medicare

getting your share

SAM
COLLINS

2024

SEMINAR PACK

aac
Info Network

About Us

American Acupuncture Council Network (AACN) is an Acupuncture management consultant firm that has been involved with the Acupuncture industry for over 30 years. Its core focus is to streamline insurance operations for thousands of Acupuncturists nationwide through its information helpline, acupuncture insurance billing education seminar and products.

Through the years, our clients have always depended on AACN to develop a simpler way to cope with the overwhelming changes in the insurance industry. AACN has one goal in mind; to provide its clients with cost-effective, high-quality, time-saving products and services. We set the industry standard because we provide the most professional, accurate and ethical services available. Attend our Acupuncture insurance billing education seminar today.

Our philosophy is to strengthen and grow the Acupuncture profession by providing education, tools, and support that continually improve the productivity, profitability, and well-being of the alternative health community as a whole. AACN is committed to its members to be accurate and ethical in its advice and information.


Platinum Membership
Expert support for billing & coding logistics, with state-specific compliance
Unlimited phone and email access
Keep Updated to stay fully compliant
Review denied claims and revise for ensuring proper reimbursement
CPT & ICD-10 Coding, general health insurance, workers' compensation, personal injury, Medicare, and VA
1 complimentary Seminar for the Practitioner or Staff Member
Annual FeeSchedule adjustments
Online Document Library: digital coding reference bank, insurance verification, informed consent, HIPPA, personal injury, fight-back letters, customizable office forms, and more!
ROI: On average, our clients generate >3x the amount of income through proper filing of claims
Monthly StrategyMeetings
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Monthly Strategies

staying ahead of the curve

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Fee Maximization
Stop losing money on half of your codes! Our expert assistance ensures correct fee applications.

Patient Base Maximization
Integrate cash, discounts, and prepay plans into your practice efficiently and effectively.

Managed Care Plans Optimization
Navigate non-acupuncture friendly plans and stop the money drain.

Claim Denials Resolution
Get those denied claims fixed and ensure timely payment.

Proper Documentation
Understand the key documentation requirements for successful claims and pre-authorization.

Diagnosis Cost Evaluation
Decipher unique payable acupuncture diagnoses to stop costs from eating into your payments.

Cupping/Moxi Claims Support
Turn those denied cupping or moxibustion claims into paid ones.

Medicare Denials Resolution
Make Medicare denials a thing of the past. Understand the unique diagnosis and format requirements.

Compliance and Audits Review
Stay on the safe side with a comprehensive compliance review, from HIPAA to coding.

Personal Injury Claims Assistance
Unlock the potential of claims worth $3000-$5000 for personal injury.

VA Claims Support
Unlock VA claims worth $2500-$3500 per patient, and learn how to get them paid.

Yearly Audit Review
Receive a yearly audit review, ensuring compliance, best practices, and secured payments.

Relative Value Unit Calculator

START

Simply fill in your current charges for the following codes and we will tell you what fees should be charging for all these codes as a result.* Only 97811 required!

97811	$
97810	$
99203	$
99213	$
97124	$
97012	$

PLEASE COMPLETE SO WE CAN SEND YOUR INSTANT RESULT

Name | Email | Mobile

SUBMIT

SCAN FOR FULL VALUE FEES

Optimizing Your Practice

- Remove barriers to care
- Fear
- Will it work?
- Access
  - Cost
  - Insurance

Medicare & Acupuncture The Door Is Open

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

In 2020, the Centers for Medicare & Medicaid Services (CMS) officially declared that Medicare would cover acupuncture for patients with chronic low back pain. This decision was made as part of an effort to support alternative, non-opioid pain therapies as well as aid in reducing the risk for opioid dependency.

Medicare Will Cover Acupuncture Back Pain

Federal officials hope this alternative treatment will help curb opioid use

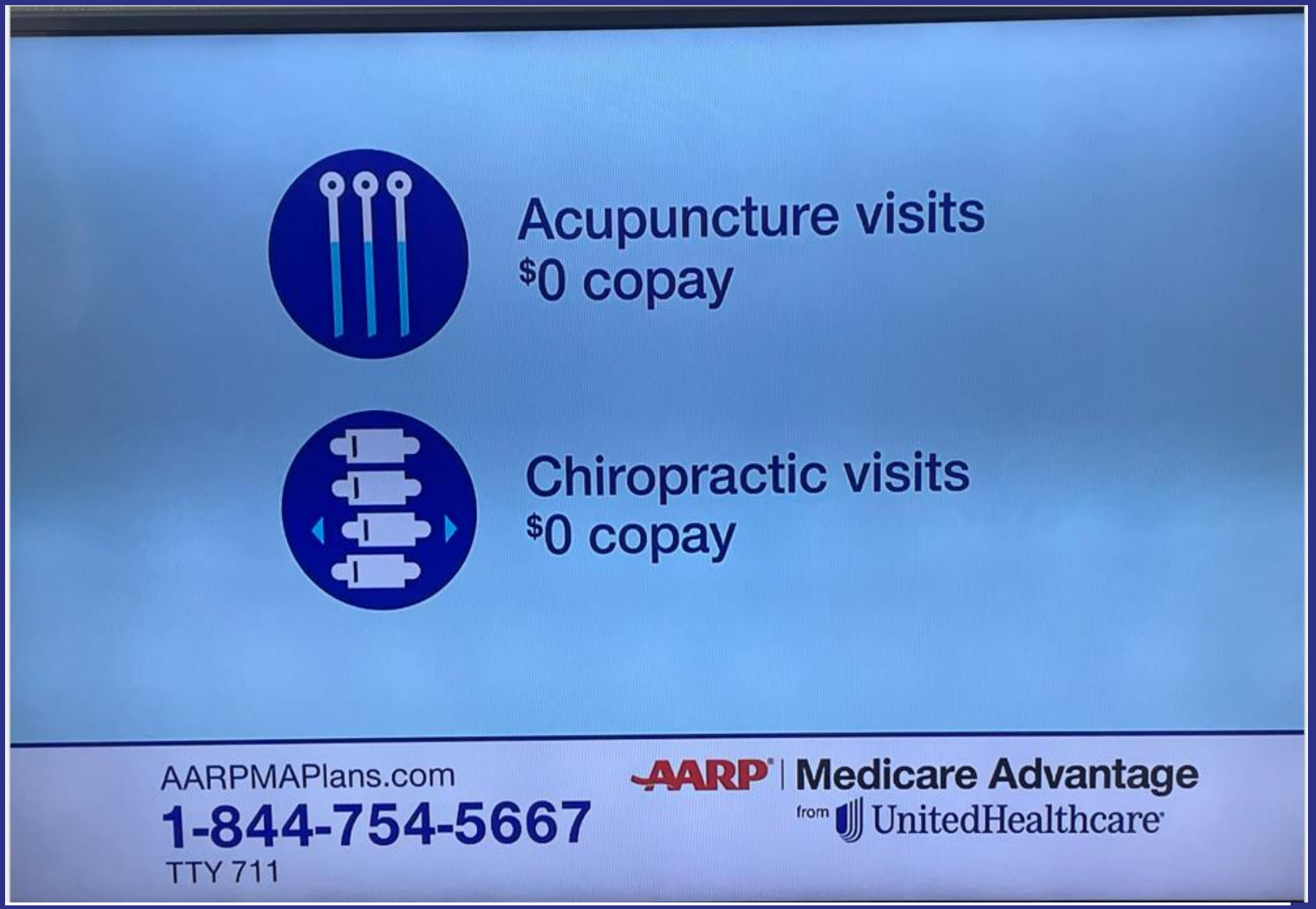
by Dena Bunis, **AARP**, January 22, 2020 | Comments: 29

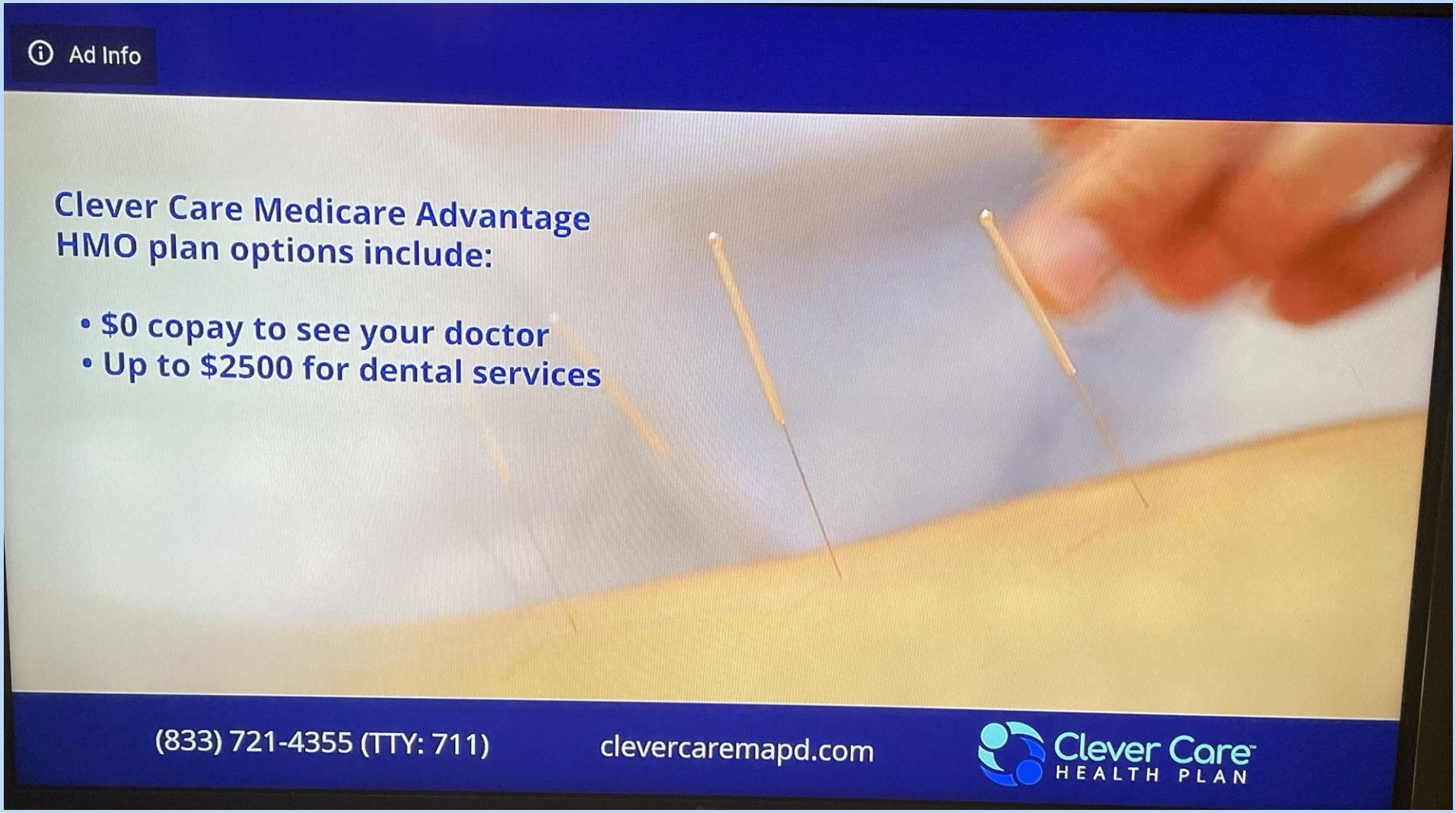
AARP Join Renew Help Member Benefits AARP Rewards Register | Login

Acupuncture for Lower-Back Pain: Really?

It's more mainstream than you may guess; how experts say it may help

by Sandra Lamb, **AARP**, February 6, 2020


Acupuncture visits
$0 copay
Chiropractic visits
$0 copay
AARPMAPlans.com
1-844-754-5667
TTY 711
AARP | Medicare Advantage
from UnitedHealthcare


Ad Info
Clever Care Medicare Advantage HMO plan options include:
• $0 copay to see your doctor
• Up to $2500 for dental services
(833) 721-4355 (TTY: 711)
clevercaremapd.com
Clever Care HEALTH PLAN

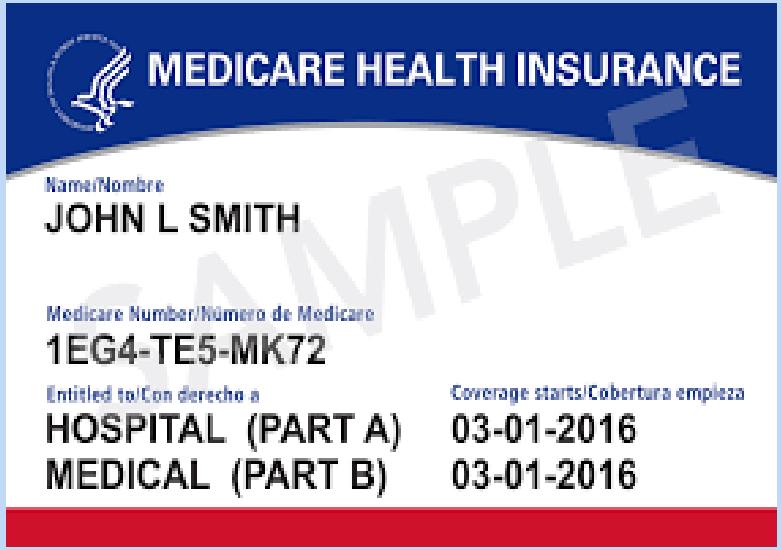
- Centers for Medicare & Medicaid Services (CMS) finalized a decision to cover acupuncture for Medicare patients with chronic low back pain. Before this final National Coverage Determination (NCD) reconsideration, acupuncture was nationally non-covered by Medicare. CMS conducted evidence reviews and examined the coverage policies of private payers to inform today's decision.
- "Expanding options for pain treatment is a key piece of the Administrations' strategy for defeating our country's opioid crisis," said HHS Secretary Alex Azar

- “We are building on important lessons learned from the private sector in this critical aspect of patient care. Over-reliance on opioids for people with chronic pain is one of the factors that led to the crisis, so it is vital that we offer a range of treatment options for our beneficiaries.”
- In 2017, opioids were involved in 47,600 deaths related to overdose. CMS is keenly focused on fighting the opioids epidemic including by supporting access to pain management using a safe and effective range of treatment options that rely less on prescription opioids, including non-pharmacological approaches.

What is Medicare?

