Steve Sisolak, Governor

NEVADA STATE BOARD OF ORIENTAL MEDICINE
APPLICATION FOR CREDIT APPROVAL OF CONTINUING EDUCATION
Pursuant to NAC 634A.137

- Please note that if your CEU course has been approved by **NCCAOM** as a core competency with the designation of **AOM-ABT, AOM-AC, AOM-BIO, AOM-CH, AOM-OM, AOM-SA, and/or AOM-ET,** then it will be automatically deemed approved and you do not have to submit this form.
- One application per course must be submitted for review and approval.
- The fee required pursuant to NAC 634A.165 of $100 (per course).
- The Board requires a syllabus, a curriculum vitae for the instructor(s), and the NCCAOM course approval # and category # if applicable.
- If the Board approves a course of continuing education pursuant to NAC 634A.137, the Board will determine the number of hours of continuing education that a licensee may receive for attending the course.
- **Please mail to: Board of Oriental Medicine, 3191 E. Warm Springs Rd., Las Vegas, NV 89120**

1. Name of Applicant or Entity: Megan Clowers
2. Address: 1905 Palacia Pointe Dr Reno, NV 89521
3. Phone number: (775) 530-5407
4. Email: megan.clowers18@gmail.com
5. Location and Address of the continuing education program: online course
6. Course approved by: NCCAOM yes [X] no [ ]
   Other entity/entities:
7. Title of Course: Insurance Billing: A complete Course
8. Date(s) and times of the course taken: 10-11-2020
9. Name of Instructor(s) and his/her degree(s): Mon West, CPC
10. CEU hours: 13
11. Did you attend in person or online: online

I swear that the above statement is nothing but true.

Signature of the Applicant or Representative of Entity: Megan Clowers

Name: Megan Clowers Date: 11/1/2020

Updated: May 2020

PDA Certificate of Completion

NCCAOM

This verifies that

Megan Clowers

State Ac#NV-2000

is awarded

13 PDA Points

for completing the online course titled

Insurance Billing - A Complete Course

12/07/2020

Course Approval Date Range: 08/29/2017 through 08/29/2021

NCCAOM Recertification Category:

PE: 13

Mori West

Mori West

NCCAOM PDA Course # PDA-1286-13

MW MORI WEST SEMINARS

Acuclaims, Inc.

23440 Hawthorne Blvd Ste 235, Torrance, CA, 90505-4771

310-944-6189

Certificate Number 196459

SPEAKER

Mori West, C.P.C.

Mori West is the President of Acuclaims, a well known and respected Medical Billing Company for Acupuncturists and Chiropractors. For over 30 plus years Mori has been providing up to date information regarding billing and coding while donating her time at both the national and state level to insure that correct information regarding insurance billing practices is put forth. She is a popular guest lecturer at Acupuncture Colleges and various State Associations. Her classes prove real-world information that comes from processing thousands of claims each week for acupuncturists across the country. She is known as a lively speaker who entertains and inspires her students.

Education

BA - Long Beach State University

2010 - 1st Cohort-Goldman Sachs 10K Small Business-Certificate of Entrepreneurship

2011 - Marshall School of Business, USC- Management Development Program- (Full Scholarship)

2016- SBA - Emerging Leader's Program

WEBINAR- #1 Insurance Billing Basics-

List of Terms

Assignment of Benefits- An authorization signed by a patient instructing his insurance company to pay a claim directly to the provider.

Authorization to Release Medical Information- An authorization signed by a patient which allows the provider to send any patient records to the patient's insurance carrier upon their request. NO insurance carrier will pay a claim unless there is an authorization on file.

Balance Billing- when an Out-of NETWORK provider charges the patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge.

Coinsurance – What a patient pays to an Out-of-NETWORK provider after the deductible amount, if any, has been satisfied. This is typically a PERCENTAGE of the total amount allowed by the insurance carrier.

Copayment – The amount the patient must pay when he sees an IN-NETWORK provider after the deductible, if any, has been satisfied. Typically this is a fixed dollar amount. This amount can vary, if he sees a specialist etc.

Deductible - A fixed dollar amount that a patient pays each year before the insurer starts to make payments for covered medical services. Plans may have both per individual and family deductibles.

