Back To Chiropractic Continuing Education Seminars

Workers' Compensation II: How to Get Paid!

~ 4 Hours

Welcome:

This course counts as 4 Hours of CE for the Chiropractic Board of Examiners for the state of California.

There is no time element to this course, take it at your leisure. If you read slow or fast or if you read it all at once or a little at a time it does not matter.

How it works:

1. **Helpful Hint: Print exam only and read through notes on computer screen and answer as you read.**
2. **Printing notes will use a ton of printer ink, so not advised.**
3. **Read thru course materials.**
4. **Take exam; e-mail letter answers in a NUMBERED vertical column to marcusstrutzdc@gmail.com.**
5. **If you pass exam (70%), I will email you a certificate, within 24 hrs, if you do not pass, you must repeat the exam. If you do not pass the second time then you must retake and pay again.**
6. **If you are taking the course for DC license renewal you must complete the course by the end of your birthday month for it to count towards renewing your license. I strongly advise to take it well before the end of your birthday month so you can send in your renewal form early.**
7. **Upon passing, your Certificate will be e-mailed to you for your records.**
8. **DO NOT send the state board this certificate.**
9. **I will retain a record of all your CE courses. If you get audited and lost your records, I have a copy.**

The Board of Chiropractic Examiners requires that you complete all of your required CE hours BEFORE you submit your chiropractic license renewal form and fee.

NOTE: It is solely your responsibility to complete the course by then, no refunds will be given for lack of completion.

Enjoy,

Marcus Strutz DC

CE Provider

Back To Chiropractic CE Seminars

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Utilization Review in Workers' Compensation

How to get paid in WC!

GLENN CRAFTS, B.S., D.C., Q.M.E.

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PRIVATE PRACTICE

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Types of Review

- **Prospective Review:** Conducted prior to the delivery of health care services
- **Concurrent Review:** Conducted when the patient is receiving the health care services or during hospitalization
- **Retrospective Review:** Conducted after the patient has received the health care services
- **Extension Review:** When additional information is requested on either a prospective or concurrent RFA
- **Reconsideration Review:** Conducted if the additional information requested by the URO is received after a decision was already made
- **Expedited Review:** Conducted if there is a serious and imminent threat to the health of the injured worker, and must be certified
- **Appeal Review:** Conducted after an adverse UR decision by a different physician reviewer who must be board certified and in the appropriate scope of practice
- **Peer to Peer Review:** Conducted after an adverse UR decision by the same physician reviewer

UR Required Decision Timeframes

Review Type:	Prospective	Concurrent	Retrospective	Expedited
When is it Performed?	Prior to delivery of services	While the service is being provided	After the service has been provided	Prior to delivery of services
Timeframe	5 Business Days from first receipt of request.	5 Business Days Same as prospective.	30 Days from receiving necessary information required to make decision.	72 Hours or less
Timeframe (Extension)	14 Calendar Days from date of receipt of the original RFA (If additional medical information is needed and request was made prior to 5th business day)	14 Calendar Days from date of receipt of the original RFA (If additional medical information is needed and request was made prior to 5th business day)	None	None

What is Day 0?

- Every provider requesting treatment must know when the decision is due.
- The majority of providers ask for treatment prospectively (i.e. before they render care).
- The initial day either the claims administrator or the Utilization Review Organization (URO) receive your Request for Authorization (RFA) is counted as Day 0 (zero).
- The decision is due within 5 business days unless a Request for Additional Information (RFI) is sent, which would extend the due date to the 14th calendar day.
- In the calendar example for November that follows, Day 0 is Friday the 4th, and absent an RFI, would be due on Monday the 14th (or the 5th business day after Veteran's day holiday.)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	31	1	2	3	4 **Prospective REQUEST RECEIVED COUNTED AS DAY 0**	5
6	7	8	9	10	11 Veteran's Day	12
13	14 **Prospective due if no addl. Info. requested**	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			3

California Treatment Guidelines

- MTUS - http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS/MTUS_Regulations.htm
- ACOEM – 2004, 2nd edition
- Official Disability Guidelines

- California's workers' compensation is highly regulated, and requires all requests for medical treatment go through (UR) Utilization Review (if the claims administrator will not immediately authorize the treatment).
- Treatment requests are only approved in UR if it meets the definition of Medical Necessity, which is determined by the mandated treatment guidelines above.
- The burden to prove medical necessity always remains with the applicant. In other words, the requesting provider must clearly substantiate the medical necessity within their Request for Authorization (RFA).

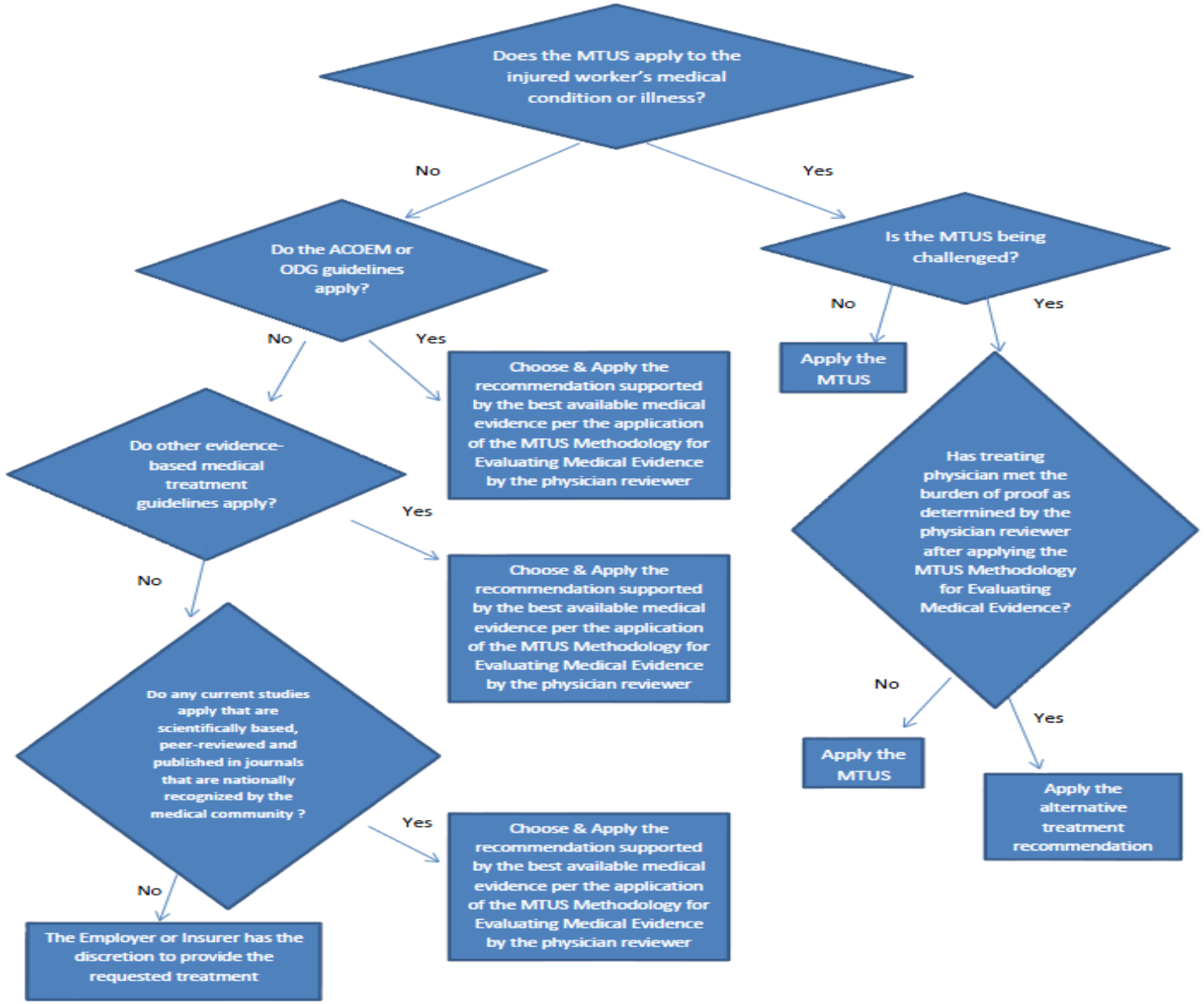
Guidelines

8 CCR § 9792.25. Presumption of Correctness, Burden of Proof and Strength of Evidence.

(a) The MTUS is presumptively correct on the issue of extent and scope of medical treatment and diagnostic services addressed in the MTUS for the duration of the medical condition. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the schedule is reasonably required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof.

