Medicare, Coding and Billing.... Oh My!
Kathy Mills Chang, MCS-P CCPC

Proper Use of the KMC University Medicare Verification Form

Medicare Verification: A Responsibility with a Reward

My Medicare Administrative Contractor (MAC)

Where in the World is my MAC?

What Does a MAC Do?
A Medicare Administrative Contractor (MAC) is a private healthcare insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries.
What Does a MAC Do?

CMS relies on a network of MACs to serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program. MACs are multi-state, regional contractors responsible for administering both Medicare Part A and Medicare Part B claims.

MACs perform many activities including:
- Process Medicare FFS claims
- Make and account for Medicare FFS payments
- Enroll providers in the Medicare FFS program
- Handle provider reimbursement services and audit institutional provider cost reports
- Handle redetermination requests (1st stage appeals process)
- Respond to provider inquiries
- Educate providers about Medicare FFS billing requirements
- Establish local coverage determinations (LCDs)
- Review medical records for selected claims
- Coordinate with CMS and other FFS contractors

Like Any Other Government Contractor

Summary of Section 509 of MACRA of 2015

The Medicare Access and CHIP Reauthorization Act (MACRA), enacted on April 16, 2015, included language in Section 509 that permits Medicare Administrative Contractors (MACs) to amend terms that took effect on or after June 30, 2015. The legislation also requires the Secretary of Health and Human Services to develop a plan that requires MACs to make public performance information for each Medicare contract, to the extent that such information does not interfere with contract negotiations. The legislation applies to all contracts in effect at the time of enactment, meaning that current MAC contracts in place can be extended beyond five years to a maximum of ten. This also means that the Agency is required to immediately make public performance information on each MAC. Read the full text of this legislation at Public Law No. 114-10.

Do You Know Your Carrier?

• What can you do on your carrier’s website?
  • Look up fee schedules
  • Review policy and procedure
  • Find your LCD
  • Sign up for bulletin board notices
  • Get training
  • Use the IVR

Look Up Fee Schedules
Largely a Self-Serve Process

Physician’s Fee Schedule Code Search & Downloads

Search using a single code

- Procedure Code: 98940
- Date of Service: 7/1/2016
- State: Colorado
- Locality: Entire State (U)
- Search

Chiropractic Lookups

Verification and the IVR

Interactive Voice Response (IVR) Unit

- Number: 1-800-252-0792

- Hours:
  - Mon - Sat: 7:30 AM to 7:30 PM
  - Sun: 10:00 AM to 7:30 PM

Specific Training-Basic and Chiropractic

- Educational Events - Upcoming:
  - Chiropractic Basic Training (CBT) Center
  - Educational Videos and Classes: "Chiropractic Basics"

Look Up for 98940

- Specific Training-Basic and Chiropractic

Lots of Items to Self-Serve

- Self Service Tools:
  - Check my enrollment status
  - Get my claim status
  - Check my eligibility
  - Find a doctor
  - Get my claim status
  - Find a drug
  - Go to the Medicare Learning Network
  - Compare plans
  - Get help with my Medicare

- System Access (Claims & Eligibility):
  - Find a doctor
  - Get my claim status
  - Check my eligibility
  - Find my plan information
  - Compare plans
  - Get help with my Medicare
  - Go to the Medicare Learning Network
  - Find a drug
  - Get my claim status
  - Check my eligibility
Partner with Your MAC

• Not automatically the “bad guy”
• Know how to interact with the MAC
• Learn who in provider services can help you

Objectives

• Understand why Medicare verification is so important
• Get to the bottom of what all of these Medicare numbers mean for your providers
• Better comprehend all the various types of coverage a Medicare patient may have, and how to confirm eligibility and coverage for each
• Learn how to customize and use a master Medicare verification form

Why Verify Medicare?

• Isn’t it so easy that it doesn’t require verification?
• Everyone has the same coverage, right?
• The layers of possible coverage are too many to ignore
• One misstep here derails all of your billing

Provider Numbers and Medicare

MEDICARE ENROLLMENT APPLICATION
REASSIGNMENT OF MEDICARE BENEFITS

CMS-855R

NPI Numbers

• National Provider Identifier: both personal and group
• A unique identification number for covered health care providers
• HIPAA established this number
• A 10-position, intelligence-free numeric identifier
• The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions

PTAN Numbers

• Provider Transaction Access Number
• MAC’s Provider Enrollment department issues to Medicare Providers
• The PTAN is the same number as a previously issued Unique Provider Identification Number (UPIN)
Tax-ID Number

• With Medicare, all numbers are assigned to the group if there is one
• Your federal ID number is the master number that identifies your practice
• All other numbers are attached to that

Types of Medicare Coverage: Part B

• Basic Medicare Part B coverage is what the majority of the senior population have
• Medicare Part B is optional
• Will usually be primary coverage

Types of Medicare Coverage: Part C

• Also known as Medicare Advantage Plans or Replacement Plans
• Better known as the “Managed Care Medicare”
• Redirected benefit to a private carrier
• Will not have Part A or B

Types of Medicare Coverage: Supplemental

• Purchased by the beneficiary to cover the “gap”
• 10 different standardized plans available
• You must know which of the 10 your patient has
• Most common covers only the 20% of allowable charges

Types of Medicare Coverage: True Secondary

• Resembles eligible group health plans (GHP)
• Could be from retirement benefits
• Often behaves like a GHP rather than a supplemental

Crosswalk Feature

• Patients must request from Secondary/Supplement
• Secondary Supplement sends info on patient to Medicare
• Medicare sends processed claim information to Secondary/Supplement
Types of Medicare Coverage: When Medicare is Secondary

- Many circumstances when Medicare may pay AFTER another insurance
- Entire lesson devoted to that concept
- Very important to understand and execute this perfectly

Verify ALL Coverage

- Confirm Medicare Part B eligibility
- Confirm secondary or supplemental eligibility
- Confirm actual chiropractic benefits for any secondary or supplemental
- If Medicare Part C confirm all benefits

Online vs. IVR vs. Phone

- You have to get the answers you want
- What will the patient be responsible for?
- Eligibility is one thing, benefits are another
- Secondary, Supplemental and Part C—biggest errors we see

Master Medicare

Welcome To Medicare
ENROLL HERE

Customize Your Form
Make a Master Template

- Customize a master
- "Save as" or print
- Keep your original unedited file for future use
- Print a group of masters to have on hand, ready for verification

These Numbers Won’t Change

**NOTE:** If you have more than one provider for whom you verify, make a master verification for each provider. List the Provider’s Name next to the NPI number.