EOB- Explanation of Benefits – The statement sent by the insurance carrier explaining how the claim was processed and paid.

Exclusive provider organization (EPO) plan –An IN-NETWORK only plan. There is NO coverage for care received from a non-network provider except in an emergency situation.

Fully insured plan - A plan purchased by either a patient OR an employer on behalf of a patient.

Indemnity plan - A type of medical plan that reimburses the patient and/or provider as expenses are incurred.

Health maintenance organization (HMO) - A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the *HMO*. It generally won't cover out-of-network providers.

Network- *Refers to providers or health care facilities that are part of a health plan's network of providers with which it has negotiated a discount.*

Preferred provider organization (PPO) plan - A plan where coverage is provided to participants through a network of selected health care providers. The enrollees may go outside the network, but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or no discounted charges from the providers.

Point-of-service (POS) plan - A POS plan is an "HMO/PPO" hybrid; Patients have both an HMO plan which they can use for less expense, or they can opt to use the PPO portion of their plan and see either an IN-network or OUT of network provider.

Out-of-pocket Maximum expense - The maximum dollar amount a patient is required to pay out of pocket during a year. Once the maximum is reached, the insurance carrier pays at 100%. Most patient cannot reach their Out of Pocket Maximum without having some type of surgery or hospitalization.

Primary care physician (PCP) - A physician who serves as a patient's primary contact within the health plan. In a managed

care plan, the primary care physician provides basic medical services, coordinates and, if required by the plan, authorizes referrals to specialists and hospitals.

Self-insured plan (aka-Self-funded plan) – A plan offered by employers who use their own money to create health insurance for their employees. Since most employers are NOT in the insurance business they contract with insurance carriers or third party administrators for claims processing and other administrative services

Usual, customary, and reasonable (UCR) charges- (aka Reasonable & Customary (R&C) - *The customary fee in that geographic area, and is reasonable based on the circumstances.*

WEBINAR- #1 Insurance Billing Basics-

Verification Instructions

Upper Section-Patient Demographic

Member ID – This is the ID number shown on the Patient's ID Card. Sometimes called Member number or Patient Number. Can be preceded by a letter prefix.

Group # - Every policy also has a group number, even those purchased by an individual.
In place of the Group Number you can use the name of the Employer if the plan is through the employer.

Social Security#- While not necessary, we get this if the patient does not have his card, or if he only has an old card. Carriers will not update old Member numbers but will give new Member number if you supply the social security number.

Birthday is mandatory. Address is not however if the ID is incorrect some carriers will provide benefits if you can give additional identifying information such as the address. Diagnosis is also not necessary to get benefits, however it is always good practice to ask about a specific diagnosis, to confirm coverage as benefits are diagnosis specific

Lower Section-Patient's Benefits

Calendar Year vs Contract Year – 90% of plans follow calendar year, the rest follow a contract year that can begin any time of year, however most are July 1 to June 30 of the following year. This is important to know when calculating deductible.

Effective Date – When the policy started.

Term Date – When the policy expired/expires.

In or Out of Network – Make sure and specify what you want, they tend to give IN network benefits.

Deductible – Ask about Individual and Family Deductible, as well as amount that have been met.

Count – How many visits are covered per year. We want to know if they start counting at the very first visit, (visits toward deductible are counted) or after the deductible is met, (better plan.)

Percentage/Co-Pay – Out of network is covered at a percentage, In network is covered with a Copay.

Self Insured Plan – Also called Self-funded. Any plan that is a result of patient's employment are referred to as self-funded. Self-Insured plans do not have prompt pay laws and do not fall under the Dept. of Ins.

Limits – 1. Can be based on Medical Necessity, no stated amount. 2. Can be a number, (24/visits/year), 3. Can be a dollar amount, $1,000/year. 4. Can also be a limit per visit, ($60 max/visit). These can be combined with other specialties, such as chiropractic.

Timely Filing- The amount of time you have to file a claim, always much less for IN network providers.

Accept Assignment – Yes means they will pay the doctor directly. All In Network providers will get paid.