(b) For all conditions or injuries not addressed by the MTUS, authorized treatment and diagnostic services shall be in accordance with other scientifically and evidence-based medical treatment guidelines that are nationally recognized by the medical community.

(c)(1) For conditions or injuries not addressed by either subdivisions (a) or (b) above; for medical treatment and diagnostic services at variance with both subdivisions (a) and (b) above; or where a recommended medical treatment or diagnostic service covered under subdivision (b) is at variance with another treatment guideline also covered under subdivision (b), the following ACOEM's strength of evidence rating methodology is adopted and incorporated as set forth below, and shall be used to evaluate scientifically based evidence published in peer-reviewed, nationally recognized journals to recommend specific medical treatment or diagnostic services:


Does the MTUS apply to the injured worker's medical condition or illness?
No
Yes
Do the ACOEM or ODG guidelines apply?
Is the MTUS being challenged?
No
Yes
No
Yes
Choose & Apply the recommendation supported by the best available medical evidence per the application of the MTUS Methodology for Evaluating Medical Evidence by the physician reviewer
Apply the MTUS
Do other evidence-based medical treatment guidelines apply?
Has treating physician met the burden of proof as determined by the physician reviewer after applying the MTUS Methodology for Evaluating Medical Evidence?
Yes
Choose & Apply the recommendation supported by the best available medical evidence per the application of the MTUS Methodology for Evaluating Medical Evidence by the physician reviewer
No
No
Yes
Apply the MTUS
Apply the alternative treatment recommendation
Do any current studies apply that are scientifically based, peer-reviewed and published in journals that are nationally recognized by the medical community ?
Yes
Choose & Apply the recommendation supported by the best available medical evidence per the application of the MTUS Methodology for Evaluating Medical Evidence by the physician reviewer
No
The Employer or Insurer has the discretion to provide the requested treatment

What is an RFA?

- **RFA = Request for Authorization**
- Providers in workers' compensation must request for treatment authorization in 1 of 3 ways:
- **DFR (Doctor's First Report)/5021**
- **PR-2 (Progress Report)**
- **Narrative RFA**
- The DFR & PR-2 are both standardized forms found at the DWC's website for download.

Chiropractic Guidelines by Body Part

- **Neck Pain** (ODG) states 9 visits over 8 weeks.
- **Cervical Strain** (ODG) states (Grade I) = 6 visits over 3 weeks; (Grade II) = 6 visits over 3 weeks; (Grade III) = 10 visits over 6 weeks; (Severe Grade III) = Up to 25 visits over 6 months.
- **Cervical Radiculopathy** (ODG) states 6 visits over 3 weeks; with functional improvement 18 visits over 8 weeks.
- **Cervical/Post Laminectomy** (ODG) states 14-16 visits over 12 weeks.
- **Low Back** (ODG) states (Mild) = 6 visits over 2 weeks; (Severe) = 6 visits over 2 weeks; (Severe w/objective/functional improvement) = 18 visits over 8 weeks.
- **Low Back (Flare-Ups)** = 1-2 visits every 4-6 months.
  Hip (ODG) states up to 10 visits.

Functional Improvement

- **Physical Impairments** (e.g., joint ROM, muscle flexibility, strength, or endurance deficits): Include objective measures of clinical exam findings. ROM should be in documented in degrees.

- Approach to Self-Care and Education Reduced Reliance on Other Treatments, Modalities, or Medications: This includes the provider's assessment of the patient compliance with a home program and motivation. The provider should also indicate a progression of care with increased active interventions (vs. passive interventions) and reduction in frequency of treatment over course of care. (California, 2007)

- For chronic pain, also consider return to normal quality of life, e.g., go to work/volunteer each day; normal daily activities each day; have a social life outside of work; take an active part in family life. (Cowan, 2008)

Qualifications of Personnel

- No person, other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the licensure and scope of the physician's practice, can delay, modify or deny, requests for authorization (RFAs) of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury.

The UR Determination

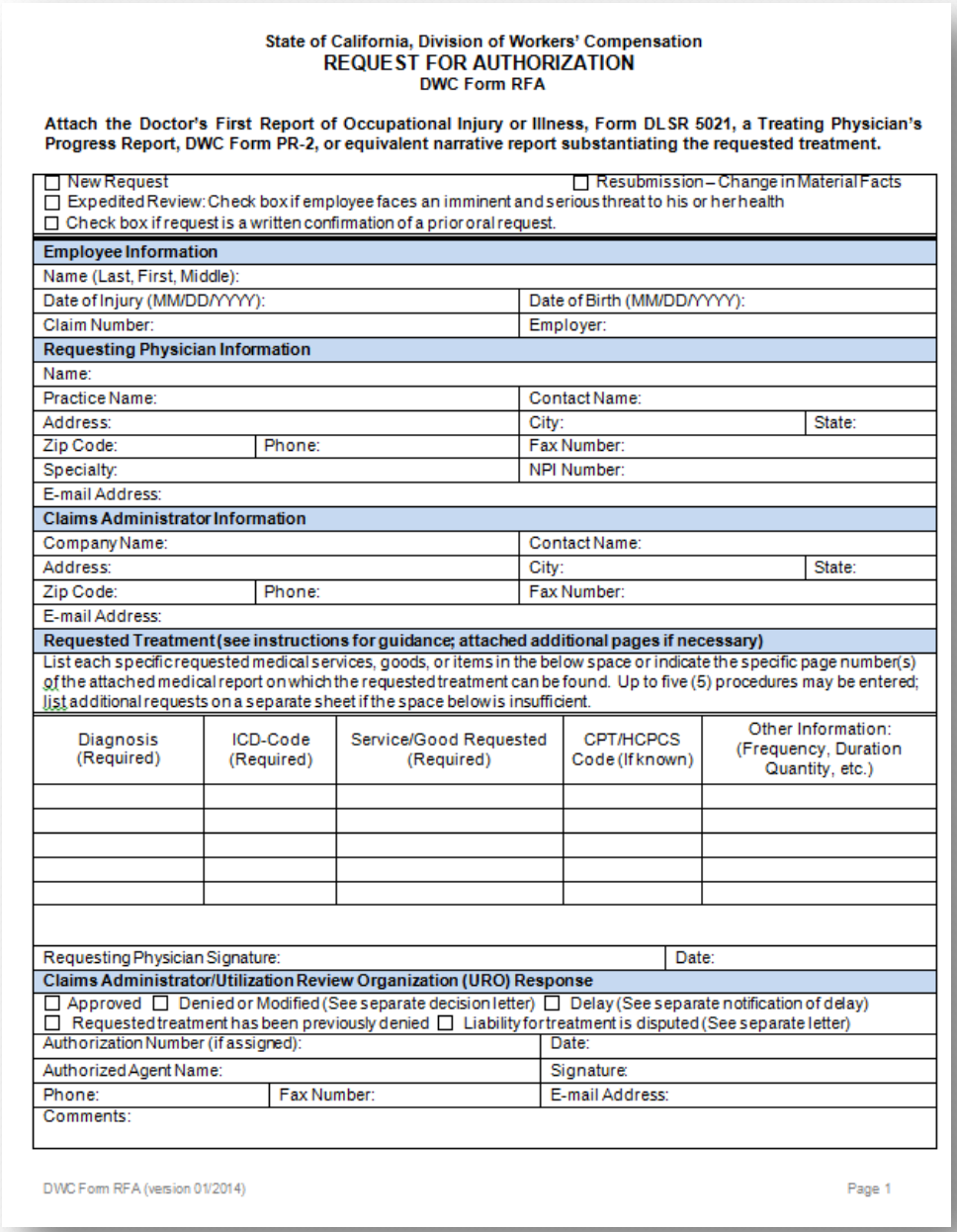
- A Utilization Review determination communication **by telephone** shall be **followed by written notice** to the physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours for concurrent review and within two business days for prospective review.
- 5:30 PST = End of Business Day (M-F)

