes:

- Goal
- Objectives for All Clusters
- Student Preparation and Materials
- Instructor Preparation
- Introduction
- Pre-instructional Activities
- Clusters 1-3 Content and Presentation Notes
 - Objective
 - Related Instructor Activity
 - On-screen demonstrations (as appropriate)
 - Questions (as appropriate)
- Assessments
 - Written exam
 - Practical exam

BILLING PACKET FOR INSTRUCTOR pp. 30 - 40

Section includes:

- Instructions for determining ICD-9 and CPT codes
- Instructions for billing for services in Lytec
- Scenarios and “completed” progress notes for 3 faux patients
- Insurance Filing Rules and Modifiers handouts

Instructor Materials

Instructional Goal

INSTRUCTIONAL GOAL
Sherman College chiropractic interns will be able to use the Lytec Practice Management System to fill out CMS-1500 insurance claim forms for their health center patients.

Materials included for goal, divided into 3 clusters

CLUSTER	OBJECTIVES	TIME																								
	Total instruction time is 1 hour. Three cluster groups have been defined for this objective.																									
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TOTAL		55 minutes																								

Objectives and steps for all clusters

Substep/Subskills	Objective
1 Click the Lytec icon to launch Lytec Application	Given a computer with Lytec practice management software installed and application icon visible on desktop, the learner will successfully double-click on the Lytec icon to launch the application.
1.1 Substep: Locate and open Health Center practice	Given a computer with Lytec practice management software installed, the learner will accurately perform the steps necessary to open the Health Center practice within Lytec.
1.2 Substep: Enter Password	Given a computer with Lytec practice management software installed, the learner will correctly enter password for the Health Center practice.
2 Click on Billing to open menu	Given a computer with Lytec practice management software installed, the learner will successfully locate and click on the Billing menu to launch submenu.
2.1 Substep: Click Charges to open Billing screen	Given a computer with Lytec practice management software installed, the learner will accurately perform the steps necessary to open the Billing screen.
3 Enter Patient File Number in Chart field	Given a computer with Lytec practice management software installed, and having patient hardcopy file, the learner will correctly enter pre-determined patient file number in the chart field of the billing screen.
4 Enter Date of Service in Date of Service field	Given a computer with Lytec practice management software installed, and having patient hardcopy file, the learner will accurately enter patient encounter date using 2-digit month, 2-digit day, and 4-digit year sequence in the date of service field of the billing screen.
5 Enter International Classification of Disease (ICD-9) code in diagnosis code field	Given a computer with Lytec practice management software installed, and having patient hardcopy file, the learner will correctly enter one international classification of disease, 9 th revision (ICD-9) code in the diagnosis field of the billing screen.
6 Enter Current Procedural Terminology	Given a computer with Lytec practice management software

(CPT) code in procedure field	installed, and having patient hardcopy file, the learner will correctly enter one current procedural terminology (CPT) code in the procedure field of the billing screen.
7 Add another procedure? Yes/No	Given a computer with Lytec practice management software installed, and having patient hardcopy file, the learner will refer to patient file to determine if there are more procedures that need to be entered.
8 Click Save button	Given a computer with Lytec practice management software installed, and having patient hardcopy file, the learner will successfully click on the Save button of the billing screen to save and exit current session.
1.1 Substep: Locate and open Health Center practice	Given a computer with Lytec practice management software installed, the learner will accurately perform the steps necessary to open the Health Center practice within Lytec.
1.2 Substep: Enter Password	Given a computer with Lytec practice management software installed, the learner will correctly enter password for the Health Center practice .
2.1 Substep: Click Charges to open Billing screen	Given a computer with Lytec practice management software installed, the learner will accurately perform the steps necessary to open the Billing screen.
3.1 Assign patient a chart number for both hardcopy and database	Given a computer with Lytec practice management software installed, and having access to a patient file, the learner will accurately follow the health center policy naming convention for assigning patient chart numbers to both hardcopy file and electronic Lytec patient file.
3.2 Validate that patient personal information is in database	Given a computer with Lytec practice management software installed, and having access to a patient hardcopy file, the learner will validate each field of patient personal information by accessing the patient screen using the pull-down List menu option.
3.3 Validate that patient insurance information is in database	Given a computer with Lytec practice management software installed, and having access to a patient file, the learner will validate patient insurance information by accessing the primary insurance screen from within the patient file screen.
4.1 Document date of patient encounter	Given a patient hardcopy file, the learner will accurately write the patient encounter date in the file using month,day, year format, in the 2/2/4 format. (ex. 01/02/2007)
4.2 Document Subjective findings in SOAP format in patient notes	During patient encounter and having patient hardcopy file, the learner will accurately list in writing the patient's subjective findings (complaints) while following the clinical SOAP note format as described in clinic procedural manual.
4.3 Document Objective findings in SOAP format in patient notes	During patient encounter and having patient hardcopy file, the learner will accurately list in writing the patient's objective exam findings while following the clinical SOAP note format as described in clinic procedural manual.
4.4 Document Assessment using SOAP format in patient notes	During patient encounter and having patient hardcopy file, the learner will accurately determine and notate a clinical impression (diagnosis) using ICD-9 codes while following the clinical SOAP note format as described in clinic procedural manual.
4.5 Document Plan using SOAP format in patient notes	Given a patient hardcopy file containing subjective, objective and assessment findings, the learner will present to the attending doctor an appropriate plan of care and upon approval, will notate plan in patient file.
5.1 Determine primary diagnosis for procedure	Given a patient hardcopy file containing SOAP notes, the learner will accurately determine from problem list found in the subjective section, the patient's primary diagnosis using an international classification of disease, 9 th revision (ICD-9) code.
5.1a State rationale and criteria for choosing primary diagnoses using clinical protocol methods.	Given a patient hardcopy file containing SOAP notes, and having chosen patient's primary diagnostic code, the learner will state in writing the rationale for choosing code, citing clinical protocol methods
5.2 Determine secondary diagnostic codes	Given a patient hardcopy file containing SOAP notes, the learner will accurately determine from problem list found in the subjective section, the patient's secondary diagnoses using international classification of disease, 9 th revision (ICD-9) codes.
5.2a State rationale and criteria for choosing	Given a patient hardcopy file containing SOAP notes, and having

secondary diagnoses using clinical protocol methods.

chosen patient's secondary diagnostic codes, the learner will state in writing the rationale for choosing codes, citing clinical protocol methods

5.3 Document diagnoses in notes	Given a patient hardcopy file containing subjective and objective examination findings, the learner will accurately list within the assessment section of the file, the patient's diagnoses using international classification of disease, 9 th revision (ICD-9) codes.
6.1 Document procedure (CPT) code in notes	Given a patient hardcopy file containing subjective, objective and assessment findings, the learner will accurately list within the plan/procedure section, and using current procedural terminology (CPT) coding, the procedures performed during a patient encounter.
6.2 Determine CPT linkage relationship with diagnosis (ICD-9) code	Given a patient hardcopy file containing complete subjective, objective, assessment and plan/procedure findings, the learner will accurately notate beside each current procedural terminology (CPT) code, the appropriate international classification of disease, 9 th revision (ICD-9) code that regionally links the diagnosis and appropriate procedure.
6.2a State rationale for linking ICD-9 code with CPT code	Given a patient hardcopy file containing complete subjective, objective, assessment and plan/procedure findings, the learner will state in writing the rationale for choosing linkage relationship.
6.3 Determine need for CPT modifier	Given a patient hardcopy file containing complete subjective, objective and assessment findings, the learner will utilize current insurance best practices and Medicare modifier rules to determine the need for a modifier on all current procedural terminology (CPT) codes listed. The learner will indicate a need by placing a check mark in the "need modifier" field next to the CPT code.
6.4 Determine modifier to use	Given a patient hardcopy file containing complete subjective, objective and assessment findings along with modifier usage indicator, the learner will utilize current insurance best practices and Medicare modifier rules to choose and notate the appropriate modifier to use for each CPT code that has been marked as needing a modifier.
6.4a State modifier definition and rules for usage	Given a patient scenario in which a modifier is needed, learner will choose correct modifier and definition from list of choices.
7.1 Refer to patient file for further documentation of more procedures	Given a patient hardcopy file, learner will accurately declare continuation or completion of data entry based on observance of additional billable procedure documentation in file.

Preparation

STUDENT PREPARATION AND MATERIALS

- Student support materials include *Patient Scenarios and Billing Packet* (1 per student) and *Insurance Filing Rules and Modifiers* handout (1 per student).
- Students should read the *Insurance Filing Rules and Modifiers* handout and be familiar with the *Patient Scenarios and Billing Packet* which are included with these instructions.
- Job aids: ICD-9 and CPT code list from within the Lytec's software Lists menu
- Cluster 1, steps for objectives 1 - 4 should be completed prior to this cluster.
- Each student should be sitting at a computer with Lytec launched, Health Center practice opened, John Doe patient billing screen launched and first date of service entered (these steps took place in Cluster 1).