Medicare is the federal health insurance program for:

- People who are 65 or older
- Certain younger people with disabilities
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD)



2023 EDITION

Medicare Beneficiaries

AT A GLANCE

WHO'S COVERED BY MEDICARE — 2021:

63.9M Americans are enrolled in Medicare

3.8M are new enrollees

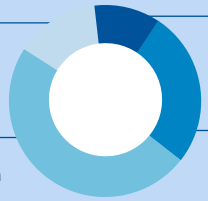
WHO THEY ARE

13% are under age 65

10% are age 85 or older

50% are between 65 and 74

27% are between 75 and 84



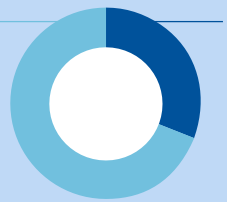
83% live in an urban metro area

18% are also enrolled in Medicaid

TYPE OF MEDICARE COVERAGE

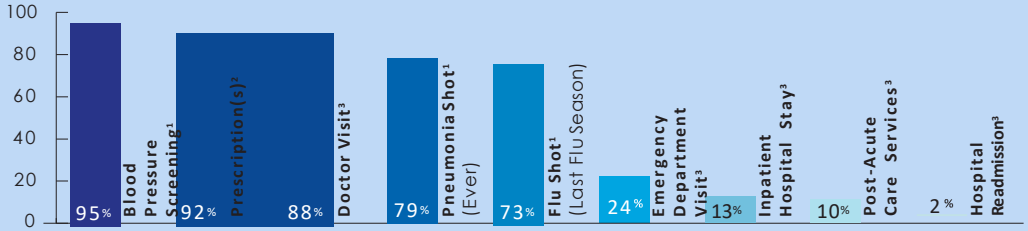
57% are in the Medicare Fee-For-Service (FFS) program

43% are in the Medicare Advantage (MA) program



76% of Medicare beneficiaries also have Part D coverage

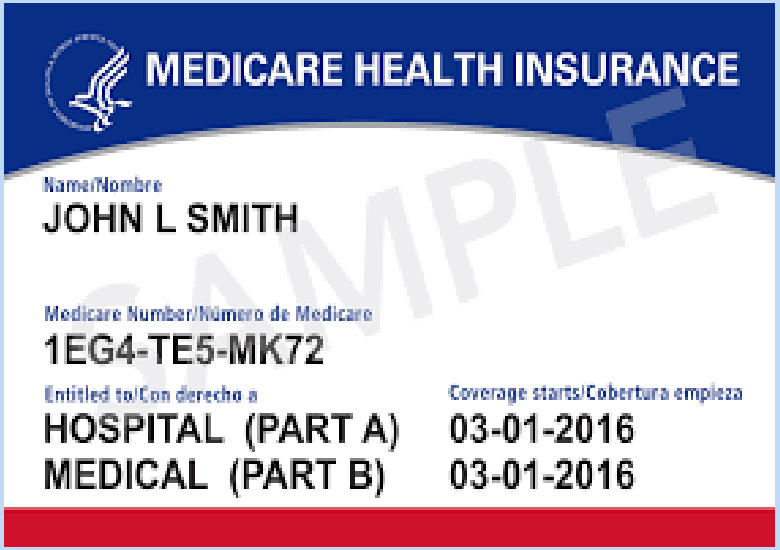
USE OF MEDICARE SERVICES



- Historically, most Medicare beneficiaries have chosen to receive their benefits through traditional Medicare, but enrollment in Medicare Advantage plans has grown rapidly over the past decade. 50% of Medicare beneficiaries are enrolled in Medicare Advantage plans in 2023 and that share will likely continue to increase in 2024.
- Past projections predicted that the 50% threshold would not be met until 2025 so it is 2 years ahead of the experts.

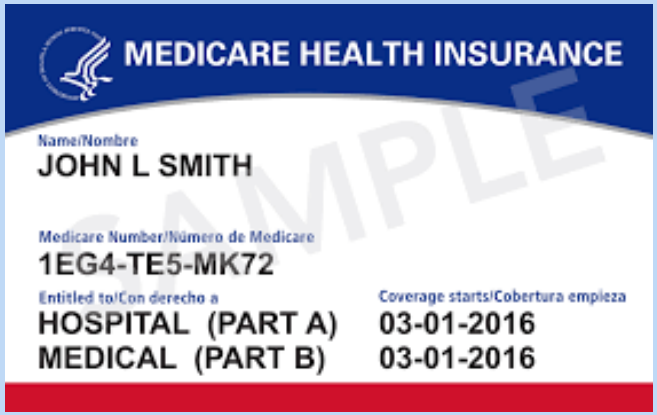
Medicare Patients

- By 2030, all baby boomers will be older than age 65. This will expand the size of the older population so that 1 in every 5 residents will be retirement age
- By 2035, there will be 78.0 million people 65 years and older compared to 76.7 million (previously 76.4 million) under the age of 18



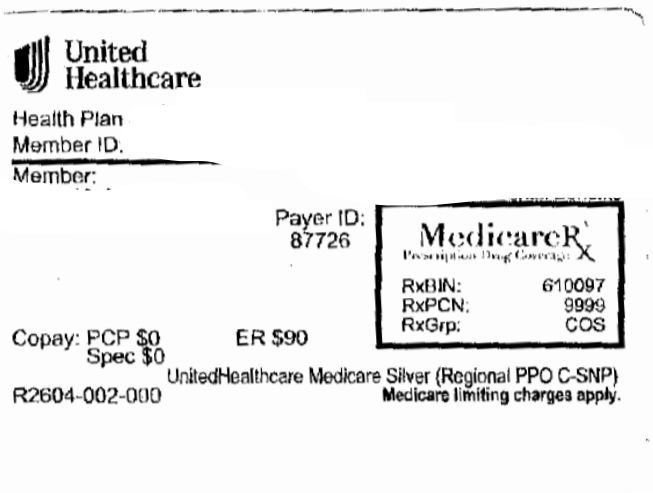
Medicare Plans

- **Original Medicare**
- Original Medicare includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- Part B has the coverage for Chiropractic
- Medicare drug coverage (Part D).
- Beneficiaries may use any doctor or hospital that takes Medicare, anywhere in the U.S.



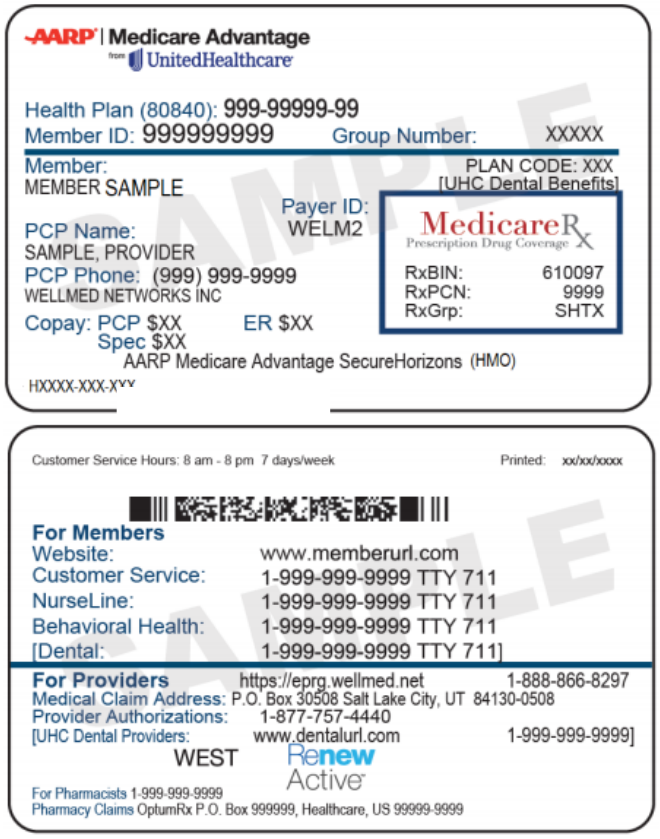
Medicare Advantage
(also known as Part C)

- Medicare Advantage is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These “bundled” plans include Part A, Part B, and usually Part D (drug plan).
- In most cases, patients will need to use doctors who are in the plan’s network.
- Plans may have lower out-of-pocket costs than Original Medicare.
- Plans may offer some extra benefits that Original Medicare doesn’t cover—like expanded chiropractic benefits, **acupuncture**, vision, hearing, and dental services.



2021 Medicare Advantage sample ID card

Member IDs for the affected plans will show the **payer ID WELM2** and have **eprg.wellmed.net** listed as the **For Providers** contact.



Sample member ID cards for illustration only. Actual information varies depending on payer, plan and other requirements.

- Since Medicare Advantage policies are provided by private insurers, Medicare Advantage plans vary from state to state, so the details of plans offered in Massachusetts are likely to differ from those available in California, Texas, and Florida. In spite of this, Medicare Advantage plans do have some details in common.
- Most are organized as health maintenance organizations, preferred provider organizations, private fee-for-service or special needs plans. Some of these plans are more likely to cover alternative therapies than others

Medicare Supplemental Plans

Plan E is a Medicare supplement (Medigap) plan that has not been available to new Medicare subscribers since 2009.

- Supplemental plans only cover the 20% not paid on covered Medicare services
- For acupuncture this means 20% of acupuncture services not paid by Medicare

Medicare Supplemental Plans

Plan F is a Medicare supplement (Medigap) plan for persons who enrolled between 2011-2019

- Supplemental plans only cover the 20% not paid on covered Medicare services
- For acupuncture this means 20% of acupuncture services not paid by Medicare

Medicare Supplemental Plans

Plan G is a Medicare supplement (Medigap) plan for persons who enrolled after 2020

- Supplemental plans only cover the 20% not paid on covered Medicare services
- For acupuncture this means 20% of acupuncture services paid by Medicare
- There are multiple lettered supplements with differences in cost and coverage

Medicare Secondary Plans

- Secondary indicates separate insurance not a supplement that has standard coverage benefits
- This may include all services such as acupuncture, therapies, exams et al
- These are also very rare and more likely when the person is working and has insurance through their employer, and they have also enrolled in Medicare.
- If a Medicare recipient enrolls in a large employer group health plan, Medicare becomes secondary to the employer plan assuming there are 20 or more employees.

Why Treat Medicare?

Aiding a population that requires your services and is often underserved for acupuncture access

Original Medicare

- You can use any doctor or hospital that takes Medicare, anywhere in the U.S.
- Covers 80% of covered services with patient liable for 20%
- Yearly deductible for 2024 $240
- Excluded services not covered are liability of the patient

Original Medicare

- Original Medicare includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- Drug coverage, requires a separate Part D plan.
- You can use any doctor or hospital that takes Medicare, anywhere in the U.S.
- To help out-of-pocket costs in Original Medicare (20% coinsurance), beneficiaries can purchase supplemental coverage
- **Acupuncture - Chronic low back pain only under adequate supervision of medical provider**

Medicare Advantage

(also known as Part C)

- Medicare Advantage is an "all in one" alternative to original Medicare. These "bundled" plans include Part A, Part B, and usually Part D benefits.
- Plans may have lower out-of- pocket costs than Original Medicare
- In most cases, patient will need to use doctors who are in the plan's network.
- Most plans offer extra benefits that Original Medicare doesn't cover— like acupuncture, vision, hearing, dental, and more
- **Billed directly by an LAc with benefits generally the same as under the insurance plan**

Medicare Part B & Acupuncture

- Medicare Part B (Medical Insurance) covers up to 12 acupuncture visits in 90 days for chronic low back pain.
- Medicare covers an additional 8 sessions when care demonstrates improvement.
- No more than 20 acupuncture treatments can be given yearly (rolling year not calendar)

National Coverage Determination (NCD30.3.3): Acupuncture for Chronic Low Back Pain

- The Centers for Medicare & Medicaid Services (CMS) will cover acupuncture for chronic low back pain under section 1862(a)(1)(A) of the Social Security Act. Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:
- Upon the most recent national coverage analysis for acupuncture specifically targeted for chronic low back pain (cLBP)CMS determined it will cover acupuncture for cLBP under section 1862(a)(1)(A) of the Act Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:
    - For the purpose of this decision, cLBP is defined as:
        - Lasting 12 weeks or longer;
        - Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease);
        - Not associated with surgery; and
        - Not associated with pregnancy

Medicare Diagnosis for Chronic Lower Back Pain

- M54.51 Vertebrogenic Low Back Pain
- M54.59 Other specified Low back pain

12480.7	NCD 30.3.3 Acupuncture for Chronic Low Back Pain Contractors shall end-date ICD-10 dx M54.5 effective September 30, 2021. Contractors shall add ICD-10 dx M54.51, M54.59 as coverable effective October 1, 2021. Contractors shall delete ICD-10 unspecified dx:	X	X			X	X			

National Coverage Determination (NCD30.3.3): Acupuncture for Chronic Low Back Pain

- An additional 8 sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Example: If the first service is performed on March 21, 2022, the next service beginning a new year can't be performed until March 1, 2023. This means 11 full months must pass from the date of the first service before eligibility begins again.

- Treatment must be discontinued if the patient is not improving or is regressing.

- Physicians (as defined in 1861(r)(1)) may furnish acupuncture in accordance with applicable state requirements.

- Physician assistants, nurse practitioners/clinical nurse specialists (as identified in 1861(aa)(5)), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:

    - A master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and

    - Current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.

National Coverage Determination (NCD30.3.3): Acupuncture for Chronic Low Back Pain

Auxiliary personnel furnishing acupuncture must also be under the appropriate level of supervision of a physician, PA, or NP/CNS required by regulations at 42 CFR §§ 410.26 and 410.27.

§ 410.26 Services and supplies incident to a physician's professional services: Conditions.

Definitions. For purposes of this section, the following definitions apply:

- (1) ***Auxiliary personnel*** means any individual who is acting under the supervision of a physician (or other practitioner), regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner), has not been excluded from the Medicare, Medicaid and all other federally funded health care programs by the Office of Inspector General or had his or her Medicare enrollment revoked, and meets any applicable requirements to provide incident to services, including licensure, imposed by the State in which the services are being furnished.

(2) ***Direct supervision*** means the level of supervision by the physician (or other practitioner) of auxiliary personnel as defined in *§ 410.32(b)(3)(ii)*.

(3) ***General supervision*** means the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required during the performance of the service.

(4) ***Independent contractor*** means an individual (or an entity that has hired such an individual) who performs part-time or full-time work for which the individual (or the entity that has hired such an individual) receives an IRS-1099 form.

(5) ***Leased employment*** means an employment relationship that is recognized by applicable State law and that is established by two employers by a contract such that one employer hires the services of an employee of the other employer.

In general, services and supplies must be furnished under the direct supervision of the physician (or other practitioner). Designated care management services can be furnished under general supervision of the physician (or other practitioner) when these services or supplies are provided incident to the services of a physician (or other practitioner).

National Coverage Determination (NCD30.3.3): Acupuncture for Chronic Low Back Pain

- As a consequence, the acupuncture provider likely deliver the service but, in most instances, must be done in the presence (same suite but not in same room) of the billing provider.
- Adequate supervision is ultimately determined by the medical provider, and they may determine adequate when not necessarily in the office at the same time
- It is not allowed billable with a simple referral only

Medicare Part B & Acupuncture

- An acupuncture provider cannot enroll in Medicare and therefore cannot make a direct claim
- For acupuncture benefits must be billed by a medical provider (MD, PA, NP or CNS)
- The acupuncture provider may perform the service under the supervision of one of the above.

Visits Beyond 12 (10)

- Add modifier KX to the acupuncture codes for visits 13-20 (10-20)
- KX = Requirements specified in the medical policy have been met
- A reexamination by the medical provider should occur at 12 visits to verify the positive response to care and the additional visits

What Does Medicare Pay?