Verify Traditional Medicare

**NOTE:** Use the IVR, the online service, or call the provider services phone number. Have your Carrier and Verification Reference Tool handy.

Verify Secondary/Supplemental

**NOTE:** Use the IVR, the online service, or call the provider services phone number.
Verify Secondary/Supplemental

NOTE: When the Secondary carrier’s coverage mirrors Group Health Insurance (GHP) such as covering all chiropractic services, opt to use the GHP verification form to collect all pertinent data.

Use Your Custom Fields

Section F - Custom

Do you cover acupuncture, when performed by a DC?

Verify Medicare Advantage Plan

Create Master Templates for Common Carriers

• If you deal with certain carriers a lot, create a template
• Customize the benefits into a master
• Personalize for each patient
• Always confirm and verify each patient

Need help?
helpdesk@kmcuniversity.com
The Voluntary Advance Beneficiary Notice (ABN) Form

A KMC University Rapid Tutorial

Mandatory ABNs are Only for Spinal CMT Codes!

But Do I Need One for Non-CMT Services?

Let's Start at the Very Beginning!...(A Very Good Place to Start!)

• CPT Codes paid by CMS to Chiropractors...
  • 98940 (Chiropractic Manipulation)
  • 98941 (Chiropractic Manipulation)
  • 98942 (Chiropractic Manipulation)

• CPT codes not paid by CMS to Chiropractors...
  • 98943 (Chiropractic Manipulation / Extraspinal)
  • All Exams, Therapies, X-rays, DME, Etc.

Voluntary Use = “MAY I?”

Mandatory ABNs are Only for Spinal CMT Codes!

GA Modifier

But Do I Need One for Non-CMT Services?

Aha!

Voluntary ABN Uses

Medicare does not require ABNs for statutorily excluded care or for services Medicare never covers. However, in these situations, you may issue an ABN voluntarily. Refer to the “What Claims Reporting Modifiers Do I Use?” section at the end of this booklet for information on claim modifiers associated with voluntary ABN use.

WHEN MAY I ISSUE AN ABN?

Voluntary ABN Uses

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ABN for Voluntary Use

You should only provide ABNs to beneficiaries if you have a fee-for-service (Fee-For-Service) Medicare. The ABN allows the beneficiary to get a second opinion about whether to get the services and accept financial responsibility for them, even though Medicare might not pay. The ABN serves as proof that the beneficiary knew and understood that Medicare might not pay. If you do not issue an ABN to the beneficiary, you are not required to bill the beneficiary for the service and you cannot be held liable for the services. The ABN also serves as an optional (voluntary) notice to beneficiaries of their financial liability prior to providing care that Medicare may never cover. Medicare does not require you to issue an ABN in order to bill beneficiaries for an item or service that is not a Medicare benefit and never covered.

- When you issue the ABN as a voluntary notice, the beneficiary does not check an option box or sign and date the notice.

Option One: Do Nothing

Option Two: Use Medicare’s Official Form

Your Options for Advance Notice for Statutorily Excluded Services in Medicare

Option One: Do Nothing

Option Two: Use Medicare’s Official Form

GY Modifier

GY Modifier
Option Three: Make Your Own Notice

DO IT YOURSELF

Option Four: A Better Way

BEETTER WAY

Patient Friendly Medicare Education

- Patient Friendly Language
- Looks “Medicare Official”
- Starts the process on the right foot

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GY Care Does Not *Have* to Be Billed to Medicare

• A patient may decide whether or not statutorily non-covered services are submitted.
• If the patient asks you to bill Medicare, you must.
• Why would we want to do that?

Modifiers Required When Billing Non-Spinal CMT Services

• **GY Modifier**: Notice of Liability Not Issued, Not Required Under Payer Policy. This modifier is used to obtain a denial on a non covered service. Use this modifier to notify Medicare that you know this service is excluded.
• **GX Modifier**: Notice of Liability Issued, Voluntary Under Payer Policy. Report this modifier only to indicate that a voluntary ABN was issued for services that are not covered.
• **GP Modifier**: Service is part of an active therapy program (Non-ABN specific).

Voluntary ABNs Can Work

• Create your strategy now
• Decide how and when you’ll notify
• Don’t use the official form, it’s confusing
• Sharpen your scripting and know the answer before the questions

The Mandatory Advance Beneficiary Notice (ABN)

Let’s Start at the Very Beginning!...(A Very Good Place to Start!)

• CPT Codes **paid** by CMS to Chiropractors...
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  - All Exams, Therapies, X-rays, DME, Etc.

**Mandatory** ABNs are Only for **Spinal CMT Codes**!
Graduation to Maintenance Care

- Medicare patients will likely move in and out of active treatment while a patient in your office.
- Have a clear understanding of the definition of maintenance care and follow the rules.

Episodes of Care

Maintenance

- Wellness
- Prevent disease
- Promote health
- Prolong/enhance the quality of life
- Supportive
- Maintain or prevent deterioration of a chronic condition

From the Horse’s Mouth!

**WHAT IS AN ABN?**

An ABN, Form CMS-1500, is a standardized notice you or your designee must issue to a Medicare beneficiary before providing certain Medicare Part B (outpatient) or Part A (limited to hospice, home health agencies [HHAs], and Religious Nonmedical Health Institutions only) items or services. You must issue the ABN when:

- You believe Medicare may not pay for an item or service;
- Medicare usually covers the item or service; and
- Medicare may not consider the item or service medically reasonable and necessary for this patient in this particular instance.

Advance Beneficiary Notice

- Must be signed when you believe a covered service (CMT) may not be covered on this visit.
- Triggering Events
  - Should be filled out in front of the patient indicating the reasons are for assuming the service is going to be denied:
    - Medicare never covers this many visits for this diagnosis
    - Medicare never covers more than one visit in the same day
    - Medicare never pays for maintenance care
    - My carrier has a published screen and this patient has exceeded the screen
Mandatory ABN Use

Mandatory ABN Uses
You must issue an ABN when:

- You expect Medicare to deny payment for an item or service because it is not reasonable and necessary under Medicare Program standards;
- Medicare considers the care to be custodial care;
- Outpatient therapy services are in excess of therapy cap amounts and do not qualify for a therapy cap exception;
- A patient is not terminally ill (for hospice providers only);
- Home health services requirements are not met; for example, the individual is not confined to the home or does not need intermittent skilled nursing care (for HHA providers).