INSTRUCTOR PREPARATION

- Review assigned student material
- Training materials include instructor lab computer (Lytec is pre-installed) and overhead monitor remote.
- Computer and overhead monitor should be turned on and the Lytec Health Center practice launched.
- Follow directions in this instructor guide to demonstrate, on-screen with Lytec, each step in this cluster.
- Reference publications:

Chirocode Institute, Inc. (2006). *Chirocode deskbook*. Phoenix, AZ: Chirocode Institute.
Centers for Medicare and Medicaid Services. (2007). *Medicare*. Retrieved November 7, 2007, from <http://www.medicare.gov>

PREINSTRUCTIONAL ACTIVITIES

Motivation: Learners will be reminded that in order to be paid for their services as doctors of chiropractic (DCs) they must bill for services rendered. They will also be reminded that the *Job Analysis of Chiropractic 2005* survey, published every five years, from the National Board of Chiropractic Examiners (2005) reports that nearly 60% percentage of a doctor of chiropractic's revenue is from insurance-related billing. Furthermore, the same approach to coding for services that is used for billing insurance is also used for cash patients, worker's compensation and other third-party payors.

National Board of Chiropractic Examiners. (2005). *Job analysis of chiropractic 2005*. Retrieved October 21, 2007, from http://www.nbce.org/publications/pub_analysis_chap.html

Objectives: Instructor will describe the importance of correctly filling out a CMS-1500 insurance claim form. A "clean" claim (one without errors and missing fields) will be processed for benefit reimbursement; therefore, learning the "rules" for commercial insurance carriers and Medicare is crucial. The Lytec software is user-friendly and will provide a way to learn the concepts and rules of CMS-1500 form protocol.

Student Groupings and Media Selection: Instructor-led, learners work individually. Class in computer lab; each student has computer, instructor utilizes large-screen projection of instructor computer for instruction.

INTRODUCTION

Health care providers communicate with insurance companies via the CMS-1500 insurance claim form. This claim form should contain all the required information needed for the insurance company to determine reimbursement benefits. Every effort should be made to produce a "clean claim." A clean claim is defined as one that meets all the necessary requirements of the insurance carrier. It is the responsibility of the provider (you) to understand what is needed by the carrier. You need to give sufficient and proper information that meets the guidelines for payment. In order to provide the correct information, you should refer to the patient case file to extract services rendered information. To practice this, we will use the *Patient Scenario and Billing Packet*. When billing for Current Procedural Terminology (CPT) codes, you should be aware that each CPT code requires an International Classification of Disease (ICD-9) code to be linked to it. Making these associations requires that you identify, extract, and notate the diagnoses and procedures rendered from the patient case file. Then, using the rules found on the *Insurance Filing Rules* handout, follow the procedure for linking each CPT with the correct ICD-9 codes. Finally, we will input this data for each patient into the billing screen in Lytec.

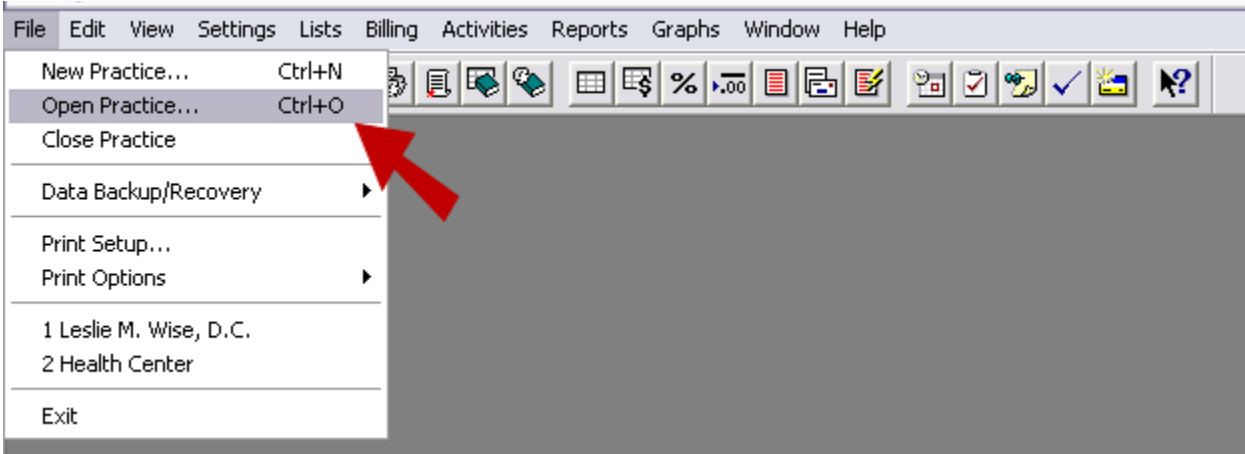
Content Presentation (divided by clusters)

CLUSTER 1:

<p>OBJECTIVE: 1.0 Click the Lytec icon to launch Lytec Application Given a computer with Lytec practice management software installed and application icon visible on desktop, the learner will successfully double-click on the Lytec icon to launch the application.</p>	<p>Sec. .30</p>
<p>RELATED INSTRUCTOR ACTIVITY</p>	
<p>Refer: Refer to the billing packet and instructions to launch Lytec.</p>	
<p>Example and Participation: : Instructor will invite students to locate and double-click on the Lytec icon on their desktops. Instructor will demonstrate with overhead projection of instructor's computer. Instructor will point to Lytec icon on desktop of instructor's computer which is being projected on the large screen in the front of the classroom.</p>	
<p>Feedback: Walk down aisle to make sure all students have launched Lytec. Provide help if needed.</p>	
<p>Screenshots:</p>	


Lytec

Doubleclick on this icon on desktop:

<p>OBJECTIVES:</p> <p>1.0 Click the Lytec icon to launch Lytec Application Given a computer with Lytec practice management software installed and application icon visible on desktop, the learner will successfully double-click on the Lytec icon to launch the application.</p> <p>1.1 Locate and open Health Center practice Given a computer with Lytec practice management software installed, the learner will accurately perform the steps necessary to open the Health Center practice within Lytec.</p> <p>1.2 Substep: Enter Password Given a computer with Lytec practice management software installed, the learner will correctly enter password for the Health Center practice.</p>	<p>Min. 1</p>
<p>RELATED INSTRUCTOR ACTIVITY</p> <p>Refer: Refer to the billing packet and instructions to launch Lytec. User: INTERN Password: subluxation</p> <p>Example and Participation: Instructor will provide billing packets handouts and read over instructions on how to locate and open the practice, as well as demonstrate these steps using the instructor's computer which is being projected on the large screen in the front of the classroom. Learns will follow and replicate steps on their own computer.</p>	
<p>Feedback: Walk down aisle to make sure all students have opened the correct practice. Provide help if needed.</p>	
<p>Screenshots:</p> 	

The 'Practice List' window displays a table with the following data:

Practice Name	Last Opened	Data Path
Health Center	11/20/2007	C:\Program Files\Lytecce\Health Center\

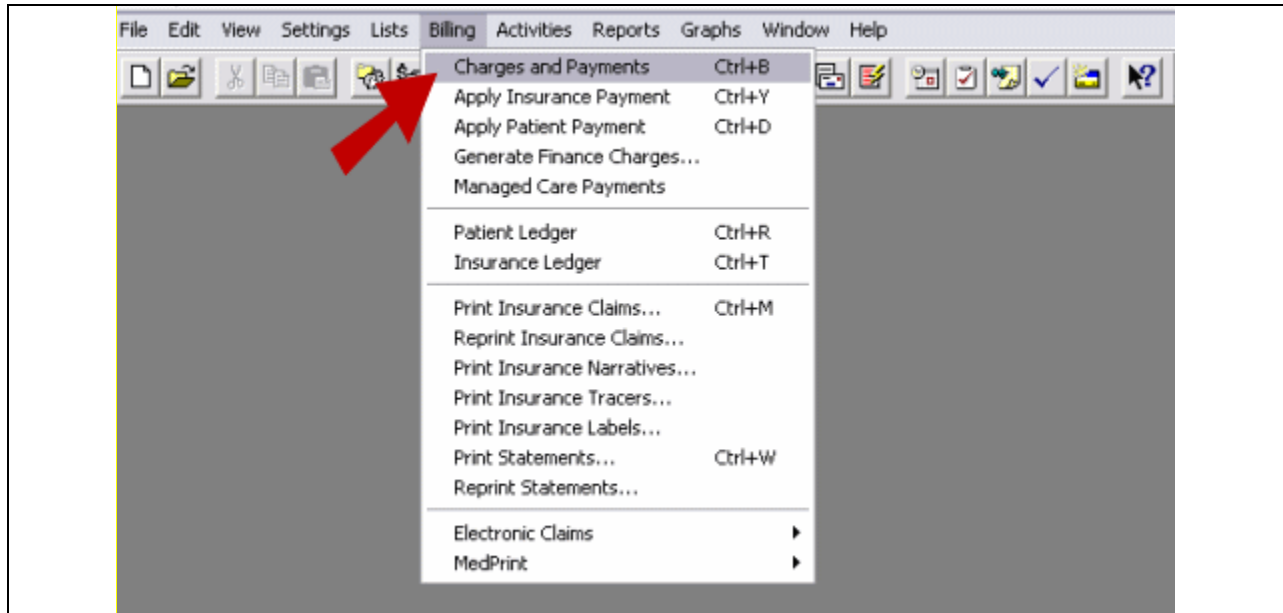
Below the table is a 'Log In' dialog box with the following fields:

User Code: OK

Password: Cancel

Login:
. User: **INTERN** Password: **subluxation**

<p>OBJECTIVES:</p> <p>2.0 Click on Billing to open menu Given a computer with Lytec practice management software installed, the learner will successfully locate and click on the Billing menu to launch submenu.</p> <p>2.1 Click Charges to open Billing screen Given a computer with Lytec practice management software installed, the learner will accurately perform the steps necessary to open the Billing screen.</p>	<p>Sec. .30</p>
<p>RELATED INSTRUCTOR ACTIVITY</p>	
<p>Refer: Instructor will refer to handout packet that includes instructions on how to open billing menu and billing screen.</p>	
<p>Example and Participation: Instructor will demonstrate these steps using the instructor’s computer which is being projected on the large screen in the front of the classroom. Learns will follow and replicate steps on their own computer.</p>	
<p>Feedback: Instructor will check each learner terminal to make sure billing screen has been opened. If not, instructor will help learner through the process by use of demonstration and/or verbal directions.</p>	
<p>Screenshots:</p> <p style="text-align: center;">Billing Menu:</p>	



Billing Screen:

Charges and Payments

Billing Information
 Patient Chart: [DOEJ] Doe, John Q
 Billing: [3340] Created: [11/15/2007]
 Provider: [] Co-Pay: \$0.00
 Location: []

Bill To:

	Bill	First Billed	Last Billed
Patient	<input type="checkbox"/>		
Primary Insur...	<input type="checkbox"/>		
Secondary In...	<input type="checkbox"/>		
Tertiary Insur...	<input type="checkbox"/>		

Detail Items:

Print	Pmt	Date From	Date To	Provider	Diagnosis	Code	Mod	POS	Amount	Units	Extended

Provider: (None selected) Code: (None selected) Tax: \$0.00 Patient Portion: \$0.00
 Diagnosis: (None selected) Reference: (None specified) Tax Paid: \$0.00 Insurance Portion: \$0.00
 Billing Balance: \$0.00
 Account Balance: \$235.00

[Billing] [Detail] [Print] [New/Open] [Save] [Close]

OBJECTIVE:

3.1 Assign patient a chart number for both hardcopy and database
 Given a computer with Lytec practice management software installed, and having access to a patient file, the learner will accurately follow the health center policy naming convention for assigning patient chart numbers to both hardcopy file and electronic Lytec patient file.

Min.
2

RELATED INSTRUCTOR ACTIVITY

Refer: Instructor will refer to handout packet that includes instructions on naming convention for patients, also completed instructor's version of progress notes for each patient contain naming convention.

Example: If patient is named John Doe, and the naming convention is to use all caps, full last name and

first letter of first name, and using no spaces, underscores or dashes, the patient chart name would be DOEJ.

Participation: Along with the instructor's on-screen demonstration, learners will be instructed to use the faux patient packet and accompanying instructions to name patient chart. Learners will have the opportunity to do this same step for the other faux patients contained in the packet.

Questions:

- What will you name John Doe? (*DOEJ*)
- What will you name Linda Martin? (*MARTINL*)
- What will you name Claude Hughes? (*HUGHESC*)

OBJECTIVES:

3.2 Validate that patient personal information is in database

Given a computer with Lytec practice management software installed, and having access to a patient hardcopy file, the learner will validate each field of patient personal information by accessing the patient screen using the pull-down List menu option.

3.3 Validate that patient insurance information is in database

Given a computer with Lytec practice management software installed, and having access to a patient file, the learner will validate patient insurance information by accessing the primary insurance screen from within the patient file screen.

Min.
1

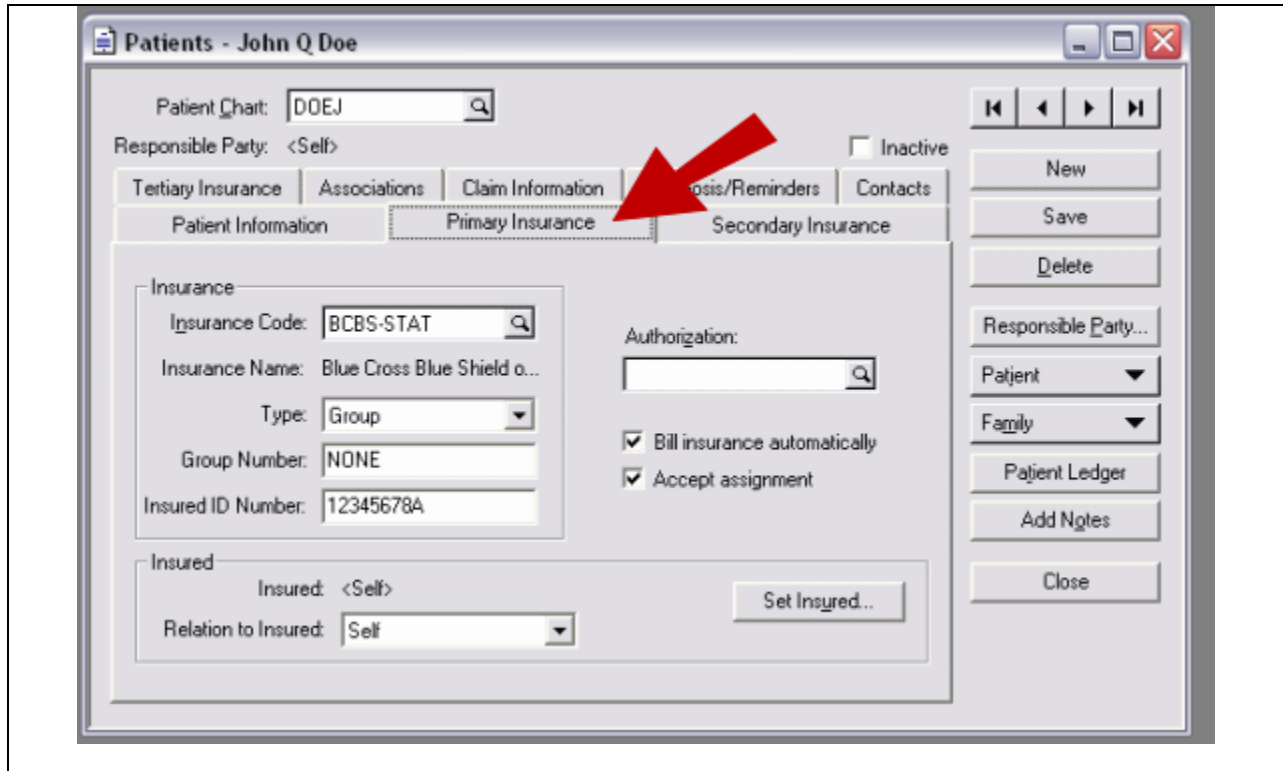
RELATED INSTRUCTOR ACTIVITY

Refer: Instructor will refer to handout packet that includes instructions to open patient's on-screen file in Lytec to determine if all personal information and insurance information needed for the insurance claim form has been entered.

Example: Instructor will demonstrate on screen demonstrate how to validate data and look for missing patient information, as well as locate insurance tab and check insurance information.

Participation: Along with the instructor's on-screen demonstration, learners will be instructed to use the faux patient packet and accompanying instructions to validate patient information. Learners will have the opportunity to do this same step for the other faux patients contained in the packet.

Screenshots:



<p>OBJECTIVES: 3.0 Enter Patient File Number in Chart field Given a computer with Lytec practice management software installed, and having patient hardcopy file, the learner will correctly enter pre-determined patient file number in the chart field of the billing screen.</p>	<p>Sec.. .30</p>
<p>RELATED INSTRUCTOR ACTIVITY</p>	
<p>Refer: Instructor will refer to handout packet that includes instructions for entering Patient File number in chart field.</p>	
<p>Example: Instructor will refer to handout packet that includes faux patient information, as well as demonstrate, by using the instructor's computer which is being projected on the large screen in the front of the classroom, how to enter patient file number in chart field of the billing screen.</p>	
<p>Participation: Along with the instructor's on-screen demonstration, learners will be instructed to use the faux patient packet to locate and enter file number in Lytec. Learners will have the opportunity to do this same step for the other faux patients contained in the packet.</p>	
<p>Screenshots:</p>	

OBJECTIVE: 4.1 Document date of patient encounter Given a patient hardcopy file, the learner will accurately write the patient encounter date in the file using month,day, year format, in the 2/2/4 format. (ex. 01/02/2007)	Min. 2
RELATED INSTRUCTOR ACTIVITY	
Refer: Instructor will refer to billing packet and Doe scenario to prompt learner to notate date of service in appropriate convention.	
Example: Instructor will give example of correct date convention using using 2-digit month, 2-digit day, and 4-digit: For January 15, 2007, the date would be entered 01/15/2007 Non examples given would include: 15/01/2007 or 15/01/07 or 01/15/07 or 1/15/07	
Participation: Along with the instructor's on-screen demonstration, learners will be instructed to use the faux patient packet and accompanying instructions to notate in patient file the date of service. Learners will have the opportunity to do this same step for the other faux patients contained in the packet.	
Questions: <ul style="list-style-type: none"> • What is John Doe's initial patient encounter date? (<i>January 15, 2007</i>) • How will you notate this? (<i>01/15/2007</i>) 	

OBJECTIVE: 4.2 Document Subjective findings in SOAP format in patient notes During patient encounter and having patient hardcopy file, the learner will accurately list in writing the patient's subjective findings (complaints) while following the clinical SOAP note format as described in clinic procedural manual.	Min. 2
RELATED INSTRUCTOR ACTIVITY	
Refer: Instructor will refer to billing packet and Doe scenario to prompt learner to notate subjective findings from patient case scenario found in information in packet.	
Example: Learners will extricate from scenario those symptoms that patient presents with. If John Doe presents complaining of headache and lower back pain, notate those symptoms in SOAP format in the patient file.	