- They will pay up to 3 units of acupuncture per visit. (Medically Unlikely Edits)
- Medicare rates vary by state and often counties but on average…
- Initial set $40-50
- Additional sets $30-40
- Examinations are not covered when done by the LAc and would be payable by the patient.
- Examination and additional services or treatment under the medical provider is a covered benefit for Medicare.

- 09 - Brazoria
- 11 - Dallas
- 15 - Galveston
- 18 - Houston (Harris County)
- 20 - Beaumont (Jefferson County)
- 28 - Ft. Worth (Tarrant County)
- 31 - Austin (Travis County)
- 99 - Rest of the State

2024 Texas Workers' Compensation Conversion Rate

$67.81 x RVU

Locality	9	11	15	18	20	28	31	99
97810	$37.76	$37.83	$37.74	$38.52	$35.97	$37.71	$38.31	$36.65
97811	$27.92	$27.97	$27.92	$28.50	$26.76	$27.90	$28.23	$27.19
97813	$44.69	$44.76	$44.64	$45.43	$42.34	$44.59	$45.43	$43.24
97814	$36.10	$36.17	$36.08	$36.86	$34.33	$36.06	$36.67	$35.01
99202	$71.17	$71.33	$71.10	$72.67	$67.23	$71.06	$72.58	$68.79
99203	$109.67	$109.99	$109.67	$112.73	$104.37	$109.65	$111.64	$106.48
99204	$164.39	$164.85	$164.43	$169.00	$157.04	$164.40	$166.98	$159.93
99205	$216.70	$217.34	$216.80	$223.07	$207.33	$216.79	$220.04	$211.03
99211	$23.04	$23.06	$22.96	$23.19	$21.28	$22.92	$23.66	$21.98
99212	$55.77	$55.89	$55.70	$56.88	$52.58	$55.66	$56.91	$53.84
99213	$89.58	$89.76	$89.51	$91.46	$84.99	$89.45	$91.11	$86.78
99214	$126.36	$126.60	$126.28	$129.00	$120.14	$126.19	$128.37	$122.54
99215	$177.75	$178.15	$177.71	$181.94	$169.47	$177.62	$180.47	$172.68
97016	$11.51	$11.52	$11.50	$11.69	$10.94	$11.48	$11.67	$11.15
97026	$6.54	$6.56	$6.53	$6.72	$6.12	$6.53	$6.72	$6.29
97110	$29.04	$29.03	$28.97	$29.20	$27.46	$28.92	$29.42	$28.04
97112	$33.33	$33.33	$33.25	$33.48	$31.47	$33.19	$33.80	$32.15
97124	$30.00	$30.01	$29.91	$30.15	$28.03	$29.86	$30.60	$28.79
97140	$26.73	$26.72	$26.67	$6.89	$25.33	$26.62	$27.05	$25.84
97530	$36.28	$36.29	$36.17	$36.42	$33.94	$36.10	$36.97	$34.83

Southern California – Area 17 (Ventura County)

97810	$ 40.77
97811	$ 29.83
97813	$ 48.64
97814	$ 39.09

99202	$ 77.88
99203	$ 118.75
99204	$ 176.71
99205	$ 232.69
99211	$ 26.02
99212	$ 61.21
99213	$ 97.33
99214	$ 136.83
99215	$ 191.72

97012	$14.81
97016	$12.46
97018	$6.10
97022	$18.71
97024	$8.04
97026	$7.26
97028	$9.10
97032	$15.20
97033	$20.96
97034	$15.02
97035	$15.02
97036	$39.06
97110	$31.60
97112	$36.38
97113	$39.97
97116	$31.60
97124	$33.28
97140	$28.99
97150	$19.25
97530	$40.17

Southern California – Area 18 (LA/OC)

97810	$ 41.31
97811	$ 30.25
97813	$ 49.28
97814	$ 49.27

99202	$ 78.89
99203	$ 120.37
99204	$ 179.36
99205	$ 235.95
99211	$ 26.31
99212	$ 61.99
99213	$ 98.61
99214	$ 138.66
99215	$ 196.82

97012	$15.01
97016	$12.62
97018	$6.18
97022	$18.93
97024	$8.14
97026	$7.36
97028	$9.21
97032	$15.40
97033	$21.22
97034	$15.21
97035	$15.21
97036	$39.49
97110	$32.00
97112	$36.83
97113	$40.45
97116	$32.00
97124	$33.67
97140	$29.36
97150	$19.50
97530	$40.65

Southern California – Area 71 (Imperial County)

97810	$ 38.92
97811	$ 28.61
97813	$ 46.31
97814	$ 37.26

99202	$ 73.89
99203	$ 113.02
99204	$ 168.83
99205	$ 222.22
99211	$ 24.42
99212	$ 58.00
99213	$ 92.63
99214	$ 130.43
99215	$ 182.97

97012	$14.21
97016	$11.89
97018	$5.76
97022	$17.64
97024	$7.55
97026	$6.83
97028	$8.57
97032	$14.57
97033	$19.91
97034	$14.32
97035	$14.32
97036	$36.68
97110	$30.16
97112	$34.68
97113	$37.96
97116	$30.16
97124	$31.49
97140	$27.71
97150	$18.40
97530	$39.56

Southern California – Area 72 San Diego Cour

97810	$ 40.83
97811	$ 29.87
97813	$ 48.76
97814	$ 40.37

99202	$ 78.04
99203	$ 118.86
99204	$ 177.03
99205	$ 232.80
99211	$ 26.14
99212	$ 61.34
99213	$ 97.50
99214	$ 137.06
99215	$ 194.02

97012	$14.84
97016	$12.49
97018	$6.11
97022	$18.78
97024	$8.06
97026	$7.28
97028	$9.12
97032	$15.23
97033	$21.03
97034	$15.06
97035	$15.06
97036	$39.25
97110	$31.71
97112	$36.52
97113	$40.13
97116	$31.71
97124	$33.42
97140	$29.09
97150	$19.31
97530	$40.35

Reimbursement

- **Medicare Fees and allowance**
  - Average New Patient: Exam and acupuncture
  - 99202 $75
  - 97810 $40
  - 97811 $60 (2 units)
  - $175
  - Average Follow-Up: Acupuncture
  - 97810 $40
  - 97811 $60 (2 units)
  - $100
    - 99202 – $75
    - 97810 - $40
    - 97811 - $30
    - 97813 - $46
    - 97814 - $37
    - 97140 - $28
    - 99212 - $60

- Note services like cupping, massage, and therapies are not covered by Medicare when done by an acupuncturist but are payable by the patient.
- However, they may have secondary insurance that may cover

11

Setting Up A Relationship Practice

- Requires an active, licensed MD/DO, PA NP, or CNS
  - Medical provider does the initial and re-evaluations for treatment plans and establishes the diagnosis
  - Billing is by the medical provider

Practice Organization

- Medical Provider
- Legal Agreement
  - Independent Contractor
  - Business Partnership

Mutual needs of the providers

Agreements - Contracts

- Work directly for a medical provider
- Medical provider sets up a satellite in your office
- Organize and set up an integrated clinic where the MD is part of the organization
- MD is that he is credentialed under the clinic (acupuncture provider) EIN number and the clinic is credentialed through Medicare.
- Best advised to obtain legal representation to setup appropriate contracts between parties

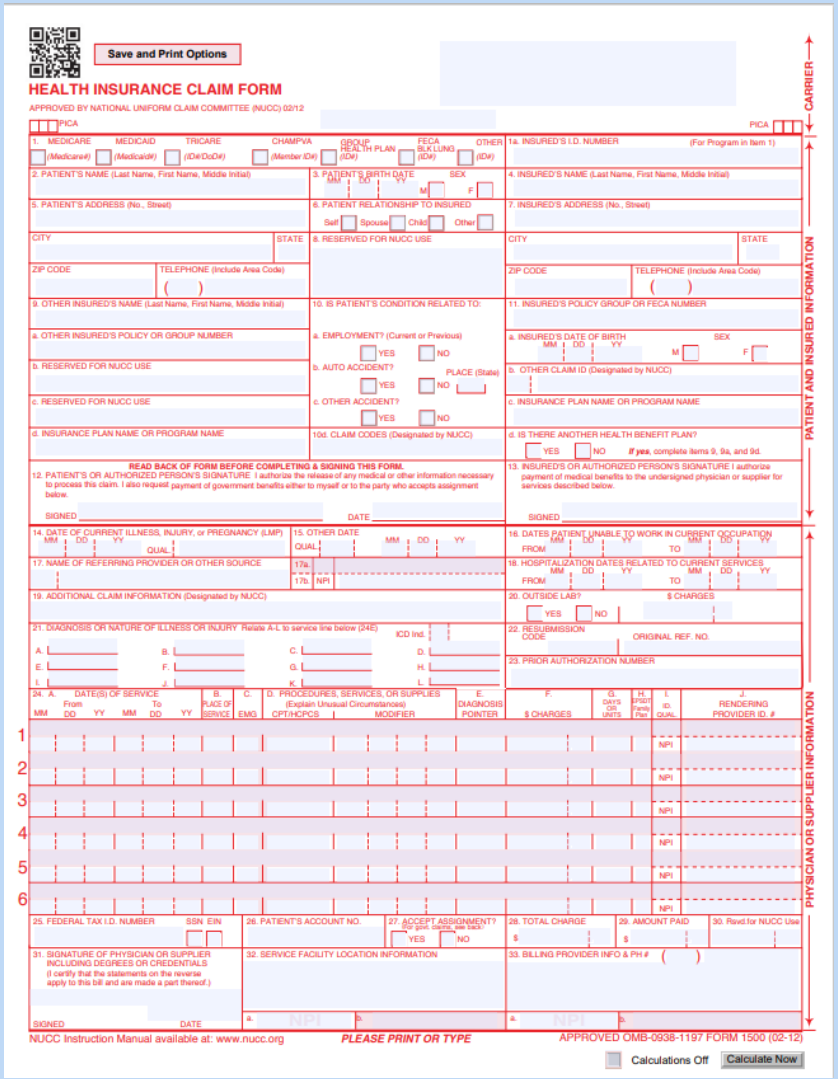
Agreements - Contracts

- It may be Flat fee per patient – only pays when you see patients
- Hourly rate

Practice Organization

- Enrollment with Medicare
- MD must be enrolled and if billing under the clinic the clinic must also be enrolled
- Acupuncture provider has no enrollment

Billing


Save and Print Options

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd.for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Calculations Off Calculate Now

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

"Incident to" Billing under MD/NP/DO NPI

- NPI of acupuncture provider is not on the claim but is documented in the chart notes by who provided the acupuncture service

Medicare Advantage (also known as Part C)

- These plans are administered by private health insurance companies with a Medicare contract. Medicare Advantage plans incorporate parts A, B, and (in most plans) part D within one plan.
- These plans must offer same acupuncture benefits as Medicare (Chronic low back pain up to 20 visits and same protocols of supervision)
- However, many offer extra benefits that Original Medicare doesn't cover— like routine acupuncture, vision, hearing, dental, and more

Plans may include more than $5,000 in healthy extras like:

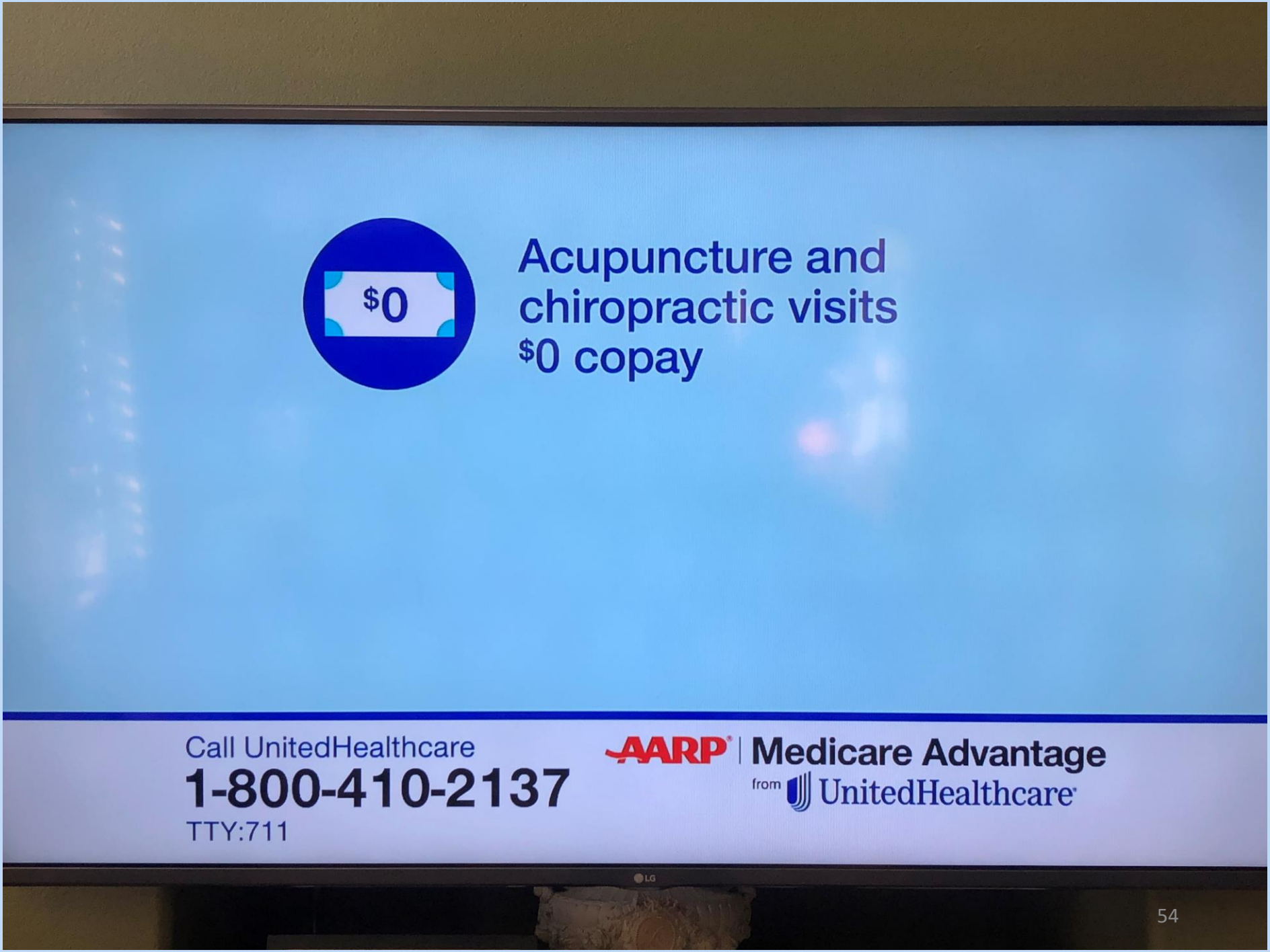
New! Acupuncture and chiropractic services[1]

Doctors on-call 24/7 by phone or video

Eyeglass frames allowance

Allowance for over-the-counter items

844.409.2602 (TTY: 711)


$0
Acupuncture and
chiropractic visits
$0 copay
Call UnitedHealthcare
1-800-410-2137
TTY:711
AARP | Medicare Advantage
from UnitedHealthcare

SBHIS INSURANCE SERVICES
Authorized Agent in California

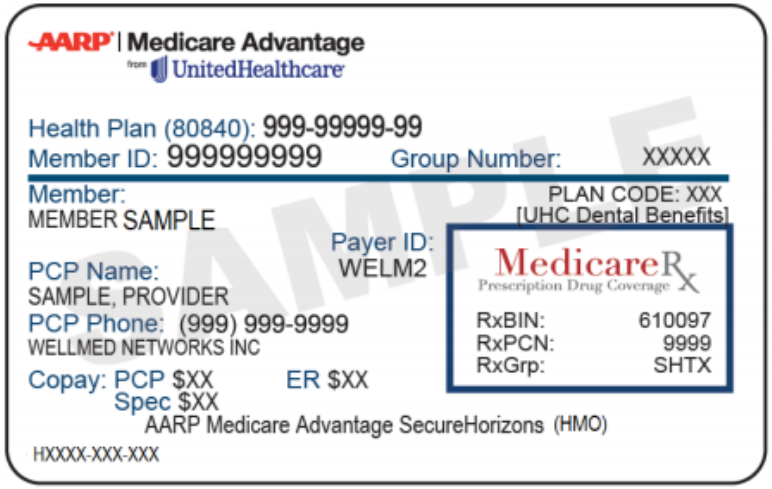
IS PROUD TO PRESENT

Anthem MediBlue Select Benefits!