DWC Form RFA

Documenting an **Incomplete DWC form RFA**:

- DWC Form RFA that:
- does not identify the employee or provider,
- does not identify a recommended treatment,
- is not accompanied by documentation (i.e. DFR, PR-2, RFA Narrative) substantiating the medical necessity for the requested treatment,
- or is not signed by the requesting physician,

Complete the DWC Form RFA and attach to your treatment request every time.



State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

☐ New Request ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
☐ Check box if request is a written confirmation of a prior oral request.

Employee Information			
Name (Last, First, Middle):			
Date of Injury (MM/DD/YYYY):		Date of Birth (MM/DD/YYYY):	
Claim Number:		Employer:	
Requesting Physician Information			
Name:			
Practice Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
Specialty:		NPI Number:	
E-mail Address:			
Claims Administrator Information			
Company Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
E-mail Address:			

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)

Requesting Physician Signature:	Date:

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

DWC Form RFA (version 01/2014) Page 1

Independent Bill Review
IBR *Fees ($)*

- Any IBR application submitted on or after January 1, 2015 will be subject to the following fee schedule:

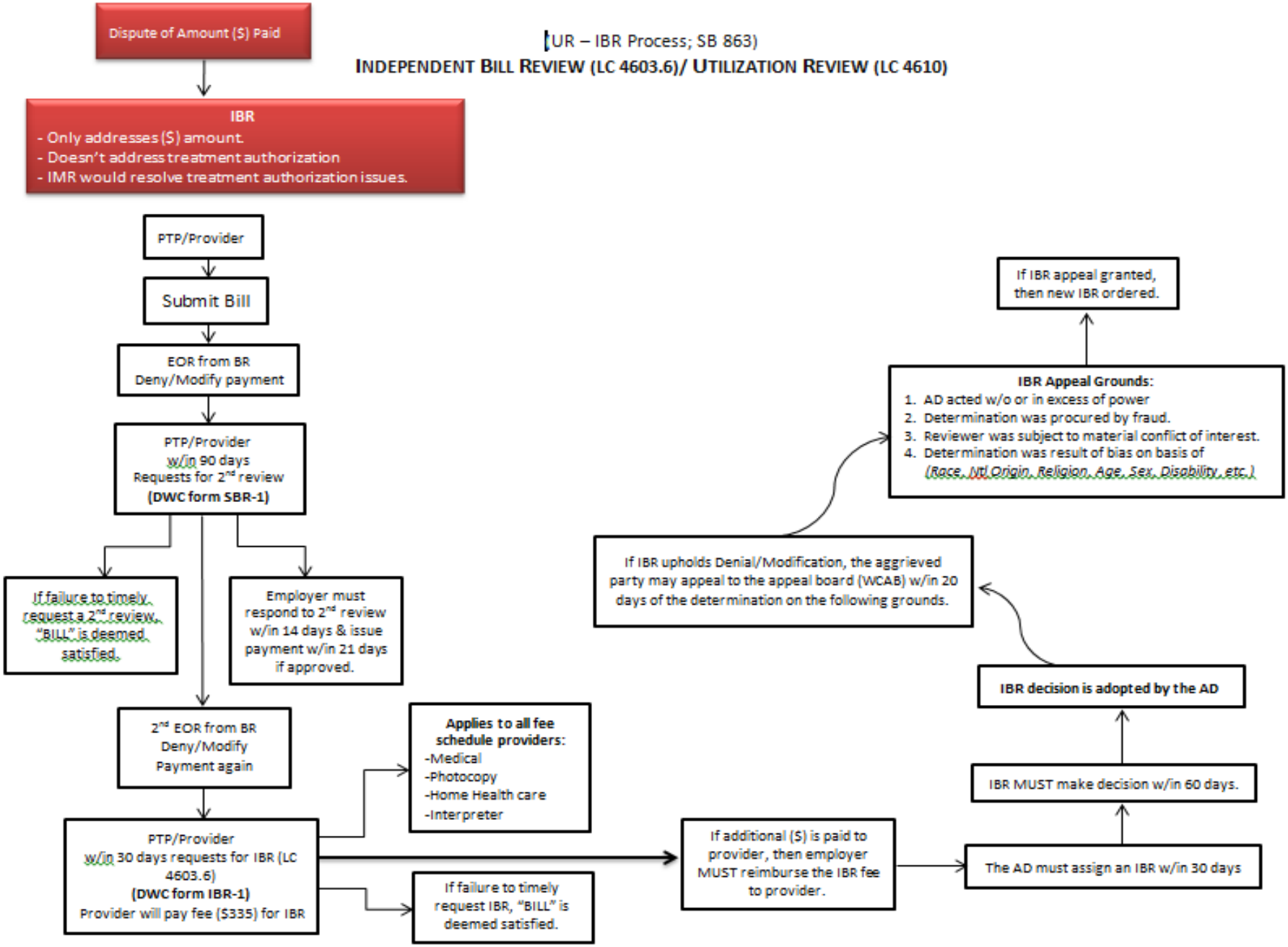
- *Completed IBR*
  Fee effective April 1, 2014: $250 per IBR
  Fee effective Jan. 1, 2015: $195 per IBR

- *Ineligible IBR Not Sent to Review****
  Fee effective April 1, 2014: $50.00 per IBR
  Fee effective Jan. 1, 2015: $47.50 per IBR

- *** Sending an IBR to review means assigning and providing the complete file to a certified coding specialist with the expertise necessary to evaluate and render decisions on all line items in dispute.

UR – IBR Process; SB 863)

INDEPENDENT BILL REVIEW (LC 4603.6)/ UTILIZATION REVIEW (LC 4610)



Independent Bill Review
IBR *Application*

- In order to contest a non-payment for treatment, the provider must first request for a 2nd Bill Review.
- The 2nd Bill Review does not cost anything for the provider to contest.
- If payment is still disputed after the outcome of the 2nd Bill Review, then the provider may submit the application for IBR.
- The provider does pay a fee for IBR.
- The following slide contains the IBR application form that must be completed and submitted with your documentation explaining why payment should be made.
- Refer to the prior slide for the IBR algorithm.