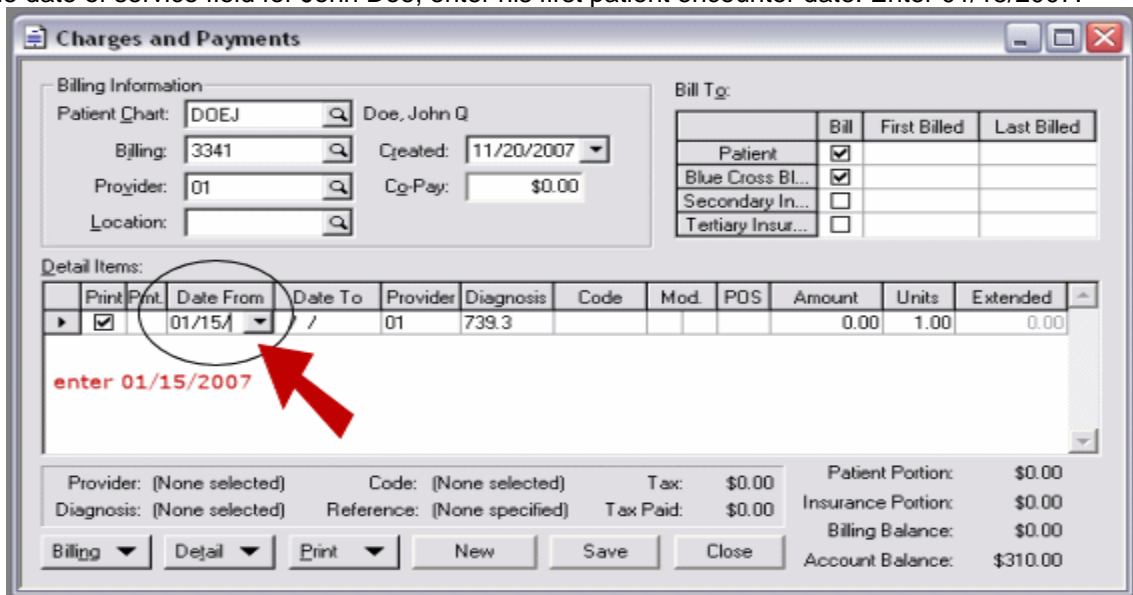
<p>Participation: Along with the instructor's demonstration, learners will be instructed to use the faux patient packet and accompanying instructions to notate patient subjective findings. Learners will have the opportunity to do this same step for the other faux patients contained in the packet</p>
<p>Feedback: Instructor and learners will discuss findings for scenario in class.</p>
<p>Questions:</p> <ul style="list-style-type: none"> • What does the scenario indicate for as Mr. Doe's presenting problems? (<i>low back pain</i>)

<p>OBJECTIVE: 4.3 Document Objective findings in SOAP format in patient notes During patient encounter and having patient hardcopy file, the learner will accurately list in writing the patient's objective exam findings while following the clinical SOAP note format as described in clinic procedural manual.</p>	<p>Min. 3</p>
<p>RELATED INSTRUCTOR ACTIVITY</p>	
<p>Refer: Instructor will refer to billing packet and Doe scenario to prompt learner to notate objective findings from patient case scenario found in information in packet.</p>	
<p>Example: Learners will extricate from scenario the objective findings. For example, John Doe's finding indicate a positive compression test, a limited range of cervical spine motion in flexion and right rotation and a thermographic reading indicating inflammation over C6-7 level. These would be notated in the patient file in SOAP note format.</p>	
<p>Participation: Along with the instructor's demonstration, learners will be instructed to use the faux patient packet and accompanying instructions to notate patient subjective findings. Learners will have the opportunity to do this same step for the other faux patients contained in the packet</p>	
<p>Feedback: Instructor and learners will discuss findings for scenario in class.</p>	
<p>Question:</p> <ul style="list-style-type: none"> • What does the scenario indicate for objective findings? <i>(Lumbar musculature in spasm, especially on the right. ROM decreased in lateral flexion x 2 and rotation x 2. Lumbar spine flexion become painful at 25 degrees. Extension is painful at 10 degrees. Lower extremity reflexes are normal bilaterally. Heel walk and toe walk are negative. Valsalva is negative. Straight leg raise is positive on the right at 45 degrees and is exacerbated by ankle dorsiflexion. Motion palpation shows restriction at L5, S1, in all planes. SI joints are freely movable. Thoracic spine unremarkable. L5)</i> 	

<p>OBJECTIVE: 4.4 Document Assessment using SOAP format in patient notes During patient encounter and having patient hardcopy file, the learner will accurately determine and notate a clinical impression (diagnosis) using ICD-9 codes while following the clinical SOAP note format as described in clinic procedural manual.</p>	<p>Min. 3</p>
<p>RELATED INSTRUCTOR ACTIVITY</p>	
<p>Refer: Instructor will refer to billing packet and Doe scenario to prompt learner to determine and notate clinical impression(s) (diagnoses) using ICD-9 codes from patient case scenario found in information in packet.</p>	
<p>Example: Learners will extricate diagnoses from the scenarios. For example, if John Doe has a lumbar subluxation, notate that as 739.3, in appropriate SOAP note format in patient notes.</p>	
<p>Participation: Along with the instructor's demonstration, learners will be instructed to use the faux patient packet and accompanying instructions to determine and notate diagnoses and ICD-9 codes. Learners will have the opportunity to do this same step for the other faux patients contained in the packet</p>	
<p>Feedback: Instructor and learners will discuss diagnoses and ICD-9 codes for scenario in class.</p>	
<p>Question:</p> <ul style="list-style-type: none"> • Based on the scenario, what would your diagnoses be? What ICD-9 codes would you use to indicate that? <i>(739.3 lumbar subluxation, 724.2 low back pain, 739.4 sacroiliac subluxation, 724.6 sacralgia)</i> 	

OBJECTIVE: 4.5 Document Plan using SOAP format in patient notes Given a patient hardcopy file containing subjective, objective and assessment findings, the learner will present to the attending doctor an appropriate plan of care and upon approval, will notate plan in patient file.	Min. 1
RELATED INSTRUCTOR ACTIVITY	
Refer: Instructor will refer to billing packet and Doe scenario to prompt learner to determine and notate appropriate plan of care from patient case scenario found in information in packet.	
Example: Learners will determine plan of care from scenarios. For example, John Doe's low back pain may be prescribed a plan of care that includes visits to the DC for 6 weeks: 3 times a week for 2 weeks and then twice a week for 2 weeks and finally down to once 1 week for the remaining 2 weeks.	
Participation: Along with the instructor's demonstration, learners will be instructed to use the patient packet and accompanying instructions to determine and notate plan of care. Learners will have the opportunity to do this same step for the other patients contained in the packet.	
Feedback: Instructor and learners will discuss plan of care for scenario in class.	
Question: <ul style="list-style-type: none"> • Based on the scenario, what plan of care is apparent, based on the subjective, objective and assessment findings? (2 visits twice a week, reassess after each. Based on clinical guidelines) 	

OBJECTIVE: 4.0 Enter Date of Service in Date of Service Field Given a computer with Lytec practice management software installed, and having patient hardcopy file, the learner will accurately enter patient encounter date using 2-digit month, 2-digit day, and 4-digit year sequence in the date of service field of the billing screen.	Min. 1
RELATED INSTRUCTOR ACTIVITY	
Refer: Instructor will refer to billing packet and Doe scenario to enter date of service in appropriate convention.	
Example: Instructor will give example of correct date convention using using 2-digit month, 2-digit day, and 4-digit: For January 15, 2007, the date would be entered 01/15/2007 Non examples given would include: 15/01/2007 or 15/01/07 or 01/15/07 or 1/15/07	
Participation: Along with the instructor's on-screen demonstration, learners will be instructed to use the faux patient packet and accompanying instructions to enter date of service. Learners will have the opportunity to do this same step for the other patients contained in the packet.	
On-screen Demonstration Using Lytec: Read the following directions aloud as you demonstrate; students should follow entering data, as well. In the date of service field for John Doe, enter his first patient encounter date: Enter 01/15/2007.	