- Medicare Advantage plans have become increasingly popular over the years for a variety of reasons. Most notably the premiums will be considerably lower than Medicare supplement plans (in some areas Medicare Advantage plans have $0 premiums) and most include Part D coverage so there is no need to purchase a standalone drug plan. Copays are fairly nominal under most plans for everything from doctor office visits to diagnostic testing, rehabilitation, outpatient surgeries and inpatient hospitalization.
- They may also include extra benefits for things that Medicare doesn't cover like dental, vision, chiropractic and routine acupuncture. Many also have free gym memberships to help keep their subscribers active and healthy. Some Medicare Advantage plans will also offer free transportation to and from doctor office visits and other medically related appointments (including to and from the pharmacy).

2021 Medicare Advantage sample ID card

Member IDs for the affected plans will show the **payer ID WELM2** and have **eprg.wellmed.net** listed as the **For Providers** contact.



Sample member ID cards for illustration only. Actual information varies depending on payer, plan and other requirements.

Medicare Advantage

- Direct access for acupuncture with no medical supervision
- Some may limit access for providers “in network”
- But many will allow any willing providers but will consider that provider to be a “deemed provider”

HMO Health Maintenance Organization

- In HMO Plans, you generally must get your care and services from doctors, other health care providers, and hospitals in the plan's network, except:
- Emergency care
- Out-of-area urgent care
- Temporary out-of-area dialysis
- HMO Point-of-Service (HMO-POS) plans are HMO plans that **may allow you to get some services out-of-network for a higher copayment or coinsurance**. It’s important that you follow the plan’s rules, and it may require prior approval.

Preferred Provider Organization (PPO)

- A Medicare PPO Plan is a type of Medicare Advantage Plan (Part C) offered by a private insurance company. PPO Plans have network doctors, other health care providers, and hospitals. Patients pay less if they use doctors, hospitals, and other healthcare providers that belong to the plan's network
- They can also use out-of-network providers for covered services, usually for a higher cost, from, a willing provider

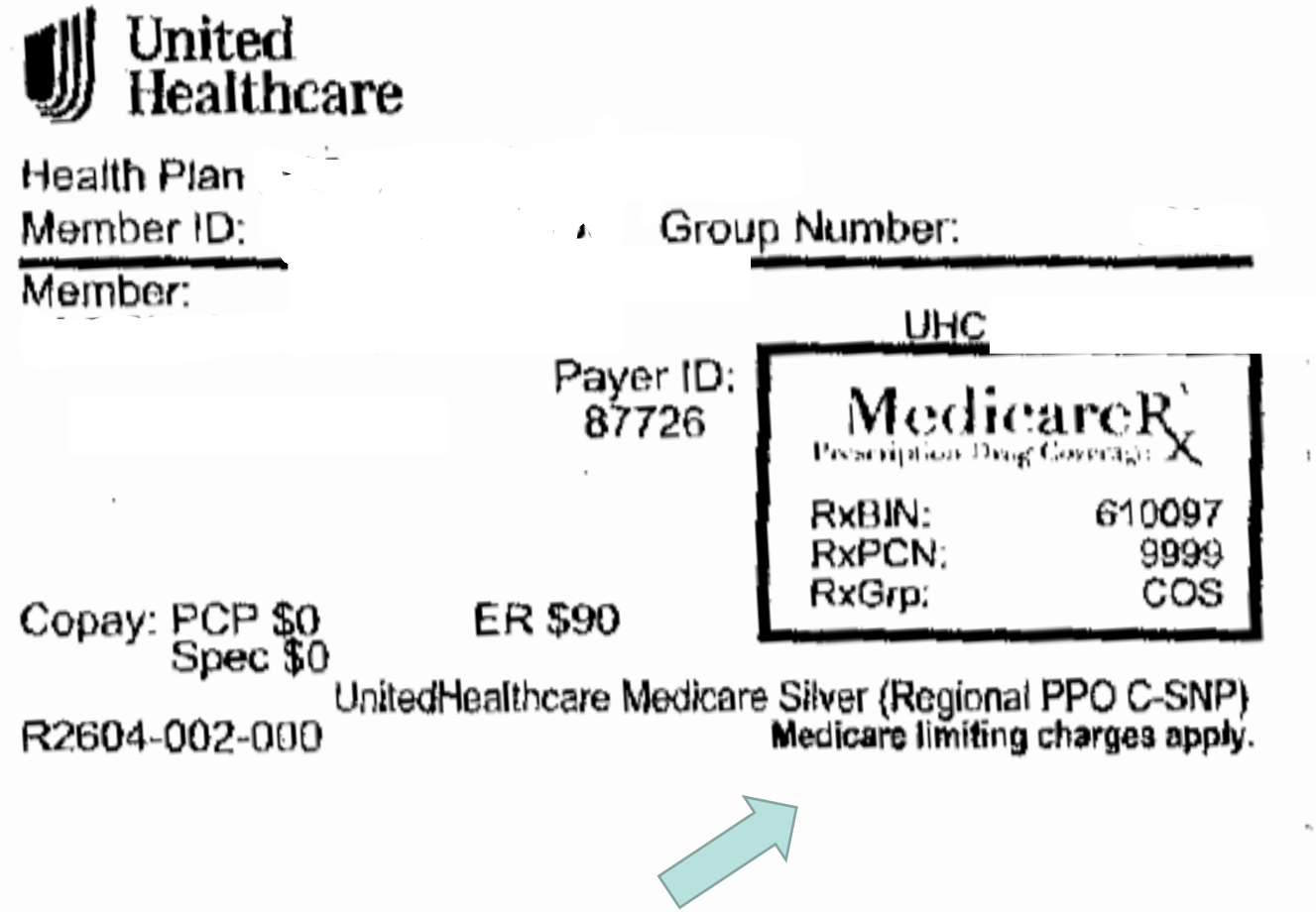
Private Fee-for-Service (PFFS) Plans

A Medicare PFFS Plan is a type of Medicare Advantage Plan (Part C) offered by a private insurance company. PFFS plans aren't the same as Original Medicare or Medigap. The plan determines how much it will pay doctors, other health care providers, and hospitals, and how much you must pay when you get care.

Deemed Provider

- An enrollee visits the office for the first time, advises the physician that s/he is a member of a **Private Fee for Service** (PFFS) plan and presents the appropriate enrollment card. Since the provider had the *opportunity* to call the phone number on the enrollee card, the provider is considered **deemed contracting** as soon as s/he provides services, *even if the provider did not actually check* the terms and conditions of payments.

Some Medicare **PFFS** plans allow “balance billing,” which lets providers charge up to 15% over what the plan pays for a covered service. This is why verification of benefits is so important as well as consulting the PFFS benefit information. Don’t leave $ on the table.


United Healthcare
Health Plan
Member ID:
Group Number:
Member:
UHC
Payer ID:
87726
MedicareRx
RxBIN: 610097
RxPCN: 9999
RxGrp: COS
Copay: PCP $0
Spec $0
ER $90
UnitedHealthcare Medicare Silver (Regional PPO C-SNP)
R2604-002-000
Medicare limiting charges apply.

Note: You, the provider, can decide whether or not to accept UnitedHealthcare MedicareDirect's terms and conditions of payment each time you see a UnitedHealthcare MedicareDirect member. A decision to treat one plan member does not obligate you to treat other UnitedHealthcare MedicareDirect members, nor does it obligate you to accept the same member for treatment at a subsequent visit.

If you DO NOT wish to accept UnitedHealthcare MedicareDirect's terms and conditions of payment, then you should not furnish services to a UnitedHealthcare MedicareDirect member, except for emergency services. If you furnish non-emergency services, you will be subject to these terms and conditions whether you wish to agree to them or not. Providers furnishing emergency services will be treated as non-contracting (i.e., non-deemed) providers and paid at the payment amounts they would have received under Original Medicare.

Special Needs Plans (SNP)

Medicare SNPs are a type of Medicare Advantage Plan (like an HMO or PPO). Medicare SNPs limit membership to people with specific diseases or characteristics. Medicare SNPs tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve.

HEALTH NET SENIORITY PLUS EMPLOYER (HMO)

health net.

Combined Acupuncture and Chiropractic Care

PLAN CWU

Health Net has teamed up with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality, affordable acupuncture and chiropractic coverage. You may obtain care by selecting a participating provider from the ASH Plans network. Although you're always welcome to consult your primary care physician, you won't need a referral to see an ASH Plans network participating chiropractor or acupuncturist.

Routine Acupuncture Care[1]

WHAT'S COVERED

Office visit copayment[2]

$5 per visit / up to 20 visits per calendar year

(visit maximums are combined for acupuncture and chiropractic services)

Initial examination, subsequent office visits, re-examination

Covered conditions

- Headache
- Back or neck pain
- Shoulder, hip, or knee joint pain
- Osteoarthritis (OA) and other arthritic pain
- Pain involving other joints and associated soft tissues
- Post-operative nausea/vomiting, nausea associated with pregnancy, and nausea associated with chemotherapy (nausea may require co-management with your physician)

Acupuncture Care

WHAT'S NOT COVERED

Services or supplies excluded under the acupuncture care program may be covered under the medical benefits portion of your plan. Consult your plan's *Evidence of Coverage* (EOC) for more information.

LIMITATIONS AND EXCLUSIONS

- Devices, personal and comfort items
- Diagnostic scanning, MRI, CT scans or thermography
- Exams or treatment other than for musculoskeletal and related disorders, pain, nausea, or other covered conditions, as described under the definition of acupuncture services above

Humana Medicare Advantage

- **Humana Medicare Advantage plans** are required to cover at least the same level of acupuncture care as Medicare Part B covers. Some Humana plans may cover even more acupuncture visits for a longer period of time
- For example, **some Humana Medicare plans** may cover up to 25 acupuncture sessions per year with a $0 copay, which is more than the maximum of 20 covered by Original Medicare. This is just one example of a Humana Medicare Advantage plan that goes above and beyond the acupuncture coverage offered by Original Medicare.

Care First Blue Cross Blue Shield Advantage Enhanced HMO

- Acupuncture for chronic low back pain $30.00 copay for acupuncture services at a Specialist office.
- Routine acupuncture services $20.00 copay for each non-Medicare-covered routine acupuncture visit (up to 12 visits a calendar year).
- Note this plan also has a chiropractic benefit but it requires preauthorization

Medicare Advantage Resource

- www.medicareadvantage.com
- Search your region and get specific information on plans offered local to your office

United Healthcare Medicare Advantage

UnitedHealthcare® Medicare Advantage
Policy Guideline

Acupuncture

Guideline Number: MPG003.10
Approval Date: May 12, 2022

Terms and Conditions

Table of Contents Page

Related Medicare Advantage Coverage Summary
- Complementary and Alternative Medicine

Policy Summary

See Purpose

Item/Service Description

General

Acupuncture is the selection and manipulation of specific acupuncture points by a variety of needling and non-needling techniques.

Indications and Limitations of Coverage

Nationally Covered Indications

Effective for claims with dates of service on and after January 21, 2020, acupuncture is only covered for chronic low back pain under section 1862(a)(1)(A) of the Social Security Act (the Act). Refer to the National Coverage Determination section 30.3.3 for specific coverage criteria.

Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:

- For the purpose of this decision, cLBP is defined as:
  - Lasting 12 weeks or longer;
  - Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease);
  - Not associated with surgery; and
  - Not associated with pregnancy
- An additional 8 sessions will be covered for those patients demonstrating an improvement.
- No more than 20 acupuncture treatments may be administered annually.
- Treatment must be discontinued if the patient is not improving or is regressing.

Physicians (as defined in 1861(r)(1)) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements.

Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:

- A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and
- A current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia

Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, physician assistant (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) required by our regulations at 42 CFR §§ 410.26 and 410.27.

Nationally Non-Covered Indications

Medicare reimbursement for acupuncture, as an anesthetic, or as an analgesic or for other therapeutic purposes, may not be made unless the specific indication is excepted. All indications for acupuncture outside of NCD section 30.3.3 remain non-covered.

After careful reconsideration of its initial non-coverage determination for acupuncture, the Centers for Medicare & Medicaid Services (CMS) concludes that there is no convincing evidence for the use of acupuncture for pain relief in patients with fibromyalgia or osteoarthritis. Study design flaws presently prohibit assessing acupuncture's utility for improving health outcomes. Accordingly, CMS determines that acupuncture is not considered reasonable and necessary for the treatment of fibromyalgia or osteoarthritis within the meaning of §1862(a)(1) of the Social Security Act, and the national non-coverage determination for acupuncture for fibromyalgia and osteoarthritis continues.