Modifiers Required When Billing CMT

- **AT Modifier:** Your assertion that the care is deemed “active”, is reimbursable, and you expect payment from Medicare.
- **GA Modifier:** Waiver of Liability Statement Issued as Required by Payer Policy. This modifier indicates that an ABN is on file and allows the provider to bill the patient if not covered by Medicare.
- **GZ Modifier:** Item or Service Expected to Be Denied as Not Reasonable and Necessary. When an ABN may be required but was not obtained this modifier should be applied.

The Patient Chooses an Option

Option 1, 2, or 3 (G)
The beneficiary, or his or her representative, must choose only one of the three options listed Medicare does not permit you to make this selection.

- If Option 1 is chosen:
  - The beneficiary wants to get the item or services at issue and accepts financial responsibility; he or she agrees to make payment now, if required. You must submit a claim to Medicare that will result in a payment decision that the beneficiary can appeal.
  - NOTE: The beneficiary must a Medicare claim form 1500 or secondary insurance plan to cover the service, the beneficiary should select Option 1.

- If Option 2 is chosen:
  - The beneficiary wants to get the item or services at issue and accepts financial responsibility. He or she agrees to make payment now, if required. You do not submit a claim to Medicare at the beneficiary’s request. When the beneficiary chooses this option, you do not file a claim and there are no appeal rights.
  - You will not violate mandatory claims submission rules under Section 1848 of the Social Security Act when you do not submit a claim to Medicare at the beneficiary’s written request when he or she selects this option.

Do Not Use Every Visit!

When AM I Prohibited From Issuing an ABN?

What is the Routine Notice Prohibition?
Medicare prohibits you from issuing ABNs on a routine basis (i.e., where there is no reasonable basis for Medicare to not cover the item or service). You must ensure that a reasonable basis exists for noncoverage associated with the issuance of each ABN. Some situations may require a higher volume of ABN instance, and as long as proper evidence supports each ABN use, you will not be violating the routine notice prohibition.
The Dirty Details

How Do I Effectively Issue an ABN?
Medicare considers issuance of an ABN effective when the notice is:

- Issued (preferably in person) to and comprehended by a suitable recipient;
- The approved, standardized ABN with all required blanks completed;
- Published far enough in advance of potentially noncovered items or services to allow sufficient time for the beneficiary to consider available options;
- Explained in its entirety with all questions related to the ABN answered, and
- Signed dated by the beneficiary or his/her representative after he or she selected one option box on the ABN.

What About AT-GA Modifiers?

• Carrier may have published screen
  • > 12 CMT in 1 month
  • > 24 CMT in 12 months
  • > amount of CMT for given 2nd diagnosis
• GA modifier is used if ABN is signed and filed
• AT modifier is used if you think it’s active

A Simple Solution

Patient Friendly Medicare Education

- Patient Friendly Language
- Looks “Medicare Official”
- Starts the process on the right foot

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Inquiring Minds Want to Know

WHAT DO I DO WITH THE VALID ABN?
In general, you should keep the ABN for 5 years from the date-of-care delivery when no other requirements under state law apply. Medicare requires you to keep a record of the ABN in all cases including those cases in which the beneficiary declined the care, refused to choose an option, or refused to sign the ABN.

When Do I Need to Issue Another ABN for an Extended Course of Treatment?
You may issue a single ABN to cover an extended course of treatment if the ABN identifies all items and services and the duration of the period of treatment for which you believe Medicare will not pay. If the beneficiary receives an item or service during the course of treatment that you did not list on the ABN and Medicare may not cover it, you must issue a separate ABN.

A single ABN for an extended course of treatment remains valid for no more than 1 year. If the extended course of treatment continues after a year’s duration, you must issue a new ABN.

Active Says YOU...or Maybe Not!?

- Carrier may have published screen
  • > 12 CMT in 1 month
  • > 24 CMT in 12 months
  • > amount of CMT for given 2nd diagnosis
- GA modifier is used if ABN is signed and filed
- AT modifier is used if you think it’s active

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Master the ABN Process

- Know WHEN an ABN is necessary for CMT
- Understand the details of when care is active vs. maintenance
- Use the ABN form correctly
- Sharpen your scripting and know the answer before the questions

How Medicare Works with Chiropractic

Basic History of Chiropractic in Medicare

- In 1972, Congress passed Public Law 92-603, which amended section 1861(r) of the Social Security Act (the Act) to define chiropractors as physicians who are eligible for Medicare reimbursement, but only for manual manipulation of the spine to correct a subluxation, or malfunction of the spine.
- Federal regulations (42 CFR § 410.21(b)) further limit Medicare payment to treatment of subluxations that result in a neuromusculoskeletal condition for which manual manipulation is appropriate treatment.
- In addition to these specific provisions, sections 1862(a)(1)(A) and 1833(e) of the Act require that all services billed to Medicare, including chiropractic manipulations, be medically necessary and supported by documentation.

Basics of Medicare

- Chiropractic experienced considerable growth in Medicare, from 11.2 million services and $255 million allowed in 1994 to 21 million services and $683 million allowed in 2004

- The Medicare Carriers Manual (the Manual) outlines additional coverage criteria for chiropractic services billed to Medicare. Pursuant to section 2251.2 of the Manual, the existence of a subluxation must be documented through an X-ray or physical examination and chiropractic services must be provided as part of a written plan of care that should include specific goals and measures to evaluate effectiveness.
- Section 2251.3 of the Manual states that chiropractic treatment "...Must provide a reasonable expectation of recovery or improvement of function."
- The same Manual section states that ". . . Ongoing maintenance therapy is not considered to be medically necessary under the Medicare program," and is therefore non-covered.
Chiropractic Services CMS Basics

• CPT Codes paid by CMS to Chiropractors...
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  • 98941 (Chiropractic Manipulation)
  • 98942 (Chiropractic Manipulation)

• CPT codes not paid by CMS to Chiropractors...
  • 98943 (Chiropractic Manipulation / Extraspinal)
  • All Exams, Therapies, X-rays, DME, Etc.

What’s Different about Chiropractic?

• DCs can not “opt out” of Medicare
• DCs only have three covered services
• DCs must use subluxation DX codes along with a secondary
• DCs can’t order any service other than CMT outside of the office
• DCs must document a subluxation on x-ray or with PART, but x-rays are not paid by Medicare for DCs

DCs Use AT Modifier

What’s the Same?

• DCs can be participating or not
• DCs are physicians
• CMT codes are a covered service under Medicare
• DCs use the same carriers as other Part B physicians
• DCs have LCDs like other Part B physicians
• DCs must document to the required standard like other Part B physicians

Which Came First?