End of Cluster 1

CLUSTER 2:

<p>OBJECTIVES: 5.1 Determine primary diagnosis for procedure Given a patient hardcopy file containing SOAP notes, the learner will accurately determine from problem list found in the subjective section, the patient's primary diagnosis using an international classification of disease, 9th revision (ICD-9) code. 5.1a State rationale and criteria for choosing primary diagnoses using clinical protocol methods. Given a patient hardcopy file containing SOAP notes, and having chosen patient's primary diagnostic code, the learner will state in writing the rationale for choosing code, citing clinical protocol methods</p>	<p>Min. 5</p>
<p>RELATED INSTRUCTOR ACTIVITY</p>	
<p>Refer: Refer to the billing packet, John Doe scenario.</p>	
<p>Example: Learners will read and extricate diagnoses from the John Doe scenario. For example, if John Doe presents with low back pain and sciatica, and was adjusted at L5, indicated as predominate subluxation, learner will extrapolate that lumbar subluxation is the primary diagnosis. Students may use job aid of ICD-9 code from list menu in Lytec.</p>	
<p>Questions:</p> <ul style="list-style-type: none"> • From the scenario, what appears to be the primary diagnosis for John Doe? (<i>Lumbar subluxation</i>). • How can you be sure? (<i>x-ray findings indicate it, adjustment sequence indicates it</i>) • What coding system is used to indicate lumbar subluxation? (<i>ICD-9</i>) • Which ICD-9 code indicates lumbar subluxation? (<i>739.3</i>) 	

<p>OBJECTIVES: 5.2 Determine secondary diagnostic codes Given a patient hardcopy file containing SOAP notes, the learner will accurately determine from problem list found in the subjective section, the patient's secondary diagnoses using international classification of disease, 9th revision (ICD-9) codes. 5.2a State rationale and criteria for choosing secondary diagnoses using clinical protocol methods. Given a patient hardcopy file containing SOAP notes, and having chosen patient's secondary diagnostic codes, the learner will state in writing the rationale for choosing codes, citing clinical protocol methods</p>	<p>Min. 5</p>
<p>RELATED INSTRUCTOR ACTIVITY</p>	
<p>Refer: Refer to the billing packet, John Doe scenario.</p>	
<p>Example: Learners will read and extricate diagnoses from the John Doe scenario. For example, if John Doe presents with low back pain and sciatica, and was adjusted at L5, indicated as predominate subluxation, with right SI and PI following, learner will extrapolate that sacralgia, sacroiliac subluxation and low back pain are secondary diagnoses. Students may use job aid of ICD-9 code from list menu in Lytec.</p>	
<p>Questions:</p> <ul style="list-style-type: none"> • From the scenario, what appears to be the secondary diagnoses for John Doe? (<i>sacralgia, sacroiliac subluxation and low back pain</i>) • How can you be sure? (<i>exam and x-ray findings indicate it, adjustment sequence indicates it</i>) • What coding system is used to indicate secondary diagnoses? (<i>ICD-9</i>) • Which ICD-9 codes fit each secondary diagnoses? (<i>sacralgia: 724.6, sacroiliac subluxation: 739.4; low back pain: 724.2</i>) 	

<p>OBJECTIVE: 5.3 Document diagnoses in notes Given a patient hardcopy file containing subjective and objective examination findings, the learner</p>	<p>Min. 8</p>
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will accurately list within the assessment section of the file, the patient's diagnoses using international classification of disease, 9th revision (ICD-9) codes.

RELATED INSTRUCTOR ACTIVITY

Refer: Refer to the billing packet, John Doe scenario.

Example Learners will have read and extricated diagnoses from the John Doe scenario in the previous steps. Notate ICD-9 codes in John Doe's patient case file, upper right corner. Students may use job aid of ICD-9 code from list menu in Lytec.

Questions:

- What are the diagnoses that you extracted from John Doe's scenario? (739.3, 724.2, 739.4, 724.6)
- How many diagnoses do there appear to be? (4)
- Where do these 4 ICD-9 codes need to be notated and in what order? (*In patient case file, in upper right corner, primary diagnosis code listed first.*) See graphic below:

PROGRESS NOTES

PATIENT: *John Doe*

CHART NAME: **DOEJ**

Diagnosis Codes:

1. ~~739.3~~ lumbar subluxation
2. 724.2 low back pain
3. ~~739.4~~ sacroiliac subluxation
4. 724.6 sacralgia

DATE OF SERVICE:	NOTES:	DIAGNOSIS CODES ICD-9s	PROCEDURE CODES CPTs	Mod. Code	Modifier? Check for Yes
01/15/07	<i>AP and Lat. Lumbar Spine X-rays</i>	724.2	72100		
	<i>AP Pelvis X-ray</i>	724.6	72170		
	<i>Adjusted: L5. Right. SI. PI on Right</i>	739.3	98940		

OBJECTIVE:

6.1 Document procedure (CPT) code in notes

Given a patient hardcopy file containing subjective, objective and assessment findings, the learner will accurately list within the plan/procedure section, and using current procedural terminology (CPT) coding, the procedures performed during a patient encounter.

Min. 8

RELATED INSTRUCTOR ACTIVITY

Refer: Refer to the billing packet, John Doe scenario and refer to the *Insurance Filing Rules and Modifiers* handout.

Examples: Learners will extricate CPT codes from the scenarios. For example, if John Doe was rendered care for lumbar subluxation and adjusted in one region only (lumbar), using the definition for the CPT codes found on the *Insurance Filing Rules and Modifiers* handout, 98940's definition would fit as the CPT code for that procedure. Students may use job aid of CPT codes from the list menu in Lytec and refer to *Insurance Filing Rules and Modifiers* handout.

Questions:

- What are the procedures that you extracted from John Doe's scenario? (*AP and Lat. Lumbar Spine X-rays, Pelvis X-rays, Office Visits and Adjustments*)
- What coding system is used to indicate procedures rendered? (*CPT*)
- What are the CPT codes you would use for each procedure?
(*AP and Lat. Lumbar Spine X-rays: 72100*
Pelvis X-ray: 72170
Office Visits and Adjustments: 98940)
- Why use 98940 and not 98941 or 98942? (*Because only 2 regions were adjusted and the definition for 98930 is 1-2 regions adjusted – this from Insurance Filing Rules handout*)
- Where do these CPT codes need to be notated? (*In patient case file, new line for each, and on correct date of service*) See graphic below:

PROGRESS NOTES		Diagnosis Codes:			
PATIENT: <i>John Doe</i>		1. 739.3 lumbar subluxation			
CHART NAME: DOEJ		2. 724.2 low back pain			
		3. 739.4 sacroiliac subluxation			
		4. 724.6 sacralgia			
DATE OF SERVICE:	NOTES:	DIAGNOSIS CODES ICD-9s	PROCEDURE CODES CPTs	Mod. Code	Modifier? Check For Yes
01/15/07	<i>AP and Lat. Lumbar Spine X-rays</i>	724.2	72100		
	<i>AP Pelvis X-ray</i>	724.6	72170		
	<i>Adjusted: L5, Right. SI. PI on Right</i>	739.3	98940		
01/18/07	<i>Adjusted: L5, Right. SI. PI on Right</i>	739.3	98940		
01/23/07	<i>Adjusted: L5, Right. SI. PI on Right</i>	739.3	98940		

OBJECTIVES:

6.2 Determine CPT linkage relationship with diagnosis (ICD-9) code

Given a patient hardcopy file containing complete subjective, objective, assessment and plan/procedure findings, the learner will accurately notate beside each current procedural terminology (CPT) code, the appropriate international classification of disease, 9th revision (ICD-9) code that regionally links the diagnosis and appropriate procedure.

6.2a State rationale for linking ICD-9 code with CPT code

Given a patient hardcopy file containing complete subjective, objective, assessment and plan/procedure findings, the learner will state in writing the rationale for choosing linkage relationship.

RELATED INSTRUCTOR ACTIVITY

Refer: Refer to the billing packet, John Doe scenario.

Examples: 72100 lumbar spine x-ray's supporting evidence/rationale for being taken (or service rendered) was due to low back pain; 724.2. Look at the 4 diagnostic codes to choose most appropriate for CPT code in question.