All types of acupuncture including dry needling for any condition other than cLBP are non-covered by Medicare.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)
20561	Needle insertion(s) without injection(s); 3 or more muscles
64999	Unlisted procedure, nervous system
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one- on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)

Modifier	Description
KX	Requirements specified in the medical policy have been met

Diagnosis Code	Description
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.26	Other intervertebral disc displacement, lumbar region
M51.27	Other intervertebral disc displacement, lumbosacral region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M51.46	Schmorl's nodes, lumbar region
M51.47	Schmorl's nodes, lumbosacral region
M51.86	Other intervertebral disc disorders, lumbar region
M51.87	Other intervertebral disc disorders, lumbosacral region
M51.A1	Intervertebral annulus fibrosus defect, small, lumbar region (Effective 10/01/2022)
M51.A2	Intervertebral annulus fibrosus defect, large, lumbar region (Effective 10/01/2022)
M51.A4	Intervertebral annulus fibrosus defect, small, lumbosacral region (Effective 10/01/2022)
M51.A5	Intervertebral annulus fibrosus defect, large, lumbosacral region (Effective 10/01/2022)
M53.2X6	Spinal instabilities, lumbar region
M53.2X7	Spinal instabilities, lumbosacral region
M53.86	Other specified dorsopathies, lumbarregion
M53.87	Other specified dorsopathies, lumbosacralregion
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.31	Sciatica, rightside
M54.32	Sciatica, leftside
M54.41	Lumbago with sciatica, rightside
M54.42	Lumbago with sciatica, leftside
M54.5	Low backpain (Deleted 09/30/2021)
M54.51	Vertebrogenic low back pain (Effective 10/01/2021)
M54.59	Other low backpain (Effective 10/01/2021)
S32.000A	Wedge compression fracture of unspecified lumbar vertebra, initial encounter for closed fracture (Deleted 04/01/2022)
S32.000B	Wedge compression fracture of unspecified lumbar vertebra, initial encounter for open fracture (Deleted 04/01/2022)
S32.000D	Wedge compression fracture of unspecified lumbar vertebra, subsequent encounter for fracture with routine healing (Deleted04/01/2022)
S32.000G	Wedge compression fracture of unspecified lumbar vertebra, subsequent encounter for fracture with delayed healing (Deleted04/01/2022)
S32.000K	Wedge compression fracture of unspecified lumbar vertebra, subsequent encounter for fracture with nonunion (Deleted 04/01/2022)
S32.000S	Wedge compression fracture of unspecified lumbar vertebra, sequela (Deleted 04/01/2022)
S32.001A	Stable burst fracture of unspecified lumbar vertebra, initial encounter for closed fracture (Deleted 04/01/2022)
S32.001B	Stable burst fracture of unspecified lumbar vertebra, initial encounter for open fracture (Deleted 04/01/2022)
S32.001D	Stable burst fracture of unspecified lumbar vertebra, subsequent encounter for fracture with routine healing (Deleted 04/01/2022)

Diagnosis Code	Description
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
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M51.A5	Intervertebral annulus fibrosus defect, large, lumbosacral region (Effective 10/01/2022)
M53.2X6	Spinal instabilities, lumbar region
M53.2X7	Spinal instabilities, lumbosacral region
M53.86	Other specified dorsopathies, lumbarregion
M53.87	Other specified dorsopathies, lumbosacralregion
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.31	Sciatica, rightside
M54.32	Sciatica, leftside
M54.41	Lumbago with sciatica, rightside
M54.42	Lumbago with sciatica, leftside
M54.5	Low backpain (Deleted 09/30/2021)
M54.51	Vertebrogenic low back pain (Effective 10/01/2021)
M54.59	Other low backpain (Effective 10/01/2021)
S32.000A	Wedge compression fracture of unspecified lumbar vertebra, initial encounter for closed fracture (Deleted 04/01/2022)
S32.000B	Wedge compression fracture of unspecified lumbar vertebra, initial encounter for open fracture (Deleted 04/01/2022)
S32.000D	Wedge compression fracture of unspecified lumbar vertebra, subsequent encounter for fracture with routine healing (Deleted04/01/2022)
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S32.000K	Wedge compression fracture of unspecified lumbar vertebra, subsequent encounter for fracture with nonunion (Deleted 04/01/2022)
S32.000S	Wedge compression fracture of unspecified lumbar vertebra, sequela (Deleted 04/01/2022)
S32.001A	Stable burst fracture of unspecified lumbar vertebra, initial encounter for closed fracture (Deleted 04/01/2022)
S32.001B	Stable burst fracture of unspecified lumbar vertebra, initial encounter for open fracture (Deleted 04/01/2022)
S32.001D	Stable burst fracture of unspecified lumbar vertebra, subsequent encounter for fracture with routine healing (Deleted 04/01/2022)

Diagnosis Code	Description
S32.001G	Stable burst fracture of unspecified lumbar vertebra, subsequent encounter for fracture with delayed healing (Deleted 04/01/2022)
S32.001K	Stable burst fracture of unspecified lumbar vertebra, subsequent encounter for fracture with nonunion (Deleted 04/01/2022)
S32.001S	Stable burst fracture of unspecified lumbar vertebra, sequela (Deleted 04/01/2022)
S32.002A	Unstable burst fracture of unspecified lumbar vertebra, initial encounter for closed fracture (Deleted 04/01/2022)
S32.002B	Unstable burst fracture of unspecified lumbar vertebra, initial encounter for open fracture (Deleted 04/01/2022)
S32.002D	Unstable burst fracture of unspecified lumbar vertebra, subsequent encounter for fracture with routine healing (Deleted 04/01/2022)
S32.002G	Unstable burst fracture of unspecified lumbar vertebra, subsequent encounter for fracture with delayed healing (Deleted 04/01/2022)
S32.002K	Unstable burst fracture of unspecified lumbar vertebra, subsequent encounter for fracture with nonunion (Deleted 04/01/2022)
S32.002S	Unstable burst fracture of unspecified lumbar vertebra, sequela (Deleted 04/01/2022)
S32.008A	Other fracture of unspecified lumbar vertebra, initial encounter for closed fracture (Deleted 04/01/2022)
S32.008B	Other fracture of unspecified lumbar vertebra, initial encounter for open fracture (Deleted 04/01/2022)
S32.008D	Other fracture of unspecified lumbar vertebra, subsequent encounter for fracture with routine healing (Deleted 04/01/2022)
S32.008G	Other fracture of unspecified lumbar vertebra, subsequent encounter for fracture with delayed healing (Deleted 04/01/2022)
S32.008K	Other fracture of unspecified lumbar vertebra, subsequent encounter for fracture with nonunion (Deleted 04/01/2022)
S32.008S	Other fracture of unspecified lumbar vertebra, sequela (Deleted 04/01/2022)
S32.009A	Unspecified fracture of unspecified lumbar vertebra, initial encounter for closed fracture (Deleted 04/01/2022)
S32.009B	Unspecified fracture of unspecified lumbar vertebra, initial encounter for open fracture (Deleted 04/01/2022)
S32.009D	Unspecified fracture of unspecified lumbar vertebra, subsequent encounter for fracture with routine healing (Deleted 04/01/2022)
S32.009G	Unspecified fracture of unspecified lumbar vertebra, subsequent encounter for fracture with delayed healing (Deleted 04/01/2022)
S32.009K	Unspecified fracture of unspecified lumbar vertebra, subsequent encounter for fracture with nonunion (Deleted 04/01/2022)
S32.009S	Unspecified fracture of unspecified lumbar vertebra, sequela (Deleted 04/01/2022)
S32.010A	Wedge compression fracture of first lumbar vertebra, initial encounter for closed fracture
S32.010B	Wedge compression fracture of first lumbar vertebra, initial encounter for open fracture
S32.010D	Wedge compression fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing
S32.010G	Wedge compression fracture of first lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.010K	Wedge compression fracture of first lumbar vertebra, subsequent encounter for fracture with nonunion
S32.010S	Wedge compression fracture of first lumbar vertebra, sequela
S32.011A	Stable burst fracture of first lumbar vertebra, initial encounter for closed fracture
S32.011B	Stable burst fracture of first lumbar vertebra, initial encounter for open fracture

Diagnosis Code	Description
S32.011D	Stable burst fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing
S32.011G	Stable burst fracture of first lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.011K	Stable burst fracture of first lumbar vertebra, subsequent encounter for fracture with nonunion
S32.011S	Stable burst fracture of first lumbar vertebra, sequela
S32.012A	Unstable burst fracture of first lumbar vertebra, initial encounter for closed fracture
S32.012B	Unstable burst fracture of first lumbar vertebra, initial encounter for open fracture
S32.012D	Unstable burst fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing
S32.012G	Unstable burst fracture of first lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.012K	Unstable burst fracture of first lumbar vertebra, subsequent encounter for fracture with nonunion
S32.012S	Unstable burst fracture of first lumbar vertebra, sequela
S32.018A	Other fracture of first lumbar vertebra, initial encounter for closed fracture
S32.018B	Other fracture of first lumbar vertebra, initial encounter for open fracture
S32.018D	Other fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing
S32.018G	Other fracture of first lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.018K	Other fracture of first lumbar vertebra, subsequent encounter for fracture with nonunion
S32.018S	Other fracture of first lumbar vertebra, sequela
S32.019A	Unspecified fracture of first lumbar vertebra, initial encounter for closed fracture
S32.019B	Unspecified fracture of first lumbar vertebra, initial encounter for open fracture
S32.019D	Unspecified fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing
S32.019G	Unspecified fracture of first lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.019K	Unspecified fracture of first lumbar vertebra, subsequent encounter for fracture with nonunion
S32.019S	Unspecified fracture of first lumbar vertebra, sequela
S32.020A	Wedge compression fracture of second lumbar vertebra, initial encounter for closed fracture
S32.020B	Wedge compression fracture of second lumbar vertebra, initial encounter for open fracture
S32.020D	Wedge compression fracture of second lumbar vertebra, subsequent encounter for fracture with routine healing
S32.020G	Wedge compression fracture of second lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.020K	Wedge compression fracture of second lumbar vertebra, subsequent encounter for fracture with nonunion
S32.020S	Wedge compression fracture of second lumbar vertebra, sequela
S32.021A	Stable burst fracture of second lumbar vertebra, initial encounter for closed fracture
S32.021B	Stable burst fracture of second lumbar vertebra, initial encounter for open fracture
S32.021D	Stable burst fracture of second lumbar vertebra, subsequent encounter for fracture with routine healing
S32.021G	Stable burst fracture of second lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.021K	Stable burst fracture of second lumbar vertebra, subsequent encounter for fracture with nonunion
S32.021S	Stable burst fracture of second lumbar vertebra, sequela
S32.022A	Unstable burst fracture of second lumbar vertebra, initial encounter for closed fracture
S32.022B	Unstable burst fracture of second lumbar vertebra, initial encounter for open fracture
S32.022D	Unstable burst fracture of second lumbar vertebra, subsequent encounter for fracture with routine healing
S32.022G	Unstable burst fracture of second lumbar vertebra, subsequent encounter for fracture with delayed healing

Diagnosis Code	Description
S32.022K	Unstable burst fracture of second lumbar vertebra, subsequent encounter for fracture with nonunion
S32.022S	Unstable burst fracture of second lumbar vertebra, sequela
S32.028A	Other fracture of second lumbar vertebra, initial encounter for closed fracture
S32.028B	Other fracture of second lumbar vertebra, initial encounter for open fracture
S32.028D	Other fracture of second lumbar vertebra, subsequent encounter for fracture with routine healing
S32.028G	Other fracture of second lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.028K	Other fracture of second lumbar vertebra, subsequent encounter for fracture with nonunion
S32.028S	Other fracture of second lumbar vertebra, sequela
S32.029A	Unspecified fracture of second lumbar vertebra, initial encounter for closed fracture
S32.029B	Unspecified fracture of second lumbar vertebra, initial encounter for open fracture
S32.029D	Unspecified fracture of second lumbar vertebra, subsequent encounter for fracture with routine healing
S32.029G	Unspecified fracture of second lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.029K	Unspecified fracture of second lumbar vertebra, subsequent encounter for fracture with nonunion
S32.029S	Unspecified fracture of second lumbar vertebra, sequela
S32.030A	Wedge compression fracture of third lumbar vertebra, initial encounter for closed fracture
S32.030B	Wedge compression fracture of third lumbar vertebra, initial encounter for open fracture
S32.030D	Wedge compression fracture of third lumbar vertebra, subsequent encounter for fracture with routine healing
S32.030G	Wedge compression fracture of third lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.030K	Wedge compression fracture of third lumbar vertebra, subsequent encounter for fracture with nonunion
S32.030S	Wedge compression fracture of third lumbar vertebra, sequela
S32.031A	Stable burst fracture of third lumbar vertebra, initial encounter for closed fracture
S32.031B	Stable burst fracture of third lumbar vertebra, initial encounter for open fracture
S32.031D	Stable burst fracture of third lumbar vertebra, subsequent encounter for fracture with routine healing
S32.031G	Stable burst fracture of third lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.031K	Stable burst fracture of third lumbar vertebra, subsequent encounter for fracture with nonunion
S32.031S	Stable burst fracture of third lumbar vertebra, sequela
S32.032A	Unstable burst fracture of third lumbar vertebra, initial encounter for closed fracture
S32.032B	Unstable burst fracture of third lumbar vertebra, initial encounter for open fracture
S32.032D	Unstable burst fracture of third lumbar vertebra, subsequent encounter for fracture with routine healing
S32.032G	Unstable burst fracture of third lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.032K	Unstable burst fracture of third lumbar vertebra, subsequent encounter for fracture with nonunion
S32.032S	Unstable burst fracture of third lumbar vertebra, sequela
S32.038A	Other fracture of third lumbar vertebra, initial encounter for closed fracture
S32.038B	Other fracture of third lumbar vertebra, initial encounter for open fracture
S32.038D	Other fracture of third lumbar vertebra, subsequent encounter for fracture with routine healing
S32.038G	Other fracture of third lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.038K	Other fracture of third lumbar vertebra, subsequent encounter for fracture with nonunion
S32.038S	Other fracture of third lumbar vertebra, sequela
S32.039A	Unspecified fracture of third lumbar vertebra, initial encounter for closed fracture
S32.039B	Unspecified fracture of third lumbar vertebra, initial encounter for open fracture

Diagnosis Code	Description
S32.039D	Unspecified fracture of third lumbar vertebra, subsequent encounter for fracture with routine healing
S32.039G	Unspecified fracture of third lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.039K	Unspecified fracture of third lumbar vertebra, subsequent encounter for fracture with nonunion
S32.039S	Unspecified fracture of third lumbar vertebra, sequela
S32.040A	Wedge compression fracture of fourth lumbar vertebra, initial encounter for closed fracture
S32.040B	Wedge compression fracture of fourth lumbar vertebra, initial encounter for open fracture
S32.040D	Wedge compression fracture of fourth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.040G	Wedge compression fracture of fourth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.040K	Wedge compression fracture of fourth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.040S	Wedge compression fracture of fourth lumbar vertebra, sequela
S32.041A	Stable burst fracture of fourth lumbar vertebra, initial encounter for closed fracture
S32.041B	Stable burst fracture of fourth lumbar vertebra, initial encounter for open fracture
S32.041D	Stable burst fracture of fourth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.041G	Stable burst fracture of fourth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.041K	Stable burst fracture of fourth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.041S	Stable burst fracture of fourth lumbar vertebra, sequela
S32.042A	Unstable burst fracture of fourth lumbar vertebra, initial encounter for closed fracture
S32.042B	Unstable burst fracture of fourth lumbar vertebra, initial encounter for open fracture
S32.042D	Unstable burst fracture of fourth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.042G	Unstable burst fracture of fourth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.042K	Unstable burst fracture of fourth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.042S	Unstable burst fracture of fourth lumbar vertebra, sequela
S32.048A	Other fracture of fourth lumbar vertebra, initial encounter for closed fracture
S32.048B	Other fracture of fourth lumbar vertebra, initial encounter for open fracture
S32.048D	Other fracture of fourth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.048G	Other fracture of fourth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.048K	Other fracture of fourth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.048S	Other fracture of fourth lumbar vertebra, sequela
S32.049A	Unspecified fracture of fourth lumbar vertebra, initial encounter for closed fracture
S32.049B	Unspecified fracture of fourth lumbar vertebra, initial encounter for open fracture
S32.049D	Unspecified fracture of fourth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.049G	Unspecified fracture of fourth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.049K	Unspecified fracture of fourth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.049S	Unspecified fracture of fourth lumbar vertebra, sequela
S32.050A	Wedge compression fracture of fifth lumbar vertebra, initial encounter for closed fracture
S32.050B	Wedge compression fracture of fifth lumbar vertebra, initial encounter for open fracture
S32.050D	Wedge compression fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing

Diagnosis Code	Description
S32.050G	Wedge compression fracture of fifth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.050K	Wedge compression fracture of fifth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.050S	Wedge compression fracture of fifth lumbar vertebra, sequela
S32.051A	Stable burst fracture of fifth lumbar vertebra, initial encounter for closed fracture
S32.051B	Stable burst fracture of fifth lumbar vertebra, initial encounter for open fracture
S32.051D	Stable burst fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.051G	Stable burst fracture of fifth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.051K	Stable burst fracture of fifth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.051S	Stable burst fracture of fifth lumbar vertebra, sequela
S32.052A	Unstable burst fracture of fifth lumbar vertebra, initial encounter for closed fracture
S32.052B	Unstable burst fracture of fifth lumbar vertebra, initial encounter for open fracture
S32.052D	Unstable burst fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.052G	Unstable burst fracture of fifth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.052K	Unstable burst fracture of fifth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.052S	Unstable burst fracture of fifth lumbar vertebra, sequela
S32.058A	Other fracture of fifth lumbar vertebra, initial encounter for closed fracture
S32.058B	Other fracture of fifth lumbar vertebra, initial encounter for open fracture
S32.058D	Other fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.058G	Other fracture of fifth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.058K	Other fracture of fifth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.058S	Other fracture of fifth lumbar vertebra, sequela
S32.059A	Unspecified fracture of fifth lumbar vertebra, initial encounter for closed fracture
S32.059B	Unspecified fracture of fifth lumbar vertebra, initial encounter for open fracture
S32.059D	Unspecified fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.059G	Unspecified fracture of fifth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.059K	Unspecified fracture of fifth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.059S	Unspecified fracture of fifth lumbar vertebra, sequela
S33.0XXA	Traumatic rupture of lumbar intervertebral disc, initial encounter
S33.0XXD	Traumatic rupture of lumbar intervertebral disc, subsequent encounter
S33.0XXS	Traumatic rupture of lumbar intervertebral disc, sequela
S33.100A	Subluxation of unspecified lumbar vertebra, initial encounter
S33.100D	Subluxation of unspecified lumbar vertebra, subsequent encounter
S33.100S	Subluxation of unspecifiedlumbar vertebra, sequela
S33.101A	Dislocation of unspecified lumbar vertebra, initial encounter
S33.101D	Dislocation of unspecified lumbar vertebra, subsequent encounter
S33.101S	Dislocation of unspecified lumbarvertebra, sequela
S33.110A	Subluxation of L1/L2 lumbar vertebra, initial encounter
S33.110D	Subluxation of L1/L2 lumbar vertebra, subsequent encounter
S33.110S	Subluxation of L1/L2lumbar vertebra, sequela
S33.111A	Dislocation of L1/L2 lumbar vertebra, initial encounter
S33.111D	Dislocation of L1/L2 lumbar vertebra, subsequent encounter

Diagnosis Code	Description
S32.050G	Wedge compression fracture of fifth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.050K	Wedge compression fracture of fifth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.050S	Wedge compression fracture of fifth lumbar vertebra, sequela
S32.051A	Stable burst fracture of fifth lumbar vertebra, initial encounter for closed fracture
S32.051B	Stable burst fracture of fifth lumbar vertebra, initial encounter for open fracture
S32.051D	Stable burst fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.051G	Stable burst fracture of fifth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.051K	Stable burst fracture of fifth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.051S	Stable burst fracture of fifth lumbar vertebra, sequela
S32.052A	Unstable burst fracture of fifth lumbar vertebra, initial encounter for closed fracture
S32.052B	Unstable burst fracture of fifth lumbar vertebra, initial encounter for open fracture
S32.052D	Unstable burst fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.052G	Unstable burst fracture of fifth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.052K	Unstable burst fracture of fifth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.052S	Unstable burst fracture of fifth lumbar vertebra, sequela
S32.058A	Other fracture of fifth lumbar vertebra, initial encounter for closed fracture
S32.058B	Other fracture of fifth lumbar vertebra, initial encounter for open fracture
S32.058D	Other fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.058G	Other fracture of fifth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.058K	Other fracture of fifth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.058S	Other fracture of fifth lumbar vertebra, sequela
S32.059A	Unspecified fracture of fifth lumbar vertebra, initial encounter for closed fracture
S32.059B	Unspecified fracture of fifth lumbar vertebra, initial encounter for open fracture
S32.059D	Unspecified fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.059G	Unspecified fracture of fifth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.059K	Unspecified fracture of fifth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.059S	Unspecified fracture of fifth lumbar vertebra, sequela
S33.0XXA	Traumatic rupture of lumbar intervertebral disc, initial encounter
S33.0XXD	Traumatic rupture of lumbar intervertebral disc, subsequent encounter
S33.0XXS	Traumatic rupture of lumbar intervertebral disc, sequela
S33.100A	Subluxation of unspecified lumbar vertebra, initial encounter
S33.100D	Subluxation of unspecified lumbar vertebra, subsequent encounter
S33.100S	Subluxation of unspecifiedlumbar vertebra, sequela
S33.101A	Dislocation of unspecified lumbar vertebra, initial encounter
S33.101D	Dislocation of unspecified lumbar vertebra, subsequent encounter
S33.101S	Dislocation of unspecified lumbarvertebra, sequela
S33.110A	Subluxation of L1/L2 lumbar vertebra, initial encounter
S33.110D	Subluxation of L1/L2 lumbar vertebra, subsequent encounter
S33.110S	Subluxation of L1/L2lumbar vertebra, sequela
S33.111A	Dislocation of L1/L2 lumbar vertebra, initial encounter
S33.111D	Dislocation of L1/L2 lumbar vertebra, subsequent encounter

Diagnosis Code	Description
S33.111S	Dislocation of L1/L2lumbar vertebra, sequela
S33.120A	Subluxation of L2/L3 lumbar vertebra, initial encounter
S33.120D	Subluxation of L2/L3 lumbar vertebra, subsequent encounter
S33.120S	Subluxation of L2/L3lumbar vertebra, sequela
S33.121A	Dislocation of L2/L3 lumbar vertebra, initial encounter
S33.121D	Dislocation of L2/L3 lumbar vertebra, subsequent encounter
S33.121S	Dislocation of L2/L3lumbar vertebra, sequela
S33.130A	Subluxation of L3/L4 lumbar vertebra, initial encounter
S33.130D	Subluxation of L3/L4 lumbar vertebra, subsequent encounter
S33.130S	Subluxation of L3/L4lumbar vertebra, sequela
S33.131A	Dislocation of L3/L4 lumbar vertebra, initial encounter
S33.131D	Dislocation of L3/L4 lumbar vertebra, subsequent encounter
S33.131S	Dislocation of L3/L4lumbar vertebra, sequela
S33.140A	Subluxation of L4/L5 lumbar vertebra, initial encounter
S33.140D	Subluxation of L4/L5 lumbar vertebra, subsequent encounter
S33.140S	Subluxation of L4/L5lumbar vertebra, sequela
S33.141A	Dislocation of L4/L5 lumbar vertebra, initial encounter
S33.141D	Dislocation of L4/L5 lumbar vertebra, subsequent encounter
S33.141S	Dislocation of L4/L5lumbar vertebra, sequela
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
S33.5XXD	Sprain of ligaments of lumbar spine, subsequent encounter
S33.5XXS	Sprain of ligaments of lumbar spine, sequela
S33.6XXA	Sprain of sacroiliac joint, initialencounter
S33.6XXD	Sprain of sacroiliac joint, subsequentencounter
S33.6XXS	Sprain of sacroiliac joint,sequela
S34.21XA	Injury of nerve root of lumbar spine, initial encounter
S34.21XD	Injury of nerve root of lumbar spine, subsequent encounter
S34.21XS	Injury of nerve root of lumbar spine, sequela
S34.22XA	Injury of nerve root of sacral spine, initial encounter
S34.22XD	Injury of nerve root of sacral spine, subsequent encounter
S34.22XS	Injury of nerve root of sacral spine, sequela
S39.002A	Unspecified injury of muscle, fascia and tendon of lower back, initial encounter (Deleted 04/01/2022)
S39.002D	Unspecified injury of muscle, fascia and tendon of lower back, subsequent encounter (Deleted 04/01/2022)
S39.002S	Unspecified injury of muscle, fascia and tendon of lower back, sequela (Deleted 04/01/2022)
S39.012A	Strain of muscle, fascia and tendon of lower back, initial encounter
S39.012D	Strain of muscle, fascia and tendon of lower back, subsequent encounter
S39.012S	Strain of muscle, fascia and tendon of lower back, sequela
S39.022A	Laceration of muscle, fascia and tendon of lower back, initial encounter
S39.022D	Laceration of muscle, fascia and tendon of lower back, subsequent encounter
S39.022S	Laceration of muscle, fascia and tendon of lower back, sequela
S39.092A	Other injury of muscle, fascia and tendon of lower back, initial encounter

Diagnosis Code	Description
S39.092D	Other injury of muscle, fascia and tendon of lower back, subsequent encounter
S39.092S	Other injury of muscle, fascia and tendon of lower back, sequela

Definitions

Acupuncture: The technique of inserting thin needles through the skin at specific points on the body to control pain and other symptoms. It is a type of complementary and alternative medicine.

Questions and Answers

1	Q:	Acupuncture is not covered by Medicare (except for chronic lower back pain), but can members still have the treatment?
	A:	Some Medicare Advantage members have a supplemental benefit package with coverage for acupuncture.
2	Q:	Does CMS have new limited coverage for acupuncture?
	A:	NCD 30.3.3 Acupuncture for Chronic Lower Back Pain (cLBP) has coverage only for chronic lower back pain, effective January 21, 2020. All types of acupuncture including dry needling for any condition other than cLBP are non-covered by Medicare.
3	Q:	Is auricular peripheral nerve simulation covered?
	A:	The service for auricular peripheral nerve simulation (CPT code 64999) will be denied as non-covered. This service is not a covered Medicare benefit because acupuncture for auricular stimulation does not meet the definition of reasonable and necessary under Section 1862(a) (1) of the Act. ANSiStim, E-Pulse, Neurostim system/NSS, P-Stim, and NSS-2 Bridge, other current or future devices when used for the procedure electro-acupuncture or auricular peripheral nerve stimulation, would also be considered a non-covered service. Any ear or auricular electrical devices (e.g., DyAnsys®) are also non-covered by Medicare as electrical acupuncture.
4.	Q:	When is the KX modifier to be used for acupuncture?
	A:	It is used for acupuncture for cLBP claims for the 13th through 20th dates of service (DOS). The 1st through 12th DOS over a 90-day period do not require the KX modifier. There is a 20 DOS maximum per annum for this benefit. By applying the KX modifier to the claim, the therapy provider is confirming that the additional DOS are medically necessary as justified by appropriate documentation in the medical record.

References

CMS National Coverage Determinations (NCDs)

NCD 30.3 Acupuncture, NCD 30.3.1 Acupuncture for Fibromyalgia, NCD 30.3.2 Acupuncture for Osteoarthritis, NCD 30.3.3 Acupuncture for Chronic Lower Back Pain (cLBP)

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	Medicare Part A	Medicare Part B
L33622 Pain Management	A52863 Billing and Coding: Pain Management	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
N/A	A55240 Billing and Coding: Auricular Peripheral Nerve Stimulation (Electro-Acupuncture Device)	Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX

UnitedHealthcare Medicare Advantage chiropractic and acupuncture coverage

Quick reference guide

Please use this quick reference guide for important phone numbers, websites and addresses related to chiropractic and acupuncture coverage for UnitedHealthcare® Medicare Advantage plan members. This guide also covers how these benefits are administered, and includes a list of common CPT® codes to use for claims submissions.

Chiropractic and acupuncture services

To check:

- Eligibility
- Benefits
- Claims

Chiropractic and acupuncture (Medicare-covered)

- **Phone:** Call the Provider Services number on the member's ID card
- **Online:** Go to UHCprovider.com and click Sign In

Chiropractic and acupuncture (routine)

- **Phone: 800-873-4575**
- **Hours:** Monday–Friday, 8 a.m.–8 p.m. ET
  Interactive Voice Response, 24 hours a day
- **Online:** myoptumhealthphysicalhealth.com

To check:

- Authorizations

Chiropractic and acupuncture (Medicare-covered)

- **Phone:** Call the Provider Authorization number on the member's ID card
- **Online:** Visit UHCprovider.com >Prior Authorization and Notification

Acupuncture services

What's covered?

Acupuncture (Medicare-covered)

Medicare covers acupuncture services for chronic low back pain only. Covered services include:

- Up to 12 visits in 90 days
- An additional 8 sessions for patients demonstrating an improvement
- No more than 20 acupuncture treatments may be administered annually
- Treatment must be discontinued if the patient is not improving or is regressing

Chronic low back pain is defined as:

- Lasting 12 weeks or longer
- Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc., disease)
- Not associated with surgery
- Not associated with pregnancy

Acupuncture (routine)

Routine acupuncture is a supplemental benefit offered on some UnitedHealthcare Medicare Advantage plans. This benefit allows members to visit acupuncturists for pain relief, neuromusculoskeletal disorders and nausea.

How to find a network acupuncture provider

Acupuncture (Medicare-covered)

Due to CMS regulations, acupuncture for chronic low back pain can only be performed by physicians or auxiliary personnel who have a master's or doctoral level degree in acupuncture or Oriental Medicine and a license to practice acupuncture in the United States or D.C. Auxiliary personnel furnishing acupuncture must be under appropriate level of supervision of a physician, PA or NP/CNS. When exclusively delivered by an independent acupuncturist, the Medicare-supported acupuncture benefit is not covered.

Please assist your patients in locating a network provider who can deliver acupuncture for chronic low back pain and meets the CMS requirements for this service.

Acupuncture (routine)

You can find a network care provider for routine acupuncture services by searching the acupuncture section of the online provider directory at Find a provider | UHCprovider.com.

Does the member require a referral to receive this service?