PRINT CLEAR

State of California
Division of Workers' Compensation
Request for Independent Bill Review
California Code of Regulations, title 8, section 9792.5.8

Employee Information	
Employee Name (Last, First, Middle):	
Date of Injury (MM/DD/YYYY):	Claim Number:
Date of Birth (MM/DD/YYYY):	Employer Name:
Provider Information	
Provider Name:	Contact Name:
Address:	
Phone:	Fax Number:
E-mail Address:	NPI Number:
Provider Type: ☐ Ambulance ☐ Clinical Laboratory ☐ DMEPOS Supplier ☐ Inpatient Hospital ☐ Hospital Outpatient ☐ Interpreter ☐ Ambulatory Surgical Center ☐ Pharmacy ☐ Qualified Medical Evaluator ☐ Agreed Medical Evaluator ☐ Treating Physician ☐ Other Practitioner – specify:_____	
Provider Specialty:	
Claims Administrator Information	
Claims Administrator Name:	Contact Name:
Address:	
Phone:	Fax Number:
E-mail Address:	
Bill Information	
Applicable Fee Schedule(s): ☐ Physician Services ☐ Inpatient Hospital Services ☐ Hospital Outpatient Departments and Ambulatory Surgical Centers ☐ Pharmaceutical ☐ Pathology and Laboratory Services ☐ DMEPOS ☐ Ambulance Services ☐ Medical-Legal Fee Schedule ☐ Interpreter ☐ Other – specify:_____ Or: ☐ Contract for Reimbursement Rates	
Date of Second Bill Review Decision (MM/DD/YYYY):	Was Billed Service Authorized? ☐ Yes ☐ No
Date of Service (MM/DD/YYYY):	
Service/Good Code in Dispute (include modifier, if any):	
Amount Billed: / Amount Paid: / Amount in Dispute:	
Reason for Disputing Reduction or Denial of Full Payment:	
Consolidation	
Should the Request be Consolidated with Other Disputed Billed Services or Goods? ☐ Yes ☐ No	
Reason for Consolidation:	
Disputed Service/Good to be Consolidated (list all; use attachment if necessary):	
Date of Service (MM/DD/YYYY):	
Service/Good Code in Dispute (include modifier, if any):	
Amount Billed: / Amount Paid: / Amount in Dispute:	
Reason for Disputing Reduction or Denial of Full Payment:	
Documents to Accompany Request (Must be Indexed and Separated)	
The original billing itemization and original supporting documentation.	
The explanation of review provided in response to the original billing.	
The request for second bill review and original documentation supporting second review.	
The explanation of review provided in response to the second bill review request.	
If applicable, the relevant contract provisions for reimbursement rates.	
Provider Signature: / Date:	
If mailed, send to: DWC-IBR c/o Maximus Federal Services, Inc., 625 Coolidge Drive, Suite 100, Folsom, CA 95630. Concurrently send a copy of this request to the Claims Administrator.	

SB863 vs. Duplicate RFAs

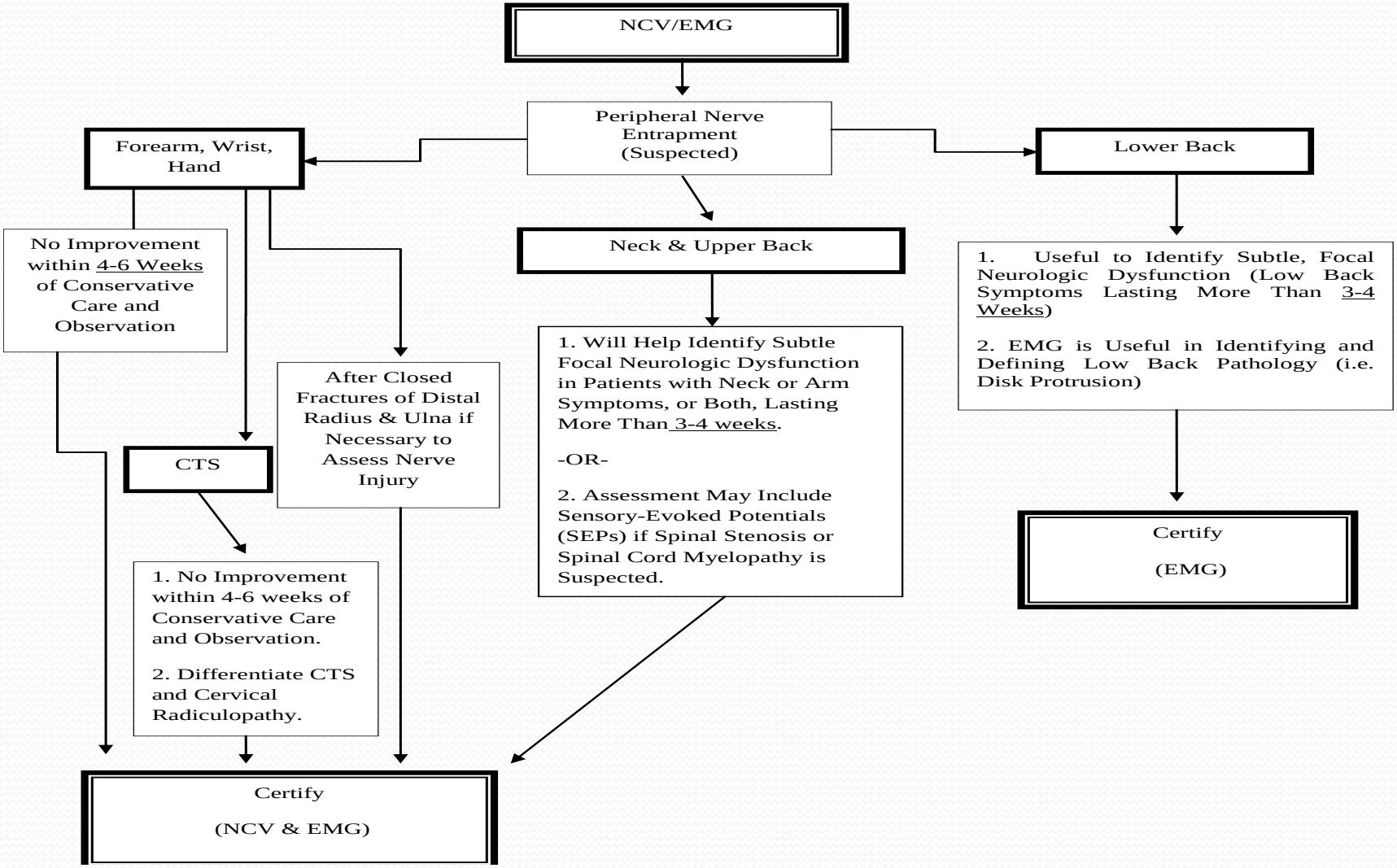
- UR determinations that modify, delay, or deny treatment recommendations are considered **valid for 12 months** absent any documented change in facts material to the basis of the utilization review decision.
- This will **eliminate needless UR on duplicate RFAs**.
- Same treatment requests from a different requesting provider will not be considered duplicative and are subject to UR based on unique and different medical evidence presented in the individual RFA.

- Title 8, California Code of Regulations 9792.9.1(h) provides that a utilization review decision to modify, delay, or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision

  If there was no documented change in the facts material to the basis of the earlier utilization review decision provided with your current DWC Form RFA, then no utilization review will be done on your DWC Form RFA listing the same treatment.

Algorithm for NCV/EMG

- The following algorithm will help the requesting provider determine if their patient meets the criteria defined in the medical treatment guidelines.
- The doctor must be sure to include the details in the guidelines to justify to UR that the treatment is in fact medically necessary.
- UR is only looking for medical necessity and the decision must be based on the treatment guidelines.
- Doctors who do not follow the treatment guidelines will most likely never have their treatment requests approved in UR.


NCV/EMG
Peripheral Nerve Entrapment (Suspected)
Forearm, Wrist, Hand
Neck & Upper Back
Lower Back
No Improvement within 4-6 Weeks of Conservative Care and Observation
After Closed Fractures of Distal Radius & Ulna if Necessary to Assess Nerve Injury
CTS
1. No Improvement within 4-6 weeks of Conservative Care and Observation.
2. Differentiate CTS and Cervical Radiculopathy.
1. Will Help Identify Subtle Focal Neurologic Dysfunction in Patients with Neck or Arm Symptoms, or Both, Lasting More Than 3-4 weeks.
-OR-
2. Assessment May Include Sensory-Evoked Potentials (SEPs) if Spinal Stenosis or Spinal Cord Myelopathy is Suspected.
1. Useful to Identify Subtle, Focal Neurologic Dysfunction (Low Back Symptoms Lasting More Than 3-4 Weeks)
2. EMG is Useful in Identifying and Defining Low Back Pathology (i.e. Disk Protrusion)
Certify (EMG)
Certify (NCV & EMG)

ICD-9 vs. ICD-10

- ICD-9 is outdated – adopted since 1979
- ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list maintained by the World Health Organization (WHO).

- The deadline for U.S. providers to begin using Clinical Modification ICD-10-CM for diagnosis coding and Procedure Coding System ICD-10-PCS for inpatient hospital procedure coding is October 1, 2015.

- Forms affected include 5021 (Doctor's First Report of Occupational Injury or Illness), PR-2 (Primary Treating Physician's Progress Report), PR-3 and PR-4 (Primary Treating Physician's Permanent and Stationary Reports).

ICD-10-CM

- ICD-10 (uses 3 to 7 digits) vs. ICD-9 (uses 3 to 5 digits)
- Coding format is similar
- ICD-10 captures laterality, fractures, subsequent encounters…
- ICD-10 offers improved metric tracking

- Digits 1-3: Category
- Digits 4-6: Etiology, Anatomical Site, Severity
- Digit 7: Extension (Injuries & External causes)

- Digit 1: Alpha (Not U)
- Digit 2: Numeric
- Digit 3, 4, 5, 6, 7: Any combination of Alpha or Numeric values

- A: Initial encounter
- D: Subsequent encounter
- S: Sequela
- X: Dummy placeholder for future coding expansion

ICD-10-CM

- ICD-10 does not affect CPT procedural coding
- ICD-10 will affect everyone covered by the Health Insurance Portability Accountability Act (HIPAA), not just Medicare & Medicaid claims
- **ICD-10-CM Code Structure**
- ICD-10 diagnosis codes have between 3 and 7 characters
- Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of any or all of the 4th, 5th, and 6th characters.
- Digits 4-6 provide more detail of etiology, anatomical site, and severity.
- A code using only the first three digits can only be used if it cannot be subdivided further.

ICD-10-CM

- The ICD-10 code will be invalid if you have not coded to the maximum number of characters required.
- Note: Not all ICD-10 codes must have 7 characters.

- ICD-10 coding can have a remarkable impact on your reimbursement

ICD-10-CM (GEM)

- **General Equivalency Mapping (GEM):**
- Bidirectional conversions between ICD-9 vs. ICD-10
- Not intended to be crosswalks.
- A tool to help map/code accurately
- Clinical judgement & decision making is still critical
- Read the coding instructions

- ICD10Data.com
- CMS.gov/icd10
- ICD10CODEsearch.com
- http://www.acatoday.org/icd-10-code-conversion/

ICD-10-CM

- What can you do immediately to take action?
- Identify common diagnoses used and compare ICD-9 vs. ICD-10.
- **Example:**
- Displacement of lumbar intervertebral disc without myelopathy
- ICD-9: **722.10**
- ICD-10: **M51.26** Other intervertebral disc displacement, lumbar region
- ICD-10: **M51.27** Other intervertebral disc displacement, lumbosacral region

ICD-10-CM

- **Example:**
- Cervical Disc Disorders - Radiculopathy
- ICD-9: **723.4**
- ICD-10: **M50.0** Cervical Disc Disorder with Radiculopathy (Not Billable – Must specify 5th digit)
- ICD-10: **M50.10** Unspecified Cervical Region
- ICD-10: **M50.11** High Cervical Region
- ICD-10: **M50.12** Mid-Cervical Region
- ICD-10: **M50.13** Cervicothoracic Region

ICD-9 to ICD-10 Crosswalk

Diagnosis	ICD-9	ICD-10
Cervicalgia	723.1	M54.2
Thoracic Myofascial Pain	724.1	M54.6
Lumbago	724.2	M54.5
Cervical Sprain of ligaments, initial encounter	847.0	S13.4XXA
Cervical Sprain of joints and ligaments of other parts, initial encounter	847.0	S13.8XXA
Thoracic Sprain of ligaments, initial encounter	847.1	S23.3XXA
Thoracic Sprain of other specified parts, initial encounter	847.1	S23.8XXA
Lumbar Sprain of ligaments, initial encounter	847.2	S33.5XXA
Carpal Tunnel Syndrome	354.0	G56.00
Ankle Sprain of unspecified ligament, initial encounter (unspecified ankle)	845.00	S93.409A
Ankle strain of unspecified muscle and tendon and foot, initial encounter (unspecified ankle)	845.00	S96.919A
Ankle Sprain of unspecified ligament (Right Ankle), initial encounter	845.00	S93.401A
Ankle Sprain of unspecified ligament (Left Ankle), initial encounter	845.00	S93.402A
Spasmodic Torticollis	723.5	M43.6
Cervicogenic Headache	784.0	R51
Headache Vascular, not elsewhere classified	784.0	G44.1
Concussion without LOC	850.0	S06.0X0A
De Quervain - Radial Styloid tenosynovitis	727.04	M65.4
Thoracic, Thoracolumbar, Lumbosacral intervertebral disc disorder unspecified	722.2	M51.9
Wrist pain unspecified	719.4	M25.539
Elbow - Lateral Epicondylitis, unspecified elbow	726.32	M77.10
Elbow - Medial Epicondylitis, unspecified elbow	726.31	M77.00
Headache - Post-Traumatic, unspecified	339.20	G44.309
MVA - Driver	E812.0	V49.88XA
MVA - Passenger	E812.1	V49.59XA

ICD-9 to ICD-10 Crosswalk

Cervical Radiculopathy	723.40	M54.12
Thoracic Radiculopathy	724.4	M54.14
Lumbar Radiculolapthy	724.4	M54.16
Lumbosacral Radiculopathy	724.4	M54.17

ICD-9 to ICD-10 Crosswalk

Head Segmental Dysfunction	739.0	M99.00
Cervical Segmental Dysfunction	739.1	M99.01
Thoracic Segmental Dysfunction	739.2	M99.02
Lumbar Segmental Dysfunction	739.3	M99.03
Sacral Segmental Dysfunction	739.4	M99.04
Pelvic Segmental Dysfunction	739.5	M99.05
Lower Extremity Segmental Dysfunction	739.6	M99.06
Upper Extremity Segmental Dysfunction	739.7	M99.07
Rib Cage Segmental Dysfunction	739.8	M99.08

ICD-10 Grace Period

- The DWC amended draft regulations to implement the transition to the 10th edition of the International Classification of Disease to provide a one-year grace period.
- Payers are directed to disregard minor errors caused solely by the more detailed billing codes in ICD-10.
- The DWC followed the lead of Medicare and Medicaid services.
- Coding the wrong laterality should be fine within the first year, but coding the wrong body part (i.e. knee vs. elbow), would not be acceptable.

Outcome Measure Tools

- Use outcome measure tools to document that your patient has functional improvement.
- Use appropriate outcome measure tools based on the body part treated.
- Document how the outcome measure tool changes over time to demonstrate if treatment is gaining functional improvement.

Outcome Measure Tools

NECK DISABILITY INDEX QUESTIONNAIRE

Patient Name _____ **Date** _____

Please read carefully:

*This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only **ONE CHOICE** which applies to you. We realize you may consider that two of the statements in any one section relate to you but please just mark the one box, which most closely describes your problem right now.*

SECTION 1 – Pain Intensity
A. I have no pain at the moment.
B. The pain is very mild at the moment.
C. The pain is moderate at the moment.
D. The pain is fairly severe at the moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

SECTION 2 – Personal Care (washing, dressing, etc.)
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, wash with difficulty and stay in bed.