Questions:

- Look at each CPT code you have listed. How do you determine which ICD-9 code to link to each CPT code and why? (*Look at definition of each code – both CPT and ICD-9. Choose the ICD-9 that most accurately fits the area or symptom; for example: pelvic x-rays would be linked with diagnosis of sacralgia. For subluxation/adjustment codes, chose the primary diagnosis code (usually a subluxation code to link with 98940, 98941, or 98942)*)
- In this scenario, which ICD-9 code should be linked to:
72100 (724.2)
72170 (724.6)
98940 (739.3)
See graphic below:

PROGRESS NOTES

PATIENT: *John Doe*

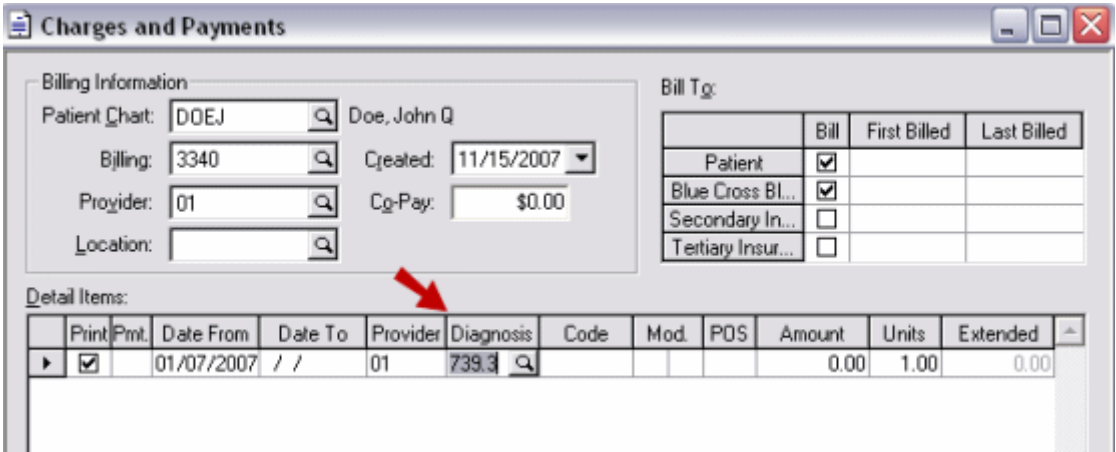
CHART NAME: **DOEJ**

Diagnosis Codes:

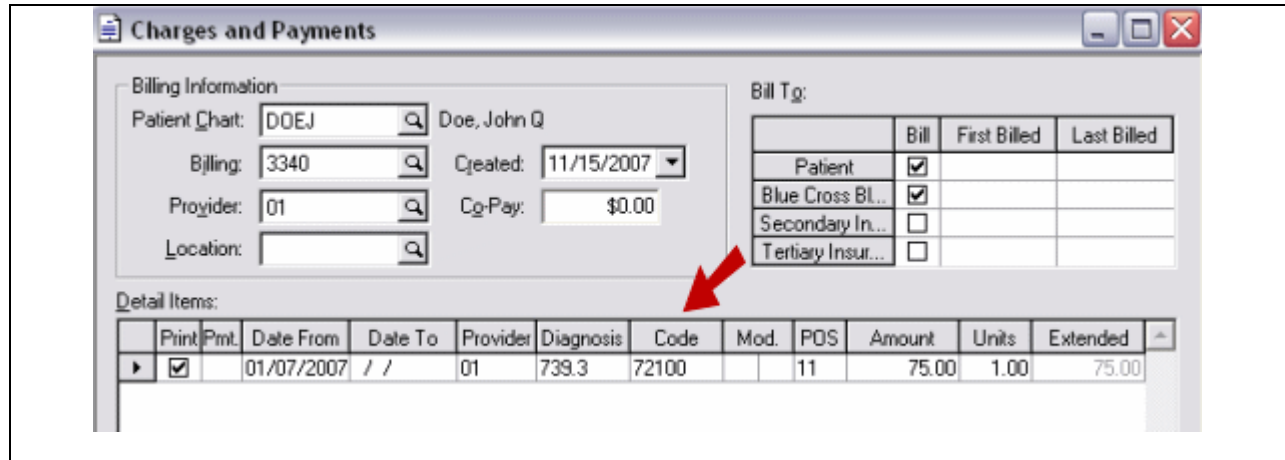
1. ~~729.3~~ lumbar subluxation
2. 724.2 low back pain
3. ~~739.4~~ sacroiliac subluxation
4. ~~727.6~~ sacralgia

DATE OF SERVICE:	NOTES:	DIAGNOSIS CODES ICD-9s	PROCEDURE CODES CPTs	Mod. Code	Modifier? Check For Yes
01/15/07	<i>AP and Lat. Lumbar Spine X-rays</i>	724.2	72100		
	<i>AP Pelvis X-ray</i>	724.6	72170		
	<i>Adjusted: L5, Right, SI, PI on Right</i>	739.3	98940		
01/18/07	<i>Adjusted: L5, Right, SI, PI on Right</i>	739.3	98940		
01/23/07	<i>Adjusted: L5, Right, SI, PI on Right</i>	739.3	98940		

<p>OBJECTIVES:</p> <p>6.3 Determine need for CPT modifier Given a patient hardcopy file containing complete subjective, objective and assessment findings, the learner will utilize current insurance best practices and Medicare modifier rules to determine the need for a modifier on all current procedural terminology (CPT) codes listed. The learner will indicate a need by placing a check mark in the “need modifier” field next to the CPT code.</p> <p>6.4 Determine modifier to use Given a patient hardcopy file containing complete subjective, objective and assessment findings along with modifier usage indicator, the learner will utilize current insurance best practices and Medicare modifier rules to choose and notate the appropriate modifier to use for each CPT code that has been marked as needing a modifier.</p> <p>6.4a State modifier definition and rules for usage Given a patient scenario in which a modifier is needed, learner will choose correct modifier and definition from list of choices.</p>	<p>Min. 5</p>
RELATED INSTRUCTOR ACTIVITY	
<p>Refer: Refer to the billing packet, John Doe scenario and refer to the <i>Insurance Filing Rules</i> handout.</p>	
<p>Examples: If John Doe were Medicare-insured, and in active treatment, and has a CPT code listed of 98940, based on your knowledge of modifier rules, determine if a modifier is necessary for this patient's CPT code.</p>	
<p>Questions:</p> <ul style="list-style-type: none"> • If John Doe were Medicare-insured, and in active treatment, and has a CPT code listed of 98940, based on your knowledge of modifier rules, would a modifier be necessary for this patient's CPT code(s)? Why or why not? (Yes; because he's Medicare insured and Medicare requires a modifier for spinal manipulation codes.) • If yes, which modifier would you use and why? (Use –AT modifier because the patient is in active treatment.) • How do you indicate need for modifier in the patient file? (Place check mark in the modifier column next to appropriate code.) • What happens if I don't use a modifier for Medicare-insured patients? (This is not considered a clean claim and will be sent back to you as missing information. You will not be reimbursed.) • Look at this scenario for John Doe. He is not Medicare-insured. Does he still need a modifier appended to his 98940 codes? (No. Commercial insurance carriers do not have the modifier rule like Medicare does) 	

OBJECTIVE: 5.0 Enter International Classification of Disease (ICD-9) code in diagnosis code field Given a computer with Lytec practice management software installed, and having patient hardcopy file, the learner will correctly enter one international classification of disease, 9 th revision (ICD-9) code in the diagnosis field of the billing screen.	Min. 2
RELATED INSTRUCTOR ACTIVITY	
<p>Refer: Refer to the billing packet, John Doe's patient case file. Follow instructions for entering ICD- 9 code in diagnostic field.</p> <p>On-screen Demonstration Using Lytec: Read the following directions aloud as you demonstrate; students should follow entering data, as well. Press enter on the keyboard to advance to the diagnosis field. Refer to your patient's progress notes. Make sure the diagnosis appearing is the one you want; i.e., the correct ICD-9 that is to be associated with the CPT code you will be entering in the next steps. If it's not the ICD-9 you want, change it by keying in the correct ICD-9 code. See graphic below:</p>	
	

OBJECTIVE: 6.0 Enter Current Procedural Terminology (CPT) code in procedure field Given a computer with Lytec practice management software installed, and having patient hardcopy file, the learner will correctly enter one current procedural terminology (CPT) code in the procedure field of the billing screen.	Min. 2
RELATED INSTRUCTOR ACTIVITY	
<p>Refer: Refer to the billing packet, John Doe's patient case file. Follow instructions for entering CPT code in procedure field.</p> <p>On-screen Demonstration Using Lytec: Read the following directions aloud as you demonstrate; students should follow entering data, as well. Press the enter key to advance to the procedure field. Refer to John Doe's patient's progress notes and enter the first procedure code for this date of service. See graphic below:</p>	



End of Cluster 2

Beginning of Cluster 3:

<p>OBJECTIVE: 7.0 Add another procedure? Yes/No Given a computer with Lytec practice management software installed, and having patient hardcopy file, the learner will refer to patient file to determine if there are more procedures that need to be entered. 7.1 Refer to patient file for further documentation of more procedures Given a patient hardcopy file, learner will accurately declare continuation or completion of data entry based on observance of additional billable procedure documentation in file.</p>	Min. 4
<p>RELATED INSTRUCTOR ACTIVITY</p>	
<p>Refer: Refer to the billing packet, John Doe's patient case file to determine if there is another service on same date or on later date that has not been entered yet into Lytec.</p>	
<p>Example: From Doe's case file: Patient: John Doe Date of Service: 04/05/2007, CPT: 98940, ICD-9: 739.3. Enter information into Lytec. Look in patient file for another service on same date or on later date that has not been entered. Enter (back to Step 4.0) if needed.</p>	
<p>Question:</p> <ul style="list-style-type: none"> Look in John Doe's patient case file and progress notes. Do you see another service that needs to be billed for this encounter date? <i>(If Yes, instruct them to go back to Objective/Step 4 and repeat sequence until you arrive back at this step. Ask same question.) (If No, instruct them to proceed to Objective/Step 8)</i> 	