Acupuncture (Medicare-covered)

Referral plans: To simplify the administrative processes for members and care providers, UnitedHealthcare is choosing **not to enforce referral requirements.** PCPs may still need to issue specialist referrals via UHCprovider.com if specialist care providers require a referral; however, claims will not be denied for missing referrals.

Open access plans: Members of open access plans don't need a referral for Medicare-covered acupuncture care.

Acupuncture (routine)

We don't require referrals for routine acupuncture care.

Acupuncture CPT codes

Medicare-covered: Acupuncture for chronic low backpain*	
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)
20561	Needle insertion(s) without injection(s); 3 or more muscles
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal 1-on-1 contact with the patient
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal 1-on-1 contact with the patient, with re-insertion of needle(s) (list separately, in addition to code for primary procedure)
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal 1-on-1 contact with the patient
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal 1-on-1 contact with the patient, with re-insertion of needle(s) (list separately, in addition to code for primary procedure)
Modifier: KX	Specified requirements have been met

*For more information on Medicare-covered acupuncture services, including links to supporting policies on cms.gov, visit UHCprovider.com > Resources >Health plans, policies, protocols and guides >For Medicare Advantage Plans >Coverage Summaries for Medicare Advantage Plans > Complementary, Alternative Medicine, and Chiropractic Services —Medicare Advantage Coverage Summary.

Common routine acupuncture codes (not a complete list)	
99201	New patient office visit/examination
99202	New patient office visit/examination
99211	Established patient office visit/examination
99212	Established patient office visit/examination
99213	Established patient office visit/examination
99214	Established patient office visit/examination
97810	Acupuncture (without electrical stimulation; initial 15 minutes)
97811	Acupuncture (without electrical stimulation; each additional 15 minutes)
97813	Acupuncture (without electrical stimulation; each additional 15 minutes)
97814	Acupuncture (with electrical stimulation; each additional 15 minutes)
G0283	Electrical stimulation (unattended)
97026	Infrared
97035	Ultrasound
97110	Therapeutic procedures; therapeutic exercises

Notes:

- Refer to your Supplemental/Routine Fee Schedule for covered acupuncture services
- All codes are subject to change
- Please follow original Medicare-covered indications and coding rules when billing Medicare-covered services and review codes at cms.gov before submitting claims

Medicare Secondary with Acupuncture

How can you bill when you need a denial from the primary and you cannot bill Medicare directly?

Getting a Denial From Medicare

- First verify the payer will not pay directly for acupuncture without a denial
- Medicare will not accept a direct claim from an LAc as an LAc is not on the list of approved providers
- However, a denial will still be necessary

Medicare will not send a denial to an acupuncturist directly, as acupuncturists cannot enroll as part of Medicare and Medicare will not accept claims from non-Medicare providers.

- Consequently, you will send a claim to Medicare but technically it comes from the patient. You must use the form 1490S Patient Request for Payment

- Technically this is from the patient, but you may send it to facilitate

With this form include a statement or separate note indicating this claim is being sent solely for a denial of acupuncture so that a secondary plan with acupuncture benefits may be billed.

- The patient will receive a denial in about 30-90 days and once you get that denial you send the claim to the secondary attaching the denial from Medicare.

- You should be able to use this denial for subsequent claims as it will show it is a statutory denial as an excluded service

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved OMB
No. 0938-1197

PATIENT'S REQUEST FOR MEDICAL PAYMENT

IMPORTANT: PLEASE READ THE ATTACHED INSTRUCTIONS PRIOR TO SUBMITTING A CLAIM TO MEDICARE

SEND ONLY THE COMPLETED FORM TO YOUR MEDICARE ADMINISTRATIVE CONTRACTOR – Include a copy of the itemized bill and any supporting documents. Make a copy of your claim submission for your records and allow at least 60 days for Medicare to receive and process your request.

Reference the Medicare Administrative Contractor Address Table for the correct address to mail your claim form.

Medicare will not process a beneficiary request for payment for diabetic test strips, Part B drugs, or for items paid for under the DMEPOS Competitive Bidding program.

Your reason for submitting this claim: (see the Instructions for additional information, check one box only)

- ○ The provider or supplier refused to file a claim for Medicare Covered Services
- ○ The provider or supplier is unable to file a claim for the Medicare Covered Services
- ○ The provider or supplier is not enrolled with Medicare

IF YOU NEED HELP, CALL 1-800-MEDICARE (1-800-633-4227). TTY USERS SHOULD CALL 1-877-486-2048.

Type of Patient's Request (see instructions for additional information, check one box only):

- ○ Influenza/Pneumococcal Vaccination, Part B (includes physician, laboratory, imaging services), Foreign Travel (including Canada and Mexico) and/or Shipboard Services
- ○ Durable Medical Equipment, Prosthetics, Orthotics and Supplies

PLEASE TYPE OR PRINT INFORMATION

SECTION 1 - PATIENT INFORMATION

Patient's Name as shown on Medicare Card *(Last, First, Middle)*

Patient's Medicare Number exactly as it is shown on the Medicare card:	Date of Birth *(mm/dd/yyyy)*	○ Male ○ Female

Street address (or P.O. Box - include apartment number)

City	State	Zip code

Telephone number

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1490s-english.pdf

SECTION 2 - INFORMATION ABOUT SERVICES FURNISHED

FOR ALL CLAIMS including Influenza and Pneumococcal Vaccinations, describe the illness or injury for which you received treatment.

Attach all supporting documentation to the form including an itemized bill with the following information:

- Date of service
- Place of service
- Description of illness or injury
- Description of each surgical or medical service or supply furnished
- Charge for each service
- The doctor's or supplier's name and address
- The provider or supplier's National Provider Identifier (NPI) If known_____

IMPORTANT: If the itemized bill is from:

- A Clinical laboratory for ordered tests
- An independent diagnostic imaging center for ordered imaging procedures
- A supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for ordered DMEPOS

The ordering & referring providers legal name **MUST** be included on the itemized bill.

Please also include the ordering & referring providers National Provider Identifier (NPI) if known.

Was the condition related to:

◯ Yes ◯ No Employment

◯ Yes ◯ No Auto Accident

◯ Yes ◯ No Treatment for chronic dialysis or kidney transplant

◯ Yes ◯ No Other Accident

SECTION 3 - INFORMATION ABOUT HEALTH INSURANCE OTHER THAN MEDICARE

Complete this section if you are age 65 or older and enrolled in a health insurance plan where you or your spouse are currently working and covered by any medical coverage other than Medicare.

◯ Yes ◯ No Are you employed and covered under an employee health plan?

◯ Yes ◯ No Is your spouse employed and are you covered under your spouse's employee health plan?

◯ Yes ◯ No Do you have any medical coverage other than Medicare, such as private insurance, MEDIGAP, employment related insurance, Medicaid, or the Veterans Administration (VA)?

Name of other Medical Insurance

~~Policy Number including Medicaid ID Number~~

~~Policyholder's Name *(Last, First, Middle)*~~

Street Address (or P.O. Box) of other Medical Insurance

City | State | Zip code

Please attach a copy of your primary insurer's Explanation of Benefits if Medicare is secondary.

SECTION 4 - SIGNATURE

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

I authorize any holder of medical or other information about me to release it to the Centers for Medicare & Medicaid Services or its designated contractor or the Social Security Administration for this Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to me.

Signature of Patient	Date Signed *(mm/dd/yyyy)*

If you cannot sign your name, mark an (X) on the signature line. Have a witness sign his/her name next to the "X" and complete the section below.

If signing this form on behalf of a Medicare patient, on the 'Signature of Patient' line above, indicate the patient's name followed by "By" and sign your name. Provide your name, address, and relationship to the patient with a brief explanation why the patient cannot sign.

Name of Witness *(Last, First, Middle)*

Street Address

City	State	Zip code

Relationship to the Patient

Signature of Witness	Date Signed *(mm/dd/yyyy)*

Briefly explain why the Patient cannot sign:

Send the completed form and supporting documentation to your Medicare contractor. Reference the Medicare Administrative Contractor Address table for the correct address to mail your claim form. If you still do not know the address of your Medicare contractor, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

MEDICARE ADMINISTRATIVE CONTRACTOR ADDRESS TABLE

FOR INFLUENZA/PNEUMOCOCCAL VACCINATION, PART B (INCLUDES PHYSICIAN, LABORATORY, IMAGING SERVICES)

If you received a service in:	Mail your claim form, itemized bill and supporting documents to:
Alabama	Palmetto GBA, LLC Mail Code: AG-600 P.O. Box 100306 Columbia, SC 29202-3306
Alaska	Noridian Healthcare Solutions, LLC P.O. Box 6703 Fargo, ND 58108-6703
American Samoa	Noridian Healthcare Solutions, LLC P.O. Box 6777 Fargo, ND 58108-6777
Arkansas	Novitas Solutions, Inc. P.O. Box 3098 Mechanicsburg, PA 17055-1816 (Address to send Medicare 1490 claims via Priority mail or through a commercial courier (UPS, FedEx) for which a PO Box cannot be used, please use the following street address: Novitas Solutions, Inc. Attention: Claims Department 2020 Technology Parkway, Suite 100 Mechanicsburg, PA 17050
Arizona	Noridian Healthcare Solutions , LLC P.O. Box 6704 Fargo, ND 58108-6704
California Northern (For Part B)	Noridian Healthcare Solutions P.O. Box 6774 Fargo, ND 58108-6774
California Southern (For Part B)	Noridian Healthcare Solutions, LLC P.O. Box 6775 Fargo, ND 58108-6775
Colorado	Novitas Solutions P.O. Box 3107 Mechanicsburg, PA 17055-1823 (Address to send Medicare 1490 claims via Priority mail or through a commercial courier (UPS, FedEx) for which a PO Box cannot be used, please use the following street address: Novitas Solutions, Inc. Attention: Claims Department 2020 Technology Parkway, Suite 100 Mechanicsburg, PA 17050
Connecticut	National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178
Delaware	Novitas Solutions P.O. Box 3397 Mechanicsburg, PA 17055-1842
District of Columbia	Novitas Solutions P.O. Box 3396 Mechanicsburg, PA 17055-1841

Risk Management

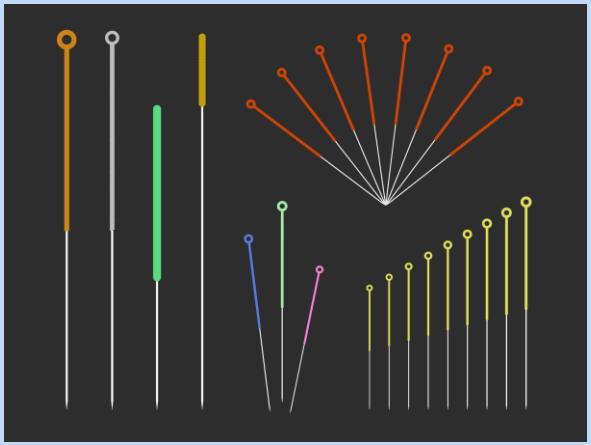
- Blood Thinners
  - The Medicare population has a higher use of blood thinners
  - The risk of bleeding and bruising is greater with acupuncture and cupping


Vickery Health & Wellness
Fatigue, Stress Tension
Anxiety, Depression, Mood Swings
Migraine and Tension Headaches
Digestive Disorders, Indigestion
Allergies, Asthma, Cough
Insomnia
Women's Health Complaints
Back, Neck and Knee Pain
Arthritis
Fibromyalgia
Autoimmune Disorders
Chronic Pain
Veterans Benefits Available
818.578.6730


Acupuncture
Acute & Chronic Pain Relief
• Neck-Shoulder-Low Back Pain
• Stress-Depression-Anxiety
• Insomnia-Migraine-Headache
• Arthritis-Sciatica
• Tendonitis-Carpal Tunnel
• Bell's Palsy-Stroke
• Nasal Allergy-Constipation
• Weight Control
• PMS-Menopause
Disposable Needles Only
Most Insurance Accepted

Acupuncture Has 2 Requirements To Be Properly Documented

- Time face to face with the patient
- Insertion of needle(s)



DOCUMENTATION GUIDELINES

Evaluation

An initial evaluation service is essential to determine whether any acupuncture services are medically necessary, to gather baseline data, establish a treatment plan, and develop goals based on the data. . . The initial evaluation service must include: An appropriate level of clinical history, examination, and medical decision-making relevant and appropriate to the individual's complaint(s) and presentation;

- Subjective historical evaluation based on standardize method such as the 10 questions;
- Specific standardized and non-standardized tests, assessments, and tools;
- Interpretation and synthesis of all relevant clinical findings derived from history and physical examination for the purpose of clinical decision-making;
- Subjective and objective measurable, description of functional status using comparable and consistent methods;
- Summary of clinical reasoning and consideration of contextual factors with recommendations;
- The establishment of a working diagnosis;
- Plan of care with specific treatment techniques or activities to be used in treatment sessions that should be updated as the individual's condition changes;
- Frequency and duration of treatment (treatment dose);
- Functional, measurable, and time-framed long-term and short-term goals based on appropriate and relevant evaluation data; and
- Prognosis and discharge plan.

Treatment Sessions

Acupuncture treatment can vary from Acupuncture alone (CPT codes 97810, 97811, 97813, 97814) to the use of a variety of modalities and procedures depending on the patient's condition, response to care, and treatment tolerance. All services must be supported in the treatment plan and be based on an individual's clinical condition. An acupuncture treatment session may include:

- A brief evaluation of the patient's progress and response to previous treatment(s);
- Acupuncture with or without electric stimulation
- Related passive modalities (e.g.: indirect moxibustion, hot/cold packs
- Functional education in self-care and home management
- Reassessment of the individual's condition, diagnosis, plan, and goals as part of the treatment session
- Coordination, communication, and documentation
- Reevaluation, if there is a significant change in the individual's condition or there is a need to update and modify the treatment plan

Documentation of treatment sessions should include at a minimum:

- Date of treatment
- Specific treatment(s) provided that match the procedure codes billed
- Total treatment time
- The individual's response to treatment
- Skilled ongoing reassessment of the individual's progress toward the goals
- Any progress toward the goals in objective, measurable terms using consistent and comparable methods
- Any barriers to expected progress or changes to the plan of care
- Name and credentials of the treating clinician

Measuring Progress in Acupuncture: Monitoring for clinically significant changes in historical/examination findings and functional status including, but not limited to:

- Pain level per VAS 1-10 scale and Frequency of symptoms
- Reported interference with daily functional activities

- Validated Functional Outcome Measures specific for condition (Clinically significant therapeutic progress (MCID, improvement in pain, impairments and objective evaluation findings)
- Length of time of relief after treatment rendered
- Monitoring for significant changes in reported patient medication or other resource utilization
- Tenderness on palpation
- Range of motion
- Observation (e.g. behavior, mobility, appearance of affected area)
- Barriers to expected progress (e.g.: co-morbid conditions, extremes of age, socio-economic factors)

Acupuncture Treatment Service: The Acupuncture service includes a brief assessment of the patient's condition, as well as documentation of the patient's response to the treatment. A reevaluation (an Established Patient E/M service) is indicated when services above and beyond the usual pre-service and post-service work associated with the acupuncture services is required. This may include circumstances where there are new clinical findings, a rapid change in the individual's status, or failure to respond to treatment interventions.