Clinically Appropriate

• Generally accepted standards of medical practice
• Within the Doctor’s scope of practice
• Based on credible scientific evidence
• May be the patient’s financial responsibility!

Medically Necessary

“The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient’s condition and provide reasonable expectation of recovery or improvement of…function.”
Active and Maintenance Care
Incidents, bursts, and episodes of care will happen throughout the patient’s experience in your office.

Chiropractic Services CMS Basics
“Chiropractic service which is eligible for reimbursement, is specifically limited by Medicare to the treatment by means of manual manipulation (i.e., by use of the hands or use of manual devices that are hand-held, with the thrust of the force of the device being controlled manually) of the spine for the purpose of correcting a subluxation.”

Diagnosis for Medicare Claims
• The primary diagnosis must be subluxation (except FL)
  Subluxation M99.0x
• Supporting musculoskeletal diagnosis Causal from subluxations, such as disc degeneration

Chiropractic Services Defined
• A subluxation usually falls into one of two categories:
  • Acute, such as strains and sprains
  • Chronic, such as loss of joint mobility

CMS Subluxation Definition
“For Medicare purposes, subluxation is defined as a motion segment in which alignment, movement integrity and/or physiological function of the spine are altered although contact between joint surfaces remains intact.”
Acute Treatment

CMS defines **Acute** as: "A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression of, the patient's condition."

Chronic Treatment

CMS defines **Chronic** as: "A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered."

Maintenance Therapy

CMS defines **Maintenance Therapy** as: "Chiropractic maintenance therapy is not considered to be medically reasonable or necessary under the Medicare program, and is therefore not payable. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy."

PART is only a Piece of the Picture

• Many chiropractors believe by documenting PART they have proven medically necessity for care
• PART is a very small (but important) element to Medicare documentation
• Medicare wants a lot more than documentation of PART only

What Does PART Mean, Anyway?

- **Pain**/tenderness evaluated in terms of location, quality, and intensity;
- **Asymmetry/Disalignment** identified on a sectional or segmental level;
- **Range of motion abnormality** (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); and
- **Tissue, tone** changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

Required PART Elements

- **Asymmetry or Misalignment**
  - Combine this with at least one of:
    - Range of Motion Abnormality
    - Pain
    - Tissue/Tone

- **Range of Motion Abnormality**
  - Combine this with at least one of:
    - Asymmetry or misalignment
    - Pain
    - Tissue/Tone

• Only 2 of 4 elements are required, but one must be “A” or “R”
Chiropractic Is PART of the BIGGER Picture

• Understand the ins and outs of Medicare
• Then understand the nuances of chiropractic in Medicare
• Strive to be the most compliant and efficient possible

Where Do the Codes Go?
E&M Coding/Documentation is Based on 7 Components

• 3 Key Components
  • Patient History
  • Examination
  • Clinical Decision Making

• 3 Contributory Components
  • Counseling
  • Coordination of Care
  • Nature of Presenting Problem

1 Additional Component: Time

Contributory Components

• Counseling and Coordination of Care
• Nature of Presenting Problem
• Time

Counseling and Coordination of Care

• When visits consist mainly of these components, time is the controlling factor
• This is due to face-to-face time being 50% of the visit
• Resist the urge to code E/M services for the typical chiropractic ROF

Most Common Definitions Used in E/M Coding

• History, Exam, CDM
• Code selection is based on the level of service provided in each of these key three components during the office visit.
• Depending upon whether it’s a New Patient or Established Patient visit, varying numbers of these three key components must be met.
Time as a Component
• When counseling and coordination of care is primary, time may be important
• More likely in a medical office
• Do not use time as a primary component

Definition of a NP
• Never been to your office before
• Have never seen anyone in your practice before. (other than multi-specialty)
• It’s been more than 3 years since they have been into the practice

Key Terms
• Problem focused (aka: problem pertinent)
• Expanded problem focused
• Detailed
• Comprehensive
• Brief
• Extended
• Complete

CPT Definitions
Body Areas:
• Head, including Face
• Neck
• Chest, including Breasts and Axilla
• Abdomen
• Genitalia, Groin, Buttocks
• Back
• Trunk
• Each Extremity

CPT Definitions: Organ Systems
• Eyes
• Ears, Nose, Throat, and Mouth
• Cardiovascular
• Respiratory
• Gastrointestinal
• Genitourinary
  – Musculoskeletal
  – Skin
  – Neurologic
  – Psychiatric
  – Hematologic/Lymphatic/Immunologic

Documentation of Consultation
• Opinion or advice regarding E/M of a specific problem is requested by another physician, insurer, employer or other appropriate source
• May initiate diagnostic and/or therapeutic services at the same or subsequent visit
### Evaluation and Management Coding

- New Patient E/M codes
- Established Patient E/M codes
- Bullet points

### 25,000 Foot View

- These are general terms needed for understanding E/M
- More specific glossary terms are provided in each lesson
- Become familiar with the “lingo” for proper E/M coding knowledge

### E/M Coding—New Patients

- Perhaps the most undervalued code in your arsenal
- Three main components: History, Exam, and Clinical Decision Making

### Selection of Type of History

<table>
<thead>
<tr>
<th>Type of History</th>
<th>History of Present Illness (HPI)</th>
<th>Review of Systems (ROS)</th>
<th>Past, Family, and/or Social History (PFSH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Brief</td>
<td>Problem Focused</td>
<td>N/A</td>
<td>Pertinent</td>
</tr>
<tr>
<td>Extended</td>
<td>Extended</td>
<td>Pertinent</td>
<td>Complete</td>
</tr>
<tr>
<td>Extended</td>
<td>Complete</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### #1 - Documentation of History

- Each type of history we will select from will contain some of all of these subcomponents
  - Chief complaint (CC)
  - History of present illness (HPI)
  - Review of systems (ROS)
  - Past, family and/or social history (PFSH)

### #2 - Examination

- Examination is the quantifiable portion of the E/M service.
- Tests and Measurements will be documented.
- Four levels of E/M must be considered.
- Problem Focused, Expanded PF, Detailed, Comprehensive.
Clinical Decision Making

- This is the “thinking” part of the E/M code.
- Think of this as the “doctoring” part of the service.