<p>OBJECTIVE: 8.0 Click Save button Given a computer with Lytec practice management software installed, and having patient hardcopy file, the learner will successfully click on the Save button of the billing screen to save and exit current session.</p>	Min. 1
<p>RELATED INSTRUCTOR ACTIVITY</p>	
<p>Refer: Refer to the billing packet, John Doe's patient case file. Follow instructions to save all entered data by clicking on the save button in the lower right corner of the billing screen. Learners will also be prompted to exit the Lytec application.</p>	
<p>Example: After learner has checked patient file for more services to enter into Lytec, and having determined there are none, will click the save button in the lower right corner of the billing screen to save all data. Learners will then exit the Lytec application by either using the File -> Exit menu selection or clicking the X in the upper right corner to end their session.</p>	

Charges and Payments

Billing Information

Patient Chart: Doe, John Q

Billing: Created:

Provider: Co-Pay:

Location:

Bill To:

	Bill	First Billed	Last Billed
Patient	<input checked="" type="checkbox"/>		
Blue Cross BL...	<input checked="" type="checkbox"/>		
Secondary In...	<input type="checkbox"/>		
Tertiary Insur...	<input type="checkbox"/>		

Detail Items:

	Print	Pmt.	Date From	Date To	Provider	Diagnosis	Code	Mod.	POS	Amount	Units	Extended
	<input checked="" type="checkbox"/>		01/15/2007	/ /	01	724.2	72100		11	75.00	1.00	75.00

Provider: Leslie M. Wise, D... Code: AP & Late... Tax: \$0.00 Patient Portion: \$0.00

Diagnosis: Low Back Pain Reference: (None spec... Tax Paid: \$0.00 Insurance Portion: \$75.00

Billing Balance: \$75.00

Account Balance: \$385.00

Buttons: Billing, Detail, Print, New, Save, Close

Exit Lytec by clicking the X in the upper right corner of application screen to end session:



End of Cluster 3

Assessments

ASSESSMENT	
1	Written – full written test included in packet. All questions and scenario from the written test pertain to this cluster. Test is given at the end of the quarter.
2	Practical – checklist included in packet. Practical test is given at the end of the quarter. All checkpoints follow sequential order on data entry as found in these instructions.

Written Exam for CMS-1500 Insurance Claim Coding

Directions for Instructor:

This written examination is in two sections: a multiple choice section and a short answer portion. The multiple choice portion is worth 20 points. The short answer portion is worth 10 points. The entire exam is worth 30 points. Exam instructions for students are included at the beginning of each section. Students have one hour to complete the entire written exam.

Before beginning the exam, ask students to follow exam policy and remove all materials from their desks, turn off all cell phones and electronic devices and place them on the floor below their tables.

Ensure that each student has a #2 pencil for the exam. Hand out the Scantron answer sheets first and then hand out the exam packet. Ask the students to write their name on both the Scantron sheet and exam packet.

Read over both sets of instructions in the exam (multiple-choice section and short answer section). Note the time before beginning the exam.

When students have completed the exam and hand in their materials, check to make sure their name is on both the Scantron answer sheet and the written exam packet.

Written Exam for CMS-1500 Insurance Claim Coding

Student Directions:

This written examination is in two sections: a multiple choice section and a short answer portion. The multiple choice portion is worth 20 points. The short answer portion is worth 10 points. The entire exam is worth 30 points. Exam instructions are included at the beginning of each section. You have one hour to complete the entire written exam.

Instructions for Multiple Choice Portion of Exam

1. You will need to use a #2 pencil to complete this exam.
2. Write your name on both the written exam handout and the Scantron answer sheet.
3. On your Scantron answer sheet, fill in the letter for the answer of your choice. Choose the "best answer." Only one "best answer" will be scored as correct. Please be sure to fill in an answer to each question.
4. There are 10 multiple choice questions. Each multiple choice question is worth 2 points for a total of 20 points on the multiple choice section.
5. The short answer portion of the exam follows the multiple choice section. Please be sure to read those instructions and complete that section before handing in your exam materials.

Note:

The written and short answer portions of the exam have been removed from the online version.

Checklist for Practical Exam with Lytec Software

Name _____ Date _____ Score _____ (18 pts possible)

Points	Performance	Yes	No
(3)	Launch Lytec application a. Double-click on Lytec desktop icon b. Locate and open Health Center practice from Open menu c. Enter correct password	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
(1)	Open billing menu a. Locate and click on Charges option to open billing screen	<input type="checkbox"/>	<input type="checkbox"/>
(3)	Enter patient file number in the chart field of the billing screen. a. Validates patient information in patient screen using the pull-down List menu option b. Validates patient insurance information in patient screen by accessing insurance tab c. Check's patient file for chart number before accurately entering it in chart field	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
(1)	Enter patient encounter date in the date of service field of the billing screen. a. Uses 2-digit month, 2-digit day, and 4-digit year sequence to enter date	<input type="checkbox"/>	<input type="checkbox"/>
(2)	Enter international classification of disease, 9 th revision (ICD-9) code in the diagnosis field of the billing screen. a. Consults patient file for ICD-9 linkage to CPT for date of service in question b. Correctly enters appropriate ICD-9 code in diagnosis field	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(4)	Enter current procedural terminology (CPT) code in the procedure field of the billing screen. a. Consults patient file for CPT for date of service in question b. Correctly enters CPT code c. Determines if modifier is needed for CPT code by checking patient file d. Enters modifier, if present; if not, leaves modifier field in Lytec blank (for this assessment, a modifier <i>is</i> present)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
(2)	Determine if there are more procedures that need to be entered. a. Consults patient file for more dates of service and/or procedures to be entered b. If yes, repeats procedure; if no, stops and saves work. (for this assessment, there are 2 more dates of service with one service each to be entered)	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(2)	Save work. a. When completed entering billings, click the save button in the lower right of the billing screen. b. Log off by exiting Lytec application	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

PATIENT SCENARIOS
AND
BILLING PACKET

DETERMINING ICD-9 AND CPT CODES

In order to determine codes for each patient and patient encounter dates, please refer to the patient scenarios and progress notes that have been provided. You may use the ICD-9 and CPT code list found in Lytec as a memory aid.

Read each patient's scenario, and using the progress notes, determine and notate the following:

- The patient's diagnoses using international classification of disease, 9th revision (ICD-9) codes. Notate these in upper right corner of progress notes.
- The patient's primary diagnosis using an international classification of disease, 9th revision (ICD-9) code. List this as the first code.
- The patient's secondary diagnoses using international classification of disease, 9th revision (ICD-9) codes. List these as codes 2-4.
- For each date of service, the procedures performed during a patient encounter. Notate each procedure using a CPT code.
- Link the appropriate international classification of disease, 9th revision (ICD-9) code with each CPT code. List the ICD-9 code in the column marked ICD-9 next to each CPT code.
- Determine the need for a modifier on all current procedural terminology (CPT) codes listed. Indicate need by placing a check mark in the "need modifier" field next to the CPT code.
- Choose and notate the appropriate modifier to use for each CPT code that has been marked as needing a modifier.

BILLING FOR SERVICES IN LYTEC

In order to bill for services for each patient and patient encounter dates, please refer to the patient scenarios and progress notes that you completed in the previous step.

1. Launch Lytec and open the Health Center practice.
2. Go Billing → Charges and Payments
3. In the **Patient Chart field**, type in or view the list of patients to select patient in question.
4. Enter the date of service using a 2 digit month, 2 digit day and 4 digit year format.
Example: 00/00/2007
5. Press enter on the keyboard to advance to the **diagnosis field**. Refer to your patient's progress notes. Make sure the diagnosis appearing is the one you want; i.e., the correct ICD-9 that is to be associated with the CPT code you will be entering in the next steps. If it is not the correct ICD-9, key in the correct code.
6. Press the enter key to advance to the **procedure field**. Refer to your patient's progress notes and use the procedure code(s) discussed in class.
7. Press the enter key on the keyboard until you come to a new line. Repeat steps above if you have another service on same date to file or a different date of service to file.
8. When you have entered all dates of service for this billing, click the **SAVE** button located in the lower right of the billing box.

SCENARIO

Patient: John Doe

Date: January 15, 2007

Presenting problem: low back pain radiation into right buttock, began two days ago following lifting and moving heavy boxes. Patient noticed pain several hours after moving last box. Pain became worse during the night and this morning is 9/10 on a pain scale. Patient took two Advil 4 hours ago.

Past history: Patient is a 48 year old well developed male with no history of previous low back problems.

Exam: Patient is 70", 185 pounds, BP: 120/80, Temp: 98.7.

Lumbar musculature in spasm, especially on the right. ROM decreased in lateral flexion x 2 and rotation x 2. Lumbar spine flexion become painful at 25 degrees. Extension is painful at 10 degrees. Lower extremity reflexes are normal bilaterally. Heel walk and toe walk are negative. Valsalva is negative. Straight leg raise is positive on the right at 45 degrees and is exacerbated by ankle dorsiflexion. Motion palpation shows restriction at L5, S1, in all planes. SI joints are freely movable. Thoracic spine unremarkable. L5 spinous process tender to percussion and surrounding soft tissue is mildly edematous.

X-rays: X-rays views taken include:
Lumbosacral 2 views and Pelvic x-ray, 1 view.

Adjusted: L5, Rt S-I, Rt P-I

Date: January 18, 2007

Patient examined. No new problems. Slight improvement. No new x-rays taken.