The E/M services may include all or some of the components of the initial evaluation, such as:

- Data collection with objective measurements taken based on appropriate and relevant assessment tests and tools using comparable and consistent methods;
- Clinical decision-making as to whether acupuncture care is still indicated;
- Organizing the composite of current health conditions and deciding a priority/focus of treatment;
- Identifying the appropriate intervention(s) for new or ongoing goal achievement;
- Modification of intervention(s);
- Revision in plan of care if needed;
- Evaluation of any meaningful changes in function;
- Deciphering effectiveness of intervention(s); and
- Updating the discharge plan as appropriate.

Standardized Tests and Measures/Functional Outcome Measures (FOMs)
Measuring outcomes is an important component of an acupuncturist's practice. Outcome measures are important in direct management of individual patient care and for the opportunity they provide the profession in collectively comparing care and determining effectiveness.

The use of standardized tests and measures early in an episode of care establishes the baseline status of the patient, providing a means to quantify change in the patient's functioning. Outcome measures, along with other standardized tests and measures used throughout the episode of care provide information about whether predicted outcomes are being realized. As the patient reaches the termination of acupuncture services and the end of the episode of care, the acupuncturist, again, measures the outcomes of their services. Standardized outcome measures provide a common language with which to evaluate the success of interventions, thereby providing a basis for comparing outcomes related to different intervention approaches. Measuring outcomes of care within the relevant components of function (including body functions and structures), activity, and participation, among patients with the same diagnosis, is the foundation for determining which intervention approaches comprise best clinical practice.

LITERATURE REVIEW

Acupuncture
The clinical utility of acupuncture is widely debated. Evaluating the clinical efficacy of acupuncture in the context of clinical trials is challenging primarily because of the difficulty of designing randomized trials with appropriate blinding of both subjects and providers. Many studies lack appropriate controls, adequate study size, randomization and/or consistent outcome measures.

Study controls for comparing real acupuncture (also referred to as verum acupuncture) typically include a placebo, sham acupuncture, standard treatment, or no treatment. Sham acupuncture is the most often used control in studies evaluating the efficacy of acupuncture. However, there is no standardized method for employing sham acupuncture and no consensus on needle placement, making it difficult to generalize findings across studies. The goal of applying sham acupuncture is to refrain from stimulating acupuncture points. In many studies, sham is

ACUPUNCTURE CODES

CPT Codes

97810 Acupuncture, one or more needles: without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.

97811 without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)

97813 Acupuncture, one or more needles, with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient

97814 with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)

How is the 15-minute session defined?

The 15-minute increment of time is defined as personal one-on-one contact with the patient. This means that the physician acupuncturist is in the room with the patient, and is actively performing a medically necessary activity that is a component of acupuncture or electroacupuncture (this would include a review of history, day-to-day evaluation, hand washing, choosing, and cleaning points, inserting and manipulating needles, removal, disposal as well as completion of the chart notes while the patient is present). The time that the needles are retained is specifically excluded to determine the time and consequently reimbursement.

1 unit (set) must include a minimum of 8 minutes face to face time with insertion (8-22 minutes = 1 unit) 2 units (sets) must be at least 23 minutes of face-to-face time (23-37 2 units)
3 units (sets)must be at least 38 minutes of face-to-face time (38-52 = 3 units)
4 units (sets) must be at least 53 minutes face-to-face (53-67 = 4 units)

Do I need to reinsert needle(s) to bill the add-on codes 97811 or 97814?

Yes. According to the CPT Assistant, June 2005/Volume 15, Issue 6, "re-insertion of the needle(s) is required for the use of add-on codes 97811 and 97814.

May I mix and match electrical and non-electrical stimulation procedures in the same session?

Yes. However, only one initial insertion of the needles is permitted per session per day. Therefore, per CPT, you should never code 97810 and 97813 on the same claim. If the first set is manual then code 97810 and if the subsequent set is electrical then 97814. You may code 97810 with 97811 or 97814. The same applies to 97813 it too can be coded with 97811 or 97814.

A simple rule of thumb is to never combine 97810 and 97813 on a single claim for acupuncture services because these two codes both describe an **initial** 15-minute treatment with the insertion of one or more needles.

Acupuncturists/East Asian Medicine Practitioners

Billing Guidelines

All claims must include both the International Classification of Diseases, Ninth Revision (ICD-9) and Current Procedural Terminology (CPT®) codes to ensure accurate processing. The diagnosis must match the diagnosis of the referring physician.

When billing for acupuncture services, please use:

- **CPT 97810** *Acupuncture, one or more needles; without electrical stimulation, initial 15 minutes of personal one on one contact with patient*
- **CPT 97811** *Acupuncture, one or more needles; without electrical stimulation, each additional 15 minutes of personal one on one contact with the patient, with reinsertion of needle(s) (List separately in addition to code for primary procedure)*
- **CPT 97813** *Acupuncture, one or more needles; with electrical stimulation, each additional 15 minutes of personal one on one contact with patient*
- **CPT 97814** *Acupuncture, one or more needles; with electrical stimulation, each additional 15 minutes of personal one on one contact with patient, with reinsertion of needle(s) (List separately in addition to code for primary procedure)*

CPT 97810 and **97813** will not be allowed when billed together for the same visit.

Only one unit of service for **CPT 97810** and **97813** is allowed per date of service, up to the benefit maximum. **CPT 97811** and **97814** must be explicitly denoted in the patient's medical record to be allowed.

8 Minute Rule for Timed Codes – One Service
For services billed in 15-minute units, count the minutes of skilled treatment provided. Only direct, face-to-face time with the patient is considered for timed codes.

- 7 minutes or less of a single service is not billable.
- 8 minutes or more of a single service is billable as 1 unit or an additional unit if the prior units were each furnished for a full one.

15 minutes:

- 8 – 22 minutes = 1 unit
- 23 – 37 minutes = 2 units
- 38 – 52 minutes = 3 units

Note: Evaluation and management (E&M) codes cannot be used as a substitute for acupuncture treatments.

Coding & Billing for Acupuncturists

Our health plan offers acupuncture benefits that may vary between products and employer groups. Therefore, it is important to check benefits and eligibility prior to rendering services. You can check benefits and eligibility via our website, Provider.ExcellusBCBS.com, or by contacting Customer Care at 1-800-920-8889.

Please follow the coding and billing guidelines established by the American Medical Association (AMA) to help ensure that your claims are processed accurately and timely.

The AMA Current Procedural Terminology (CPT) codes are used for acupuncture services:

- **97810** (acupuncture, 1 or more needles; without electrical stimulation, **initial** 15 minutes of personal one-on-one contact with the patient)
- **+97811** (acupuncture, 1 or more needles; without electrical stimulation, for each additional 15 minutes of personal one-on-one contact with the patient, with reinsertion of needles)
- **97813** (acupuncture, 1 or more needles; with electrical stimulation, **initial** 15 minutes of personal one-on-one contact with the patient)
- **+97814** (acupuncture, 1 or more needles; with electrical stimulation, for each additional 15 minutes of personal one-on-one contact with the patient, with reinsertion of needles)

According to the AMA CPT guidelines, acupuncture is reported based on 15 minute increments of personal (face-to-face) contact with the patient. For CPT codes **97810** and **97813**, the following specific preliminary activities are included in the initial service.

Preliminary Activities *Time spent performing these services is counted towards the 15 minutes personal contact time required for the initial service.*	
▪ Chart review	▪ Greeting patient
▪ Obtaining a brief account of the results of the previous treatment and any significant changes that have occurred since the last visit	▪ Hand washing
▪ Palpation of tender points	▪ Needle selection
▪ Marking and cleaning of sites	▪ Removal of needles and closure of sites

It's important to note that the initial acupuncture codes 97810 or 97813 may be billed only once during an encounter for needle insertion regardless of the number of needles inserted initially. In order to bill the add-on acupuncture codes **+97811** and/or **+97814**, the personal contact with the patient **must** include reinsertion of needle(s). This reinsertion does not mean removing and reinserting the same needle(s), but an additional insertion of a new needle(s).

Personal contact time applies when billing the add-on CPT codes as well. Only actual personal contact time performing acupuncture services counts. Total personal contact time along with sets of needles, removal of needles and reinsertion of new needles where applicable, must be documented in the patient's medical record. Please be aware that total needle retention time is not billable.

For additional coding and billing guidance, refer to the following web resources:

- **AMA CPT Manual:** http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page
- **AMA CPT Assistant:** https://www.aapc.com/code/ama-cpt-assistant.aspx

Provider.ExcellusBCBS.com

Excellus


Quiet Please

Optum
PO Box 105067
Atlanta, GA 30348

UnitedHealthcare®

10/27/2020 to 10/27/2020	97814		ACUP 1/> NDLS W/ELEC STIMJ EA 15 MIN W/RE-INSJ	$300.00	HP	The information submitted does not contain sufficient detail to support all related charges billed.

Claim/Coding Logic

Not supported. The medical records submitted do not indicate that the needles were reinserted and does not indicate the time spent face-to-face for this service.

Date	CPT Code	Mod	CPT Description	Claim Amount	Denial Code	Reason
10/19/2020 to 10/19/2020	97813		ACUPUNCTURE 1/> NDLS W/ELEC STIMJ 1ST 15 MIN	$225.00	HR	Charges were reconsidered and claim was processed per member benefits as a result of the additional information provided.

Claim/Coding Logic

Supported.

Date	CPT Code	Mod	CPT Description	Claim Amount	Denial Code	Reason
10/19/2020 to 10/19/2020	97814		ACUP 1/> NDLS W/ELEC STIMJ EA 15 MIN W/RE-INSJ	$300.00	HP	The information submitted does not contain sufficient detail to support all related charges billed.

Claim/Coding Logic

Not supported. The medical records submitted do not indicate that the needles were reinserted and does not indicate the time spent face-to-face for this service.

Date	CPT Code	Mod	CPT Description	Claim Amount	Denial Code	Reason

Two publications

1. CPT Changes An Insider's View 2005
2. CPT Assistant January 05:16-17, June 05:5, June 6:20, August 06:04

The key factor to documentation for acupuncture is that it requires two components

1. Documentation of face to face time
2. Documentation of points and sets

And they must be distinguished to demonstrate that the time meets the 8-minute standard for each set/unit and each set is clearly defined.

Treatment/ Needle Set 1
Face to face time 20 minutes
Points needled:
Shenman, UB 62 and SI3 bilaterally
R- Da Bu, R- Ling Gu, L Si Mi San (nose pt) GB34
E-stim added to UB62 and GB34
Needle retention time after insertion 12 minutes

After the patient rested with needles, withdrew and repositioned.

Treatment/ Needle Set 2
Face to face time 18 minutes
Points needled:
Hautojiji points from T7-L5 with E stim
GB30, UB32, UB40, UB62, SI3, GB34
E-stim added to Hautojiji points and ashi points (left hip)
Needle retention time after insertion 10 minutes

Note the above indicates 2 sets of electroacupuncture with a total time face to face 38 minutes. In total patient was treated for a total of 60 minutes with 38 minutes face to face

The 15-minute increment of time is defined as personal one-on-one contact with the patient. This means that the physician acupuncturist is in the room with the patient, is actively performing a medically necessary activity that is a component of acupuncture or electroacupuncture (this would include a review of history, day-to-day evaluation, hand washing, choosing, and cleaning points, inserting and manipulating needles, removal, disposal as well as completion of the chart notes while the patient is present). The time that the needles are retained is specifically excluded to determine the time and consequently reimbursement.

John Doe, LAc
121212 Broadway, Any City, USA 00000
555 -555-1212

Acupuncture SOAP Note

Patient Name: John Matthew **DOB:** 12/17/86 Date:

Chief Complaint: Lower back pain

Subjective – Sign/Symptoms (review of chief complaint):
Pain level today 5. Very stiff after prolonged sitting but overall moving more freely than initial. Stretching has been helping to relieve symptoms. Pain was significantly less after last treatment with pain about level 2 for several hours.

Objective

Tongue: pink body, slightly wet with thin white coat
Pulse: wiry
Palpation –Tenderness and spasm +2 lumbar paraspinal muscles greatest at L/S junction
ROM–Trunk flexion and extension increase pain and about 75% of normal

Assessment (diagnosis):	**ICD10**
Low back pain	**M54.59**
Muscle spasm of the back	**M62.830**

Treatment Plan:
3x week for 2 weeks visit 3 of 6
Reduce pain and restore normal ADL
Nourish Kidney Yin, Move Qi & Blood, relieve stagnation and pain.

Acupuncture	**Points Inserted/Re-inserted**	**Face to Face time**	**Retention time**
Set 1	GB 34, GB 41, LV 8	5:20-5:45pm	10 min
Set 2	LV 3, SI 3, SI 8, HT 7	5:55-6:05pm	5 min
Set 3	HT 3, LV 14, Ren 6, Ear SM	6:10-6:30pm	10 min

*Clean Needle Technique (CNT) is used in every treatment.
Face-to-face time includes day-to-day evaluation, hand washing, choosing and cleaning points, inserting and manipulating needles, monitoring, removal, and disposal of needles, and completion of the chart notes with patient present.

Therapy Code/description	**Area(s) of application**	**Time**
97026 Infra-red heat	Lumbar spine	20 min

Comments and responses to care: Pt reported pain as minimal post-care and had 100 ROM. Follow up at home with intermittent heat and knee to chest and hamstring stretches

Signature: Date:

EVALUATION & MANAGEMENT 2024 UPDATE

NEW PATIENT
A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

99202 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

99203 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99204 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

99205 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

ESTABLISHED PATIENT
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

99211 **Office or other outpatient visit** for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional.

99212 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

99213 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

99214 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99215 **Office or other outpatient visi**t for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

What Time Does Not Count

Time spent on activities normally performed by clinical staff

- Time spent on separately reportable services
  - Treatment
  - Travel

Time now represents total provider time spent on date of service, including:

- Physician or other qualified health care professional time includes the following activities, when performed:
- **Preparing to see the patient (eg, review of tests)**
- **Obtaining and/or reviewing separately obtained history**
- **Performing a medically appropriate examination and/or evaluation**
- **Counseling and educating the patient/family/caregiver**
- **Documenting clinical information in the electronic or other health record**
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

99201-99215 Code Selection

Code selection levels are now based on:

- Total time

  Spent by the provider on the day of visit face-to-face and non-face-to-face

  OR

- Level of Medical Decision Making (MDM)

  Severity and complexity of presenting problem

  Four types of MDM are recognized: straightforward, low, moderate, and high

Medical Decision Making

Includes 4 Levels

- Straightforward
- Low
- Moderate
- High

A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified healthcare professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice.

New Patient

- **99202** Meet or exceed15 min
- **99203** 30 minutes
- **99204** 45 minutes
- **99205** 60 minutes

Medical Decision Making*

- **99202** 1 self limited or minor problem
- **99203** 2 or more / acute injury
- **99204** Acute complicated injury
- **99205** Threat to life or bodily function