Complexity of Clinical Decision Making

- The levels of E/M services recognize four types of medical decision making:
  - Straightforward
  - Low complexity
  - Moderate complexity
  - High complexity

Clinical Decision Making Matrix

<table>
<thead>
<tr>
<th>Number of Diagnoses or Management Options</th>
<th>Amount and/or Complexity of Data to be Reviewed</th>
<th>Risk of Complications and/or Morbidity or Mortality</th>
<th>Type of Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
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Established Patient Evaluation & Management Code Selection

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CMT Codes
CMT Codes

- 98940-98943 are the basic building blocks and best description of the DC's work.
- Most comprehensive physician code to describe chiropractic services.
- Basic service around which everything else is built.

Thoracic Spine

- 12 Vertebra: T1-T12
- Also called the dorsal spine
- Kyphotic Curve
  - From the Greek: hump
  - AKA hunchback

Cervical Spine

- 7 vertebra: C1-C7
- Occiput
- Atlas = C1
- Axis = C2
- Atlanto-Axial = C1-C2
- Cervical Lordosis: refers to the curve of the spinal; could be hypo or hyper

5 Spinal Regions

- 98940 – 1-2 Regions
- 98941 – 3-4 Regions
- 98942 – 5 Regions
- Common Ratios
  - 98940 – 40%
  - 98941 – 45%
  - 98942 – 10%

Lumbar Spine

- 5 Lumbar Vertebra: L1-L5
- Pelvic
- Sacrum
- Coccyx
- Lumbar lordotic curve
- Many areas to understand below the belt

Extremity Adjusting – 98943

- REGIONS
  - Head
  - Upper extremities (shoulder to fingers)
  - Lower extremities (hip to toes)
  - Anterior ribs
  - Abdomen
- May be billed once per visit
- Can be billed along with spinal CMT code
HCPCS Coding: An Overview

HCPCS Codes

HCPCS Codes: HCPCS (Healthcare Common Procedure Coding System) is a coding system used to describe certain items and services provided by healthcare establishments.

• Until 1996 using HCPCS codes was optional for reporting to Medicare, Medicaid and other insurance carriers.
• The introduction of HIPAA resulted in the mandatory use of HCPCS codes when billing to Medicare, Medicaid and other insurance carriers for the purpose of creating uniform and consistent processing of insurance claims.

Levels of HCPCS Codes


Level II – Codes for products, supplies and professional services that are not assigned a current CPT code.
  • DMEPOS (durable medical equipment, prosthetics, orthotics, and supplies) and are alphanumeric, consisting of a single alphabetical letter and four numbers.

Level III – Local codes created by state agencies, contractors and private insurers for use in specified jurisdictions and programs. Discontinued for use in 2003 to ensure consistent coding standards.

HCPCS Level I

CPT codes
• Traditional coding
• AMA controls and edits
• We cover these extensively in other lessons

HCPCS Level II

• Alpha numeric
• Start with a letter (A-V)
• DMEPOS codes
  • Durable Medical Equipment (DME)
  • Orthotics
  • Prosthetics
  • Supplies
• Unassigned (CPT) procedure codes
  • Services/procedures
  • Medications
  • Misc.
• Each starting letter categorizes based on type

HCPS Service Codes
**G Codes**

*Temporary Procedures & Professional Services*

G0283 - Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

**PQRS**

G8730 - Pain assessment documented as positive utilizing a standardized tool AND a follow-up plan is documented

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**CPT (HCPCS) - S8990**

- **S8990**: Physical or manipulative therapy performed for maintenance rather than restoration
- The S8990 code can be used once per encounter
- Covers ALL CMT, modalities, and procedures
- For Non-Medicare Medicare - 9894X-

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**A Codes**

*Transportation, Medical & Surgical Supplies, Miscellaneous & Experimental*

- A4452 – Tape, waterproof, per 18 square inches
- A4595 - Electrodes per pair
- A9273 - Hot or cold wrap/pack
- A9300 - Exercise equipment

---

**S Codes**

*Temporary National Codes (Non-Medicare)*

- S8948 - application of a modality to one or more areas; low-level laser; each 15 minutes
- S9090 - Vertebral Axial Decompression, per session
- S9390 - Electrical stimulation of auricular acupuncture points; each 15 minutes of personal one-on-one contact with the patient

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**HCPCS Supply and Medication**

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**J Codes**

*Drugs Administered Other Than Oral Method, Chemotherapy Drugs, Medications for injections*

- J1100 - Injection, dexamethasone sodium phosphate, 1mg
- J3301 - Injection, triamcinolone acetonide, not otherwise specified, 10 mg (Kenalog)
- J3420 - Injection, vitamin b-12 cyanocobalamin, up to 1000 mcg
DME and Orthotics

Pricing, Data Analysis and Coding (PDAC)
Noridian Healthcare Solutions, LLC
PDAC Contractor since August 2008:
• Officially assigns HCPCS codes for DMEPOS
• Conducts DMEPOS data analysis
• PDAC is not required but can be helpful if billed item is over $500 and 3rd Party has issues with payment
• What if DME/orthotic item does not have PDAC letter or assignment?

E Codes

Durable Medical Equipment
• E0720/E0730 TENS unit
• E0849 Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible
• E0855 Cervical traction equipment not requiring additional stand or frame
• E0856 Cervical traction device, cervical collar with inflatable air bladder
• E0860 Traction equipment, overdoor, cervical

L Codes

Orthotic/Prosthetic Procedures
• Knee braces
• Foot orthotics
• Back braces
• Wrist braces
• Cervical collars

L Codes

• L0648 - Lumbar-Sacral Orthosis, Sagittal Control, With Rigid Anterior And Posterior Panels, Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Produces Intracavitary Pressure To Reduce Load On The Intervertebral Discs, Includes Straps, Closures, May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf
• L1832 – Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
• L3020 - Foot, insert, removable, molded to patient model, longitudinal/metatarsal support, each
• L3030 - Foot, insert, removable, formed to patient foot, each

K Codes

Temporary Codes for Durable Medical Equipment Regional Carriers
• K0901 : Knee orthosis (fo), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf
• L1843 : Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
Can I Supply in Office?