Adjusted: L5, Rt S-I, Rt P-I

Plan: See in 5 days.

Date: January 23, 2007

Patient examined. No new problems. Improved. Some residual pain. No new x-rays taken.

Adjusted: L5, Rt S-I, Rt P-I

Plan: Dismissed.

PROGRESS NOTES

PATIENT: John Doe

CHART NAME: DOEJ

- Diagnosis** 1. 739.3 lumbar subluxation
Codes: 2. 724.2 low back pain
 3. 739.4 sacroiliac subluxation
 4. 724.6 sacralgia

DATE OF SERVICE:	NOTES:	DIAGNOSIS CODES ICD-9s	PROCEDURE CODES CPTs	Mod. Code	Modifier? Check for Yes
01/15/07	A-P and Lat. Lumbar Spine Xrays	724.2	72100		
	A-P Pelvis Xray	724.6	72170		
	Adjusted: L5, Right. SI, PI on Right	739.3	98940		
01/18/07	Adjusted: L5, Right. SI, PI on Right	739.3	98940		
01/23/07	Adjusted: L5, Right. SI, PI on Right	739.3	98940		

SCENARIO

Patient: Linda Martin

Date: January 20, 2007

Presenting problem: Sub-occipital headaches 3x week. Worse in the morning; eases toward evening. Pain between shoulder blades, sometimes radiates into the sternal area.

Exam: Cervical compression test positive; distraction test negative. Tenderness along nuchal line and over C1 TPs. Restriction of motion in forward and backward nod. Tender SPs, T3, T4. Motion restricted in flexion extension.

X-rays: X-rays views taken include:
AP & Lat. Cervical Spine X-ray
AP & Lat. Thoracic Spine X-ray

Adjusted: C1, T4

Date: January 24, 2007

Patient examined. No new problems. Findings consistent with initial exam.

Adjusted: C1, T4

Plan: See in 5 days.

Date: February 1, 2007

Patient examined. No new problems. Minor improvement in cervical ROM. Thoracic problems same.

Adjusted: C1, T4

Plan: Dismissed.

PROGRESS NOTES

PATIENT: *Linda Martin*

CHART NAME: MARTINL

- Diagnosis Codes:**
1. 739.1 cervical subluxation
 2. 723.1 cervicalgia
 3. 739.2 thoracic subluxation
 4. 724.1 pain in thoracic spine

DATE OF SERVICE:	NOTES:	DIAGNOSIS CODES ICD-	PROCEDURE CODES CPTs	Mod. Code	Modifier? Check for
1/20/07	<i>A-P and Lat. Cervical Spine X-ray</i>	723.1	72040		
	<i>A-P and Lat. Thoracic Spine X-ray</i>	724.1	72070		
	<i>Adjusted: C1, T4</i>	739.1	98940		
1/24/07	<i>Adjusted: C1, T4</i>	739.1	98940		
2/01/07	<i>Adjusted: C1, T4</i>	739.1	98940		

SCENARIO

Patient: Claude Hughes

Date: February 3, 2007

Presenting problem: Low back pain with some radiation into right leg. Occasional numbness but never below the knee.

Past history: Severe low back attack 10 years ago. Improved with rest and exercise. No medical intervention.

Exam: Patient is 70", 185 pounds, BP: 140/90, Temp: 98.7.

Lumbar musculature in spasm, especially on the right. ROM decreased in lateral flexion x 2 and rotation x 2. Lumbar spine flexion become painful at 25 degrees. Extension is painful at 10 degrees. Lower extremity reflexes are normal bilaterally. Heel walk and toe walk are negative. Valsalva is negative. Straight leg raise is positive on the right at 45 degrees and is exacerbated by ankle dorsiflexion. Tender SPs, T6. Motion palpation shows restriction at L5, S1, in all planes. SI joints are freely movable.. L5 spinous process tender to percussion and surrounding soft tissue is mildly edematous.

X-rays: X-rays views taken include:
Lumbosacral 2 views and Pelvic x-ray, 1 view.

Findings: DJD at L5/S1 with decreased disc space, lipping, spurring, and subchondral sclerosis. Rt. SI joint space very narrow. Remaining lumbar disc spaces are narrowed and lipping is present at L1 superior body.

Recommendations: Active treatment 3x week.

Adjusted: L5, Rt S-I, P-I, T6

Date: February 6, 2007

Complaints and findings consistent with initial exam. No adjustment reaction last time.

Adjusted: L5, Rt S-I, P-I, T6

Plan: See in 5 days.

Date: February 12, 2007

Complaints and findings consistent with initial exam. No adjustment reaction last time.

Adjusted: L5, Rt S-I, P-I, T6

Plan: See in 3 days.

PROGRESS NOTES

PATIENT: *Claude Hughes*

CHART NAME: HUGHESC

- Diagnosis Codes:**
1. 739.3 lumbar subluxation
 2. 722.52 lumbar IVD degen.
 3. 739.4 sacroiliac subluxation
 4. 724.2 low back pain

DATE OF SERVICE:	NOTES:	DIAGNOSIS CODES ICD-9s	PROCEDURE CODES CPTs	Mod. Code	Modifier? Check for
02/03/07	<i>A-P and Lat. Lumbosacral X-rays</i>	722.52	72100		
	<i>Adjusted: L5, Right S1, T6</i>	739.3	98941	-AT	√
02/06/07	<i>Adjusted: L5, Right S1, T6</i>	739.3	98941	-AT	√
02/12/07	<i>Adjusted: L5, Right S1, T6</i>	739.3	98941	-AT	√

**INSURANCE FILING RULES
BASED ON MEDICARE***

- Ø ID number is patient's social security number ending with an "A". Occasionally ending with a "D". Always check the patient's Medicare card for confirmation. EXAMPLE: 222-99-1234A
- Ø ON HCFA, the Policy/Group Number field (box 11) MUST contain the word "NONE".
- Ø If you need a to take a set of x-rays for your Medicare patient, be aware that Medicare will not pay for x-rays.
- Ø If you have taken x-rays and patient has a secondary insurance which you have determined will pay for x-rays, you will need to go ahead and file on the HCFA form the x-ray code(s). Medicare will deny benefits, but their denial is necessary information for the secondary insurance carrier. You will need to make a copy of the EOB that contains the denial and send it along with the HCFA form to the secondary insurance.
- Ø Medicare Part B has a \$110 deductible.
- Ø CMT Codes accepted by Medicare as printed in the January 1996 Medicare Advisory are as follows:
 - 98940 (one to two regions/segments adj)
 - 98941 (three to four regions/segments adj)
 - 98942 (five or more regions/segments adj)** this code often times will trigger a request for additional information, SOAP notes, etc.
- Regions = cervical, thoracic, lumbar, pelvic, extremities*
- Ø In SC, at least 12 visits allowed per year. (some states allow more) Use one CMT code per visit. Modalities not allowed.
- Ø Once you have applied and been accepted to file with Medicare, they will assign you a PIN number. This number needs to appear in box 33 on HCFA's that are generated to go to Medicare.

Reality: failure to comply with the above rules will yield a rejection of your claim. You won't even know what you left out and Medicare is famous for not being forthcoming with exactly what you did wrong. You will have to phone them to get that information. Be aware that Medicare holds your claim for 27 days by US mail and 14 if you file electronically.

* Medicare is the regulating agency that all other health insurance entities eventually follow. HCFA (Health Care Financing Administration) has, as of June 2001, renamed itself **Centers for Medicare and Medicaid Services (CMS)**. You may hear HCFA referred to as CMS, and vice versa. The standard insurance claim form has been renamed the CMS-1500 form, although you will also hear it referred to as the HCFA-1500 form until usage of "CMS" has become comfortable.

New Medicare Rules and The Use of Modifiers

Use the -AT modifier for all Active Treatment.

The modifier -AT declares that your Medicare patient should be paid because you have supporting documentation for all the phases of active care. This means all care up to, but not including Maintenance care. Commencing October 4th, 2004, every Medicare claim needs to have the -AT modifier appended to 98940, 98941, or 98943 CMT codes for those in the Active Treatment phases of care.

Use the -GA modifier when the patient becomes Stable and enters the Maintenance phase of care.

Communicate that status to the patient and get the ABN form signed. Appending the modifier -GA signifies that the patient understands that they could be responsible for the bill.

Use either the -AT or the -GA modifier. Using no modifier at all equals a rejection and no payment.

This and all other associated changes was announced on May 28th, 2004, by CMS.

The implementation date by all carriers is October 4th, 2004. It seems appropriate to start using the -AT modifier now for all Active Treatment, unless your carrier objects. Alert! Included in the changes are new frequency limits which are to be set by each local carrier. Stay alert and watch for more details from your carrier and state association insurance committees.

BACKGROUND INFORMATION:

The -AT modifier has recently been changed from Acute Care to Active Treatment by CMS. It is a key component of the new initiatives to clarify the coverage phases of care by Medicare. We (the ChiroCode Institute) have asked CMS over the years to consider codes for each phase of care (Acute, SubAcute, Rehabilitation, and Maintenance).

However, the current decision by Medicare is to have only one modifier for all phases of Active Treatment for CMT spinal care.