SECTION 3 – Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives extra pain.
C. Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
D. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 – Reading
A. I can read as much as I want with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I can hardly read at all because of severe pain in my neck.
F. I cannot read at all.

SECTION 5 - Headaches
A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 – Concentration
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I cannot concentrate at all.

SETION 7 – Work
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8 – Driving
A. I can drive without any neck pain.
B. I can drive as long as I want with slight pain in my neck.
C. I can drive as long as I want with moderate pain in my neck.
D. I cannot drive as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9 – Sleeping
A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hr. sleepless).
C. My sleep is mildly disturbed (1-2 hrs. sleepless).
D. My sleep is moderately disturbed (2-5 hrs. sleepless).
E. My sleep is greatly disturbed (3-5 hrs. sleepless).
F. My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 – Recreation
A. I am able to engage in all my recreation activities with no neck pain at all.
B. I am able to engage in all my recreation activities with some pain in my neck.
C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
D. I am able to engage in a few of my usual recreation activities because of pain in my neck.
E. I can hardly do any recreation activities because of pain in my neck.
F. I cannot do any recreation activities at all.

OTHER COMMENTS:

_____

_____

_____

_____
Examiner

With Permission from: Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415.

Outcome Measure Tools

The Roland-Morris Low Back Pain and Disability Questionnaire

Patient name: _____ **File #**_____ **Date:**_____

Please read instructions: When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

- ☐ I stay at home most of the time because of my back.
- ☐ I change position frequently to try to get my back comfortable.
- ☐ I walk more slowly than usual because of my back.
- ☐ Because of my back, I am not doing any jobs that I usually do around the house.
- ☐ Because of my back, I use a handrail to get upstairs.
- ☐ Because of my back, I lie down to rest more often.
- ☐ Because of my back, I have to hold on to something to get out of an easy chair.
- ☐ Because of my back, I try to get other people to do things for me.
- ☐ I get dressed more slowly than usual because of my back.
- ☐ I only stand up for short periods of time because of my back.
- ☐ Because of my back, I try not to bend or kneel down.
- ☐ I find it difficult to get out of a chair because of my back.
- ☐ My back is painful almost all of the time.
- ☐ I find it difficult to turn over in bed because of my back.
- ☐ My appetite is not very good because of my back.
- ☐ I have trouble putting on my sock (or stockings) because of the pain in my back.
- ☐ I can only walk short distances because of my back pain.
- ☐ I sleep less well because of my back.
- ☐ Because of my back pain, I get dressed with the help of someone else.
- ☐ I sit down for most of the day because of my back.
- ☐ I avoid heavy jobs around the house because of my back.
- ☐ Because of back pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of my back, I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because of my back.

Instructions:

1. The patient is instructed to put a mark next to each appropriate statement.

2. The total number of marked statements are added by the clinician. Unlike the authors of the Oswestry Disability Questionnaire, Roland and Morris did not provide descriptions of the varying degrees of disability (e.g., 40%-60% is severe disability).

3. Clinical improvement over time can be graded based on the analysis of serial questionnaire scores. If, for example, at the beginning of treatment, a patient's score was 12 and, at the conclusion of treatment, her score was 2 (10 points of improvement), we would calculate an 83% (10/12 x 100) improvement.

Attach the DWC Form RFA to your Request

- Always attach the DWC Form RFA to your treatment request (i.e. Doctor's First Report, PR-2, or Narrative Request for Authorization (RFA).
- Your treatment request may not be addressed if you do not include the DWC Form RFA.

Sample DWC form RFA

- The following is a sample of a completed DWC form RFA.
- Be sure to always include the DWC form RFA with your treatment requests by attaching to your DFR/PR-2 or Narrative RFA.
- Be sure to include the procedural codes being requested (i.e. 98940, 97140-59, etc.)
- Be sure to include the diagnoses.
- Be sure to include the duration, frequency, quantity being requested.
- Be sure to sign your request.

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

☒ New Request ☐ Resubmission – Change in Material Facts

☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health

☐ Check box if request is a written confirmation of a prior oral request.

Employee Information			
Name (Last, First, Middle): LAST, First			
Date of Injury (MM/DD/YYYY): 03/07/2014		Date of Birth (MM/DD/YYYY): 06/20/1920	
Claim Number: 1234567890 EAMS#: ADJ-123456		Employer: City of San Jose	
Requesting Physician Information			
Name: Glenn Crafts, DC			
Practice Name: Chiropractic Pain Care Center		Contact Name: Glenn Crafts	
Address: 123 Rose Blvd., Suite 123		City: San Jose	State: CA
Zip Code: 95128	Phone: 408-555-1234	Fax Number: 408-555-1235	
Specialty: Chiropractic		NPI Number: 1234567890	
E-mail Address:			
Claims Administrator Information			
Company Name: Managed Care Administrators		Contact Name:	
Address: PO Box 123		City: Concord	State: CA
Zip Code: 94522	Phone: 925-555-1234	Fax Number: **925-555-1235**	
E-mail Address:			
Requested Treatment (see instructions for guidance; attached additional pages if necessary)			
List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.			

Note: Myofascial Release CPT = 97140 97250 is now obsolete.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Lumbosacral Radiculitis	724.4	Chiropractic Manipulation	98940	8 Treatments
Lumbosacral Radiculitis	724.4	Myofascial Therapy	97250	8 Treatments
Lumbosacral Radiculitis	724.4	Therapeutic Exercise	97110	8 Treatments
Lumbosacral Radiculitis	724.4	Interferential Therapy	97014	8 Treatments
Lumbosacral Radiculitis	724.4	Ultrasound	97035	8 Treatments
Lumbosacral Radiculitis	724.4	Traction	97012	8 Treatments

Requesting Physician Signature:	Date: **04/8/2015**

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

Sample PR-2 (RFA)

- The following is a sample of a completed PR-2 Request for Authorization.
- Make sure you don't forget to attach the DWC form RFA with your treatment request.
- Include the procedural codes being requested (i.e. 98940, 97140-59, etc.)
- Include the diagnoses.
- Include the duration, frequency, quantity being requested.
- Sign your request.
- Review the treatment guideline and make sure you document how your patient meets the required criteria for medical necessity.
- Document Functional Improvement
- (i.e. ADLs, Outcome Measures, Pain Scale, AROM, Muscle Strength, Neuro findings, Ortho Tests, Diagnostics, Consult findings, QME/AME/Med-Legal Findings, Work Status, etc.)

State of California Additional Pages Attached ☐
Division of Worker's Compensation

PRIMARY TREATING PHYSICIANS PROGRESS REPORT (PR-2)

Check the box (es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e. has reached maximum medical improvement), do not use this form. You may use DWC Form PR-3 or IMC Form 81556.

☒ Periodic Report (required 45 days after last report) ☒ **Change in treatment plan** ☐ Discharged
☐ **Change in work status** ☐ Need for referral or consultation ☐ Info. Requested by: _____
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☒ other: **RFA (Prospective- 8 Visits)**

Patient:
Last: WORKER First: Joe M.I: Sex: M DOB: 06/20/29
Address: 1001 Street Drive City: San Jose State: CA Zip: 95123
Occupation: Operator SS#: 000-00-0000 Phone: 555-555-0000
Claims Administrator: 925-555-0000 Claims Examiner: Adjustor Jones Email: adjustor@adjustor.com
Name: **Claims Administrator** Claim Number: **123456789** **EAMS#: ADJ-12345** D.O.I.: 03/07/2014
Address: PO Box 000 City: San Jose: CA Zip: 94123 **UR Fax: 000-555-0000**
Employer name: City of ABC

Subjective complaints: (As of 04/06/15)

Patient has continued to show and demonstrate functional improvement with treatment to date. The outcome measures listed below clearly confirms that he has improved with diminishing Roland Morris scores, which began at 11/50 to now 5/50. He continues to work full duty without any restrictions. I kindly request that an additional 8 visits be authorized to continue to gain function, increase range of motion, decrease pain, and fully restore ADLs to this injured worker and most importantly to prevent losing any gains to date with regard to the aforementioned and including strength, limited neurological deficits/paresthesias into his lower extremity and ability to perform his work duties. The goal is to continue to achieve positive symptomatic and objective measureable gains in functional improvement to return to pre-injury level. He previously reported moderate lower back pain that may become severe and refers into the right lower extremity, which is now reported as slight pain becoming moderate pain at its worst. Frequency of pain is also decreased with care from frequent to constant, which is now intermittent. Difficulty to perform ADLs has also improved (i.e. able to drive/ride motorcycle longer without back/leg pain, improved lifting, pushing, pulling ability with diminished LBP).

Objective findings: (As of 04/08/15)

Inspection: Right antalgic lean resolved.

Palpation: Palpable tenderness/trigger points with moderate (previously severe) spasm over lumbar paraspinals, right quadratus lumborum, and right piriformis. Right posterior serratus inferior trigger point resolved.

Lumbar AROM: Moderately (previously severely) diminished with flexion, extension; Slight (previously moderately) decreased with left (previously bilateral) lateral flexion and rotation.

Orthopedic Exam: (+) SLR on the right for localized SI joint pain & upper hamstrings. (prior pain into the right gluteus resolved). (+) Right Seated Kemps for SI joint pain locally (previously elicited radiation into the right gluteus.) Valsalva was unremarkable. Seated Dural Nerve Root Stretch test produced localized lumbar pain/restriction in forward flexion.

Myotomal Testing: (4-5/5) Lumbar pain with psoas resolved, but mild to slight pain with quadriceps and slight to moderate pain with hamstrings testing.

Neurological Testing: DTR's +2/4 B/L UE. Other neuro tests unremarkable (light touch, 2 pt discrimination, vibration)

Outcome Measure Tools: Roland Morris

03/23/15=RM: **11**/50
04/06/15=RM: **5**/50

Diagnoses:

1. LUMBAR SPINE UNSPEC. RADICULITIS (724.4)

Treatment Plan: Chiropractic Manipulative Therapy with Ice/Heat (98940), Myofascial therapy (97250), Therapeutic exercises (97110), Interferential therapy (97014), Traction (97012) and Ultrasound (97035); 2 *times a week for 4 weeks = 8 Chiropractic Visits*

UR REQUEST FOR PRE-AUTHORIZATION (PROSPECTIVE): 8 TREATMENTS

Home care exercises: Static hamstrings, quadratus lumborum & piriformis stretching and core stabilization exercises as described at this office.

Work/Status: This patient has been instructed to:

- ❑ Remain off work until: _____
- ❑ Return to *modified* work on _____ with the following limitations or restrictions:
- ☑ Return to full duty on 04/06/2015 with no limitations or restrictions

Primary Treating Physician: Date of exam: 04/06/15

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3

Signature: _____ Cal. Lic. # DC-12345

Executed at: Santa Clara County, CA Date: 04/08/15
Name: Glenn Crafts, D.C., Q.M.E. Specialty: Chiropractic
Address: 123 N. Rose Blvd., Suite 101 San Jose, Ca 95123 Phone: (408) 555-1234
Next report due no later than: 05/23/2015 Fax: (408) 555-1235

DWC Form Pr-2 (rev. 1/1/99)

Know What to Bill!

- Always review your UR approval/authorization to make sure:

1. Only bill for treatment approved/authorized.
2. Only bill within the Certification Date Range listed.
3. Only bill for the quantity approved (and provided).

- Also note the service type (i.e. Prospective RFA) and the

Claimant: [redacted]

Claim #: [redacted]
DOI: 03/07/2014
RFA Received: 04/08/2015
Decision Date: 04/17/2015

Employer:

Carrier/TPA:
Claims Examiner:
Review #:

UTILIZATION REVIEW DETERMINATION

[redacted] *Managed Care has been asked to notify you that the adjuster,* [redacted] *has given authorization* for the below noted treatment request.

REQUEST FOR AUTHORIZATION:

Additional chiropractic visits for low back Qty. 8

After careful review of the submitted medical information listed below, the determination is noted below.

DETERMINATION:

Your Initial Prospective UR request has received a recommendation of: Carrier Approval.

Authorization Timeframe:
04/17/2015 - 07/17/2015

Should this employer be part of a specific network, facility and/or vendor information is noted below.

When to use the -59 Modifier

- Don't forget that if you are performing Myofascial Release on the same date of service as providing Chiropractic Adjustments, then you should include the -59 modifier to ***show they are distinct***.
- The myofascial release must also be performed on a different body region than the body region where the chiropractic adjustment was performed.
- For example, you adjust the thoracic spine and provide myofascial release therapy to the cervical spine.
- Previously 97250 was used to bill for myofascial release, but the code now accepted in bill review is 97140.

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

A. 7244 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL RE

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.
1	04	15	15	04	15	15	11		97140	59	A	44 28	1		NPI
2	04	15	15	04	15	15	11		98940		A	38 50	1		NPI
3	04	15	15	04	15	15	11		97014		A	19 80	1		NPI
4	04	15	15	04	15	15	11		97012		A	19 80	1		NPI
5	04	15	15	04	15	15	11		97110		A	38 00	1		NPI
6	04	15	15	04	15	15	11		97035		A	22 44	1		NPI

Don't forget to bill for your PR-2 & Re-Exam

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

A. 7244 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL RE

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.
1	05	06	15	05	06	15	11		WC002		A	15 00	1		NPI
2	05	06	15	05	06	15	11		99213	25	A	47 60	1		NPI

Don’t forget to bill for your PR-2 & Re-Exam

- Re-Exams are billable.
- The Re-Exam was necessary to determine course of care.
- The subsequent Request for Authorization (i.e. PR-2) is also billable.
- The provider can bill for both the re-exam & the PR-2 separately.

Physical Medicine Modalities

CPT	Description
THERAPEUTIC PROCEDURES:	**Physician/therapist <u>required</u> to have direct (one on one) patient contact**
97140-59 (Myofascial Release)	Manual therapy techniques (i.e. mobilization/manipulation, manual lymphatic drainage, manual traction) 1 or more regions, each 15 minutes
97110 (Therapeutic Exercise)	Each 15 minutes; therapeutic exercises to develop strength & endurance, ROM & flexibility.
97112 (Neuromuscular Re-education)	Movement, balance, coordination, posture and/or proprioception for sitting/standing activities.
MODALITIES:	***Supervised*: <u>Does not require</u> direct (one on one) patient contact by the provider**
97012 (Traction)	Mechanical
97014 (Electrical Stimulation)	EMS Unattended
97010 (Moist Heat Therapy/Cryotherapy)	1 or more areas; hot or cold packs
MODALITIES:	***Constant Attendance*: Requires direct (one on one) patient contact by the provider**
97035 (Ultrasound)	Therapeutic ultrasound
CHIROPRACTIC MANIPULATIVE Tx	Influence joint and neurophysiological function.
98940 (Chiropractic Manipulation)	CMT (Spinal; 1 to 2 regions)

Physical Medicine Modalities

MICHIGAN STATE UNIVERSITY | Radiology Department

(517) 353-5053 | D100 Clinical Center. East Lansing, MI 48824

MRI CPT CODING GUIDE

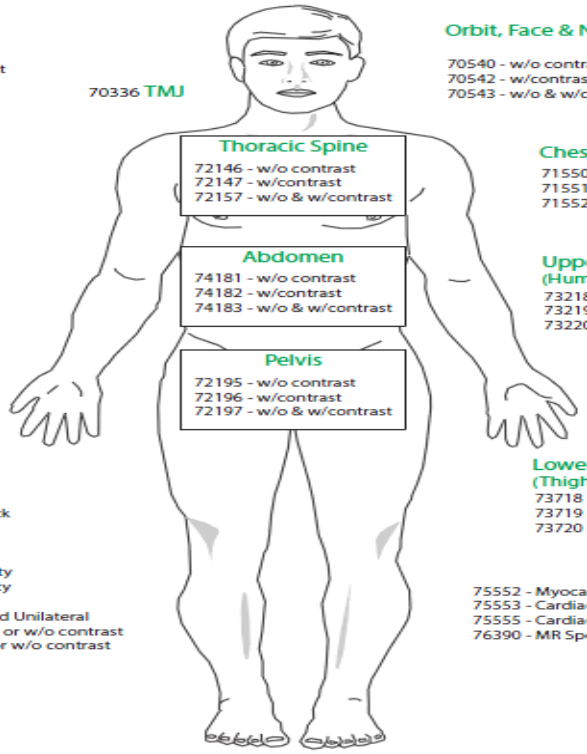
Brain (IAC's, Pituitary)
70551 - w/o contrast
70552 - w/contrast
70553 - w/o & w/contrast

Cervical
72141 - w/o contrast
72142 - w/contrast
72156 - w/o & w/contrast

Orbit, Face & Neck
70540 - w/o contrast
70542 - w/contrast
70543 - w/o & w/contrast

70336 TMJ

Upper extremity, joint
(Shoulder, Elbow, Wrist)
73221 - w/o contrast
73222 - w/contrast
73223 - w/o & w/contrast



Chest (clavicle)
71550- w/o contrast
71551 - w/contrast
71552 - w/o & w/contrast

Lumbar
72148- w/o contrast
72149 - w/contrast
72158 - w/o & w/contrast

Upper extremity, other than joint
(Humerus, Forearm, Hand)
73218 - w/o contrast
73219 - w/contrast
73220 - w/o & w/contrast

Lower extremity, joint
(Hip, knee, ankle)
73721 - w/o contrast
73722 - w/contrast
73723 - w/o & w/contrast

Lower extremity, other than joint
(Thigh, lower leg, foot)
73718 - w/o contrast
73719 - w/contrast
73720 - w/o & w/contrast

70541 - MR Angio Head/Neck
71555 - MRA Chest
72159 - MRA Spinal Canal
72198 - MRA Pelvis
73225 - MRA Upper Extremity
73725 - MRA Lower Extremity
74185 - MRA Abdomen
75660 - MRA External Carotid Unilateral
77058 - Breast, Unilateral w/ or w/o contrast
77059 - Breast, Bilateral w/ or w/o contrast

75552 - Myocardium
75553 - Cardiac w/contrast
75555 - Cardiac MRI/Limited Study
76390 - MR Spectroscopy

www.rad.msu.edu

Revised February 14, 2013

Modifier -25

- Modifier -25 allows physicians to be reimbursed for treatment/services rendered that would be denied if the modifier is not included.
- The modifier -25 indicates to payers that another significant, separately identifiable evaluation and management (E/M) service was performed by the same physician and on the same day.
- Example: Patient comes in for treatment, but reports new area of complaint, which requires exam.

New Patient Exam Billing Modifier -25

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
12/30/13	99204	25	NEW OV/OTH O/P VST/EVAL	1.00	150.00	146.12	124.20	0.00	124.20	NONE WE
										G7 Z306
										G4 ZB26
										G4 P303
										G1 ZC93
										G1 P300
12/30/13	98940		CHIROPRACTIC MANIPULATION	1.00	38.50	27.17	23.09	0.00	23.09	PM8 U868
										NONE WE
										G4 ZB26
										G4 P303
										G1 ZC93
										G1 P300
12/30/13	97140	59	MANUAL THERAPY							
12/30/13	97250	59	MYOFASCIAL RELEASE	1.00	44.28	29.52	25.09	0.00	25.09	PM9 M736
										NONE WE
										G4 ZB26
										G4 P303

Modifier -59

Definition

- CPT Manual:
- Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures [and/or] services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician…
- If you're providing two distinct and separate treatment/services during the same treatment period (DOS), then you should use the modifier -59
- This is needed to distinguish between Myofascial Release & Chiropractic Manipulation performed on the same DOS.

Myofascial Release Definition

- CPT: 97140
- Manual therapy techniques (eg. Mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes.

- CPT: 97250 (Obsolete)

Myofascial Release 97140-59 vs. 97250

- Beginning 01/01/14 the code switched to 97140
- Prior to that it was 97250
- The current accepted code is the 97140
- Add the -59 Modifier to distinguish from manipulation

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
12/30/13	99204	25	NEW OV/OTH O/P VST/EVAL	1.00	150.00	146.12	124.20	0.00	124.20	NONE WE
										G7 Z306
										G4 ZB26
										G4 P303
										G1 ZC93
										G1 P300
12/30/13	98940		CHIROPRACTIC MANIPULATION	1.00	38.50	27.17	23.09	0.00	23.09	PM8 U868
										NONE WE
										G4 ZB26
										G4 P303
										G1 ZC93
										G1 P300
12/30/13	97140	59	MANUAL THERAPY							
12/30/13	97250	59	MYOFASCIAL RELEASE	1.00	44.28	29.52	25.09	0.00	25.09	PM9 M736
										NONE WE
										G4 ZB26
										G4 P303

EOR – OMFS vs. PPO Penetration

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID
01/09/14	97140	59 61 1	MANUAL THERAPY	1.00	44.28	26.31	22.36	0.00	22.36
01/09/14	97110		THERAPEUTIC PROCEDURE	1.00	19.80	19.80	16.83	0.00	16.83
01/09/14	97110		THERAPEUTIC PROCEDURE	1.00	38.00	37.79	32.12	0.00	32.12
01/09/14	97035	61 1	ULTRASOUND THERAPY	1.00	22.44	11.75	9.99	0.00	9.99
01/09/14	97012	61 1	PHYS MED TRTMT-1 AREA	1.00	19.80	14.45	12.28	0.00	12.28

EOR – OMFS vs. PPO Penetration

- Providers are subject to the official medical fee schedule (OMFS), and additional PPO network reductions if the provider has agreed to join the billed network.
- Some Medical Provider Networks (MPNs) are networked with individual group health plan networks (i.e PPOs) to provide additional savings to the claims administrator/employer.

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C–C corporation, S–S corporation, P–partnership) ►
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
___ – ___ – ____

or

Employer identification number
___ – _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person** ► | **Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

W-9 Form

- Always include a W-9 form when submitting a bill for the first time to a new claims administrator.
- This will avoid unnecessary delays in receiving payment.
- The W-9 is required in most circumstances to set up new vendors.

Resources

- State of California Dept. of Insurance – *www.insurance.ca.gov*
- UR and Causation section of FAQs: *http://www.dir.ca.gov/dwc/UtilizationReview/UR_FAQ.htm*
- Division of Workers' Compensation Dept. of Industrial Relations - *http://www.dir.ca.gov/DWC*
- URAC – *www.urac.org*
- MTUS Regulations: *http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS_Regulations/MTUS_Regulations.htm*.
- ACOEM-Occupational Medicine Practice Guidelines 2nd Edition 2004
- CWCI
- ICD-10-CM PMIC 2015

Thanks So Much For Being Here Today!

Hope To See You Soon

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