- Scope of practice dictates
- 3rd Party carrier
  - May or may not cover your Rx
  - May or may not let you dispense
- DME Vendor may be the only one covered
- Cash is an option (if in scope)

DME Accreditation

- Separate DME license
- Only a few agencies can accredit
- High Expense
- Collective bargaining
- Lots of extra work involved
- Requires multiple Onsite inspections (at least one by CMS)

Supervised Modalities

- 97010-97028 DO NOT require one-on-one contact by the provider
- Billed only once per encounter
- Are not time based for billing purposes
- Expected 2-12 visits
- However documentation should include the time spent on the modality

97010 Hot/Cold Packs

- Application of hot packs, ex. hydrocollater packs or moist towels
- Application of Ice packs or cryotherapy
- Often a non-covered service
- Does NOT include applying Biofreeze or any other type of topical analgesic

97012 Mechanical Traction

- Force used to create tension of soft tissue or to separate joints
- Untimed & billed only once a visit
- Intersegmental or Roller tables meet criteria, BUT check with 3rd party payer guidelines
- Flexion Distraction technique is a CMT & should be coded as an adjustment
S9090 Decompression

S9090 - Vertebral Axial Decompression, per session

Differs from traction:
- Angle(s)
- Computer assistance
- Muscle guarding consideration
- Intent

97014 Electrical Stimulation (EMS)

• Application of Electric stimulation to a specific area for nerve or muscle disorders
• Billed only once per visit
• Some payers allow 2-4 visits
• Sometimes you must use G0283 instead of 97014 for unattended EMS

Presently United Health Care & Medicare are the only carriers that require G0283

Constant Attendance Modalities

97032-97039 require direct one-on-one patient contact by provider
• Expected 6-12 visits
• These are timed based codes for billing
• Documentation should include total time spent

97032 Attended Electrical Stimulation

• Application of a modality to one or more areas; electrical stimulation [manual] each 15 minutes
• Most often combo unit
• You can’t just move the pads and call it attended!

97035 Ultrasound

• Ultrasound, each 15 mins. One or more areas
• Great for adhesive scars, spasm, soft tissue

Therapeutic Procedures (97110-97546)

• Therapeutic Procedures are time-based codes for billing purposes
• The patient is ACTIVE in the encounter
• Requires direct one-on-one patient contact
• Documentation should include both the total time spent and the time spent doing each activity/exercise.
• Codes are billed per 15 min increments
97110 Therapeutic Exercise

• Therapeutic Exercise, each 15 mins. One or more areas
• Incorporates one:
  • Strength
  • Endurance
  • Range of motion
  • Flexibility
• Must show functional deficit in the above during examination

97112 Neuromuscular Re-education (NMRE)

• Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception
• Proprioceptive Neuromuscular Facilitation (PNF), Feldenkrais, Bobath, BAP’S, Boards, and desensitization techniques
• Most likely indicated for neurological conditions

97116 Gait Training

• Direct one-on-one contact in the performance of progressive exercises or activities designed to improve gait in a patient with a neuromuscular disorder to maximize safety and efficiency
• Training on ambulation or gait or movement activities on the gait training
• Parallel bars, progression and modifications
• Progression to ambulation system

97150 Group Exercise Code

Therapeutic Procedure(s), group, (2 or more individuals)
• Once per encounter, not timed!
• Some carriers do not cover at all

97530 Therapeutic Activities

• Dynamic activities to improve functional performance, direct (one-on-one) with the patient (15 minutes)
• Incorporates two or more:
  • Strength
  • Endurance
  • Range of motion
  • Flexibility
• Must show functional deficit in the above during examination

97124 Massage

• Passive procedure used for restorative effect
• Used for effleurage, petrissage, and/or tapotement, stroking, compression, and/or percussion
• Considered separate and distinct from CMT
97140 Manual Therapy

• Includes soft tissue and joint mobilization, manual traction, trigger point therapies, passive range of motion, and myofascial release.
• With CMT - must be in a separate body region
• May require a -59 modifier

When To Use 97140

• To effect changes in soft tissues, articular structures, and neural or vascular systems
• To address a loss of joint motion, strength, or mobility
• Must be part of an active treatment plan directed at a specific outcome
• Daily routine visit documentation should include progress toward those stated goals

Is This 97140 or 97124?

When to Use 97124

• Used to improve muscle function, stiffness, edema, muscle spasms or reduced joint motion
• When treatment is friction based, relaxation type massage that is less specific than 97140

Timed Coding Rules

The Intersection of 15 Minutes and 8 Minutes

Guidelines for Timed Codes

CMT and the ACR have developed guidelines concerning timed codes. There is often confusion around timed coding rules. To avoid misapplication of the Timed Coding Guidelines it is important to review the “Valid” sections (15-minute or 8-minute Timed Coding Rule). One common mistake is confusion between “Valid” and “Invalid” sections. The Valid section lists what constitutes a valid code, whereas the Invalid section lists what does not constitute a valid code. The ACR has outlined guidelines that apply to both the 15-minute and 8-minute Timed Coding Rules.

Timed Coding Rules: 15-minute Treatment

1. The biller should review the “Valid” section for the appropriate time service code to determine if a code is valid.

2. The ACR has established criteria for determining whether a code is valid. The criteria include:
   a. The code must be a valid CPT code.
   b. The code must be within the time duration specified in the “Valid” section.
   c. The code must be rendered by a physical therapist or physical therapist assistant.
   d. The code must be rendered in a single visit.

3. If any of these criteria are not met, the code is invalid.

Timed Coding Rules: 8-minute Treatment

1. The biller should review the “Valid” section for the appropriate time service code to determine if a code is valid.

2. The ACR has established criteria for determining whether a code is valid. The criteria include:
   a. The code must be a valid CPT code.
   b. The code must be rendered by a physical therapist or physical therapist assistant.
   c. The code must be rendered in a single visit.
   d. The code must be rendered in a patient encounter.

3. If any of these criteria are not met, the code is invalid.

By following these guidelines, physical therapists and billing professionals can ensure that codes are applied correctly and are in compliance with the ACR’s Timed Coding Rules.
Supervised Modalities

- 97010-97028 do not require one-on-one contact by the provider
- Billed only once per encounter
- Are not time based for billing purposes
- Documentation should include the time spent on the modality

Constant Attendance Modalities

- 97032-97039 require direct one-on-one patient contact by provider.
- These are timed based codes for billing
- Documentation should include total time spent

Therapeutic Procedures (97110-97546)

- Therapeutic Procedures are time-based codes for billing purposes
- The patient is active in the encounter
- Require direct one-on-one patient contact by provider of the service
- Documentation should include the time spent and procedure performed

Medicare’s “8-Minute Rule” Meets “15 Minute Rule”

- For time-based codes, you must provide direct treatment for at least eight minutes in order to receive reimbursement from Medicare
- CMS and CPT have clarified that any timed based service, provided on its own, is not billable if performed for less than 8 minutes

AMA/CPT Says “Each 15 Minutes”

- For a single timed code being billed in a visit:
  - Less than 8 min = 0
  - 8 up to 23 min = 1
  - 23 up to 38 min = 2
  - 38 up to 53 min = 3
  - 53 up to 68 min = 4
  - And so on