Diagnosis Exclusions – Some plans specifically exclude treatment for weight loss or smoking.

	CODE	REQUIRED KEY COMPONENTS	PROBLEM SEVERITY
OFFICE VISIT NEW PATIENT **Not seen within past three years**	**99201**	Requires a **problem**-focused history, a **problem**-focused examination and **straightforward** medical decision making.	Usually, the presenting problem(s) are self-limited or **minor**. **10 minutes** face-to-face with the patient.
	99202	Requires an **expanded** problem-focused history, an **expanded** problem-focused examination and **straightforward** medical decision making.	Usually, the presenting problem(s) are of **low** to **moderate** severity. **20 minutes** face-to-face with the patient.
	99203	Requires a **detailed** history, a **detailed** examination and medical decision making of **low** complexity.	Usually, the presenting problem(s) are of **moderate** severity. **30 minutes** face-to-face with the patient.
	99204	Requires a **comprehensive** history, a **comprehensive** examination and medical decision making of **moderate** complexity.	Usually, the presenting problem(s) are of **moderate** to **high** severity. **45 minutes** face-to-face with the patient.
	99205	Requires a **comprehensive** history, a **comprehensive** examination and medical decision making of **high** complexity.	Usually, the presenting problem(s) are of **moderate** to **high** severity. **60 minutes** face-to-face with the patient.
OFFICE VISIT ESTABLISHED PATIENT **Seen within past three years**	**99211**	Services which may **not** require the presence of a physician.	Usually, the presenting problem(s) are **minimal**. Typically, **5 minutes** are spent performing or supervising these services.
	99212	Requires at least 2 of following 3: a **problem**-focused history; a **problem**-focused examination; **straightforward** medical decision making.	Usually, the presenting problem(s) are self-limited or **minor**. **10 minutes** face-to-face with the patient.
	99213	Requires at least 2 of following 3: an **expanded** problem-focused history; an **expanded** problem-focused examination; medical decision making of **low** complexity.	Usually, the presenting problem(s) are of **low** to **moderate**. **15 minutes** face-to-face with the patient.
	99214	Requires at least 2 of following 3: a **detailed** history; a **detailed** examination; medical decision making of **moderate** complexity.	Usually, the presenting problem(s) are of **moderate** to **high** severity. **25 minutes** face-to-face with the patient.
	99215	Requires at least 2 of following 3: a **comprehensive** history; a **comprehensive** examination; medical decision making of **high** complexity.	Usually, the presenting problem(s) are of **moderate** to **high** severity. **40 minutes** face-to-face with the patient.

ACUPUNCTURE CPT CODES

	CODE	DESCRIPTION OF SERVICE
ACUPUNCTURE	**97810**	Acupuncture, 1 or more needles; **without** electrical stimulation, **initial 15 minutes** of personal one-on-one contact with the patient (Do not report 97810 in conjunction with 97813)
	97811	Acupuncture, **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) (Use 97811 in conjunction with 97810, 97813)
	97813	Acupuncture, **with** electrical stimulation, **initial 15 minutes** of personal one-on-one contact with the patient. (Do not report 97813 in conjunction with 97810)
	97814	Acupuncture, **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) (Use 97814 in conjunction with 97810, 97813)
MODALITIES	**97010**	Application of a modality to one or more areas; **HOT** or **COLD PACKS**
	97016	Application of a modality to one or more areas; **VASOPNEUMATIC DEVICES**
	97026	Application of a modality to one or more areas; **INFRARED**
	97039	Unlisted modality (**specify type** and **time** if constant attendance)
THERAPEUTIC PROCEDURES	**97110**	Therapeutic procedure, one or more areas, **each 15 minutes**; **THERAPEUTIC EXERCISES** to develop strength and endurance, range of motion and flexibility
	97124	Therapeutic procedure, one or more areas, **each 15 minutes**; **MASSAGE**, including effleurage, petrissage and/or tapotement (stroking, compression, percussion) (For myofascial release, use 97140)
	97140	**MANUAL THERAPY** techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, **each 15 minutes**
	97139	Unlisted therapeutic procedure (**specify**)

CODING TIPS

Time reported under acupuncture CPT codes 97810 – 97814 is based on the clinician's **face-to-face time** with the patient as reported in the patient's medical records, and **NOT** the duration of the acupuncture needle placement.