- For multiple timed codes provided in the same session, add up the total minutes of skilled, one-on-one, time based therapy and divide that total by 15
  - If eight or more minutes are left over, you can bill for one more unit
  - If seven or fewer minutes remain, you cannot bill an additional unit
6 Minutes of Therapeutic Exercise

- Do not bill any CPT code
- Threshold not met
- Document the chart to include the exercise performed and note it was 6 minutes of time spent

21 Minutes of Therapeutic Exercise

- Abdominal hollowing exercises = 12 minutes
- Cervical range of motion exercises = 9 minutes
- Total time = 21 minutes = 1 billable unit
- Note the chart with all services performed and time spent on each along with total time

28 Minutes of Therapeutic Exercise

- Lumbar Isometric Exercises = 13 minutes
- Lumbar stretching = 9 minutes
- Lumbar strengthening exercises = 6 minutes
- Total time = 28 minutes = 2 billable units
- Note the chart with all services performed and time spent on each along with total time

26 Minutes of NMR & 25 Minutes of Therapeutic Exercises

- 26 minutes of various proprioceptive strengthening exercises
- 13 minutes of lumbar(806,349),(899,374)(806,349),(898,375) stabilization exercises
- 12 minutes of lumbar stretching exercises
- Total time = 51 minutes = 3 billable units
- Documentation includes all services and time spent

51 divided by 15 = 3 with 6 left over
Did not make it to a fourth unit

10 Minutes of TherEx; 5 Minutes of Ultrasound and 5 Minutes of Manual Therapy

- 10 + 5 + 5 = 20 total minutes = 1 billable unit
- US and MT are each less than TE
- Bill where most time was spent
- Total time didn’t reach 23 minutes
**Why Do a Coding Audit?**

- Third Party Payers use algorithms to analyze patterns of bad billing practices and have established outlier data
- Self-auditing your billing and coding allows you to have a snapshot view of your profile
- Information gathered can assist you in recognizing problem areas so they might be corrected

**What Should Be Reviewed in a Coding Audit?**

- E/M Code Usage
- Statistical E/M Code Matching
- Ratio of codes within a code set: E/M; CMT; Modality and Procedure
- Modalities vs. Procedures

**Evaluation and Management-Established Pt.**

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</table>

**Compare E/M Deficit to Reimbursement Values**

720 Missing Established Pt. E/M Codes (+++++)

720 X $45.16 = $32,515.20

(99212!)
Perform Coding Audits Frequently

- Start today
- Takes very little time
- Repeat Quarterly or semi-annually to keep you on track
- Our KMCU Practice Performance Profile includes this audit

Modalities and Procedures

- Revise policies and procedures: Distribute copies of the updates that came as a result of the audit.
- Provide additional training in specific areas: For their education and to improve their coding and documentation, providers receive individual feedback as needed. For example, a physician with a pattern of under-coding may be asked to review the appropriate CPT or ICD-10 codes, as well as the documentation guidelines, to strengthen his or her coding skills.

Post Audit Necessities

- Make refunds, if appropriate: Your self-audits may reveal that incorrect codes have been submitted or that certain bills should not have been submitted at all.
- Take disciplinary action, if necessary: If a team member refuses to adapt his or her coding and documentation patterns to ensure compliance with applicable regulations, disciplinary action may be warranted.
- Change the focus of the audits: Issues and problem areas identified in a self-audit may help determine the scope of the next round of auditing.
Coding and Billing Compliance is Critical

- Your billing must match your documentation
- Understanding how to report timed codes = peace of mind

Policies and Procedures to Address THESE Risks

Today’s Focus

Confused by Discounting Rules?

Definitions

1. Dual Fee Schedules
2. Improper Time of Service Discounts
3. Improper Collection Policies
4. Inducement Violations
5. False Claims Act Violations
6. Anti-kickback Statue Violations
1. Avoid Dual Fee Schedules
- Charging more to insurance companies than you do to cash patients
  - Illegal in many states
  - Misrepresents charges to carriers
  - False Claims Act violation
  - May violate provider agreements
  - Triggers investigations

2. Time of Service Discounts
- Discount based on bookkeeping savings
  - May or may not be defined
  - Often not defensible or unreasonable
  - May not be permissible on Federally insured patients

3. Inducement Violations
- Per the OIG: “incentives that are only nominal in value are NOT prohibited by [inducement law]"
- No more than $10 per item or $50 in the aggregate annually
- Even one free examination, x-ray, or therapy is a risk

4. False Claims Act Violations
- Establishes liability when any person or entity improperly receives from or avoids payment to the Feds
- Prohibits “knowingly presenting or causing to be presented, a false claim for payment or approval

Did Someone Say Groupon?

On March 28, 2013, the Minnesota Board of Chiropractic Examiners (MBCE) updated its website to clarify that Groupon-type advertising, where the amount paid by the patient is split between the advertising company and the provider, constitutes fee splitting and is prohibited. The following is taken directly from the Board’s website:

“It has come to the attention of the Board that certain forms of advertising/marketing may place the licensee at significant risk of being in violation of the laws related to fee-splitting. Licensees should remember that certain forms of conduct that are available to the general public may be inappropriate or impermissible for use by health care professionals. One such form of advertising/marketing is exemplified by online batch-offer companies, such as Groupons and Living Social. The structure currently utilized by these and similar companies is simply not appropriate for doctors of chiropractic, as it constitutes ‘fee splitting,’ which is prohibited by the practice act.”

4. False Claims Act Violations
- Prohibits “knowingly presenting or causing to be presented, a false claim for payment or approval
- Examples:
  - Waiving deductibles or co-payments and not reporting to carriers
  - Up-coding for higher reimbursements
  - Down-coding based on payer type
5. Anti-Kickback Violations

A person who offers or transfers to a Medicare or Medicaid beneficiary any remuneration that the person knows or should know is likely to influence the beneficiary’s selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services may be liable for civil money penalties (CMPs) of up to $10,000 for each wrongful act. The statute defines “remuneration” to include, without limitation, waivers of copayments and deductible amounts (or parts thereof) and transfers of items or services for free or for other than fair market value.
Consider Your “Highest” Fee

### Regulated Fees

- By agreement, these fees are “imposed”
- Take the patient, take the fee
- Not considered a “discount”
- CMT only for Medicare
- WC, No-Fault and PIP defined by state guidelines
You Are Likely Already Discounting

When a patient that has insurance enters your office for care – they are bringing another “person” to the relationship

Doctor - Insurance Company

Insurance Company - Patient

Are You Making This Mistake?

<table>
<thead>
<tr>
<th>Actual Charge</th>
<th>CPT Codes</th>
<th>Reimbursement (without Medicare)</th>
<th>Your Average Reimbursement</th>
<th>Average Reimbursement vs Actual Charge</th>
<th>Localized 75th Percentile Value</th>
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<tbody>
<tr>
<td>$40,000</td>
<td>99201</td>
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<td>$25.00</td>
<td>100%</td>
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Clear Understanding of Hardship Fees

• Do you need a hardship fee schedule?
• Your hardship agreement can co-exist with other fee schedules
• You must set the standard up front, have qualifying factors, and verify eligibility.
• Utilize a standardized form and system

Mistakes and Blunders

• What may NOT be financial hardship?
  • No insurance
  • High deductible
  • I don’t wanna pay that much
  • My other doctor didn’t charge my copays
  • Pulse and a spine
  • Don’t confuse it with what a general discount is!! That’s what CHUSA is for!

Co-Pay or Deductible Waivers for Hardship

• The waiver is not offered as part of any advertisement or solicitation;
• Waivers are not routinely offered to patients;
• The waiver occurs after determining in good faith that the individual is in financial need;
• The waiver occurs after reasonable collection efforts have failed.
What About Professional Courtesy?

- Who do you offer courtesy to?
- Staff?
- Other DCs? Clergy? Military?
- What about when insurance is involved?
- Is it in writing?

Define Your Policy

It is the policy of this office to offer Professional Courtesy arrangements. To keep our policy legal, we adhere to the following guidelines:

- The pricings listed below are offered to all members of the stated groups without regard to volume or value of referrals.
- May include only those services regularly offered by the practice.
- Are included in written policy and have been approved by by legal practice management.
- Cannot be offered for cases unless the insurance company paying the bill is informed in writing or there is documented and verified financial hardship.
- Does not violate anti-kickback laws or claim submission rules and regulations.

Define Your Policy

We offer discounts to the following groups at the following levels:

- Staff members of [insert practice name] are offered treatment in the office at [insert percent] discount.
- Durable medical equipment, nutritional supplies, or other handout items are offered to staff members.
- Active Duty military (except for Medicare) and active or reserve military personnel.
- Active Duty military members of our staff are offered treatment at [insert percent] discount upon verification.
- For the purpose of this policy, immediate family members are considered to be defined as such:
- Spouses and children (age 18 or under).
- Physicians in our community are offered treatment in the office at [insert percent] discount.

NOTE: In situations where auto accidents, workers' compensation accidents, other personal injury or other medical/legal situations occur, where reporting actual fees is necessary, and the party receiving professional courtesy wishes to receive treatment at this office, the party may decide to settle out of this office, and elect to be charged our full rate and actual fee at this time. The party will place into writing what the office is directed to do, and in that time the party would be responsible for and expected to pay full fees in order to have them respected at a third party for non-medical reasons.

However, if the party who qualifies for Professional Courtesy wishes to use third party health insurance for any reason, they must opt out of this policy, because the office will collect 100% of all copayments, co-insurance, and any exempt deductible, as with any other patient.
Doctor - ChiroHealthUSA

Patient - Doctor

ChiroHealthUSA - Patient

Patient - ChiroHealthUSA

Ideal Fee System

Deborah Rush
ChiroHealthUSA, Inc.
July 16, 2015

Initial Visit
Exam: $120
X-Rays: $130
CMT: $65
97014: $35
Total: $350

Routine Visit
CMT: $65
97110: $50
97014: $35
97012: $35
Total: $185

Initial Visit
Capped Fee: $150
Or 20% Discount

Routine Visit
Capped Fee: $65
Or 20% Discount

Modalities: $10
Procedures: $20

100% Poverty: 75% Discount
125% Poverty: 50% Discount
150% Poverty: 25% Discount

Re-Exams: $25
Each Film: $15
To request a Copy of the Sample 1-Page Financial Policy

Text “Policy” to (601) 227-7720

The Billing Process
10 Important Time Management Steps

1. Time doesn’t change.
2. Are you wasting time?
3. Set time related goals.
4. Implement a time management plan.
5. Use time management tools.
6. Prioritize, Prioritize and then Prioritize some more.
7. Delegate when appropriate.
8. Install proper routines.
9. Set task related time limits.
10. Be systematic.

Administrative Time

• **Administrative Time**: Time spent on prevention and implementation that is not directly related to a service. Time spent during trainings, meetings, general planning, and time OFF the floor.
  • One of the biggest offenses to organization
  • Doctor admin time: marketing, Day 1.5, team meetings, planning

General Team Member Admin Time

• Insurance Follow Up
• Posting Payments
• Reactive and Proactive Calls
• Verification
• Collections Calls
• Recalls
• Doctor’s PRN or Monthly Duties
Charge Collection/Entry

- Garbage In/Garbage Out
- Use a routing slip
- Use in your balancing process
- Know the trouble spots for data entry

Why Careful Charge Entry Matters

**Doctors**
- Services which are performed will be billed
- Supplies will not walk out the door
- All the T’s are crossed and I’s are dotted

**Team Members**
- Systematic daily entry will ensure that you don’t get behind
- Checks and balances will make sure you don’t miss anything

Leaky Bucket—The Doctor to Front Desk Communication Line

- Lack of the use of a routing slip
- Supplies given out without FD knowing
- New service performed other than TX plan, not communicated
- Upgrade of frequency of visits and not scheduled

Financial Data Charting

- Refers to organizing the patient chart and preparing it for billing
- Create systemized steps or checklists
- Applies to reactivations, new conditions, and NP as well
Organize and Systematize

- Copy of picture ID
- Copy of insurance card
- Diagnosis
- Treatment plan
- Verification
- History
- Consultation
- Exam forms

Important To Get It Right

- Perfect the information in the computer account
- Add all necessary data
- Final set of eyes before it goes out
- Add this process to your SOP manual

Billing Timelines

- Can vary by carrier
- With Electronic Billing can be very quick
- Paper billing takes longer
- EFTs mean your money gets to you faster

Four Categories of Organization

1) Mail to go to the doctor
2) Checks and ‘zero pays’ to post and process
3) Items which need a phone call to resolve
4) Items which need an action to resolve

RECEIVED

- Everything gets stamped with the date it was received
- It immediately gets sorted into one of the four folders
- Oldest to the front and newest to the back
Successful Follow Up is an A-R-T

- Follow this recipe for success:
  - **A** = Attack Immediately
  - **R** = React Proactively
  - **T** = Tickle Relentlessly