1) Review of the chart
2) Greeting patient
3) Obtaining a brief account of the results of the previous treatment and any significant changes that have occurred since the last visit
4) Selecting points for the day's treatment
5) Post-service charting and instructions to the patient

Documentation in the clinical record must support the level of service as coded and billed.

The **Key Components - History, Examination**, and **Medical Decision Making** - must be considered in determining the appropriate code (level of service) to be assigned for a given visit.

History

type of patient		type of history	details of History		
new	est.		HPI	ROS	other history
	99211		M.D. presence not required, minimal problem, typically 5 minute service		
99201	99212	problem focused	brief (1-3 elements)		
99202	99213	exp. prob. focused	brief (1-3 elements)	prob. pertinent (1 system)	
99203	99214	detailed	ext. (≥4 elements)	extended (2-9 systems)	pertinent (1 area)
99204		comprehensive	ext. (≥4 elements)	complete (≥10 systems)	complete (≥ 2 areas)
99205	99215	comprehensive	ext. (≥4 elements)	complete (≥10 systems)	complete (≥ 2 areas)

Examination

type of patient		type of exam	details of Examination
new	est.		
	99211		exam may not be necessary
99201	99212	problem focused	limited - affected area or organ system
99202	99213	exp. prob. focused	limited - affected area / organ system + other related / symptomatic areas
99203	99214	detailed	extended of affected area / organ system + related / symptomatic areas
99204		comprehensive	general multi-system exam or complete exam of single organ system
99205	99215	comprehensive	general multi-system exam or complete exam of single organ system

Medical Decision Making

type of patient		type of decision making	details of Medical Decision Making		
new	est.		# of diagnoses / management options	amount/complexity of data	risk of complications / morbidity / mortality
	99211		may not require medical decision making		
99201		straightforward	minimal	minimal	minimal
99202	99212	straightforward	minimal	minimal	minimal
99203	99213	low complexity	limited	limited	low
99204	99214	moderate complex.	multiple	multiple	moderate
99205	99215	high complexity	extensive	extensive	high

Note: for **new** patients, **all three key components** must meet or exceed the above requirements for a given level of service; for **established** patients, **two of the three key components** must meet or exceed the requirements.

Details of History

HPI elements (8):
- location
- quality
- severity
- duration
- timing
- context
- modifying factors
- assoc. signs/symptoms

other history areas
(req. for 99203/14 & up)
- past history
- family history
- social history

ROS systems (14):
- symptoms (e.g. cough)
- eyes
- ears/nose/throat/mouth
- cardiovascular
- respiratory
- gastrointestinal
- genitourinary
- musculoskeletal
- integumentary
- neurologic
- psychiatric
- endocrine
- hematologic/lymphatic
- allergic/immunologic

Details of Examination

body areas:
- head, including face
- neck
- chest, inc. breasts, axillae
- abdomen
- genitalia, groin, buttocks
- back, including spine
- each extremity

organ systems:
- constitutional (vital signs, general)
- eyes
- ears, nose, throat, mouth
- cardiovascular
- respiratory
- gastrointestinal
- genitourinary
- musculoskeletal
- integumentary
- neurologic
- psychiatric
- hematologic/lymphatic /immunologic

- **four additional factors** may be considered in determining the appropriate code (level of service) for a visit:
  1. **nature of the presenting problem** (minimal, self-limited/minor, low, moderate, or high severity)
  2. **coordination of care with other health care professionals** *
  3. **counseling** *
  4. **time** - see chart below for "typical" time spent face-to-face with patient/family for the various levels of service

	5 min.	10 min.	15 min.	20 min.	25 min.	30 min.	40 min.	45 min.	60 min.
new patient		99201		99202		99203		99204	99205
est. patient	99211	99212	99213		99214		99215		

* when counseling or coordination of care comprises more than 50% of the visit or service rendered, time is the key factor in determining the appropriate code and the total time spent should be clearly documented.

for more detail, please consult the AMA's annual Physician's Current Procedural Terminology, available from the AMA and other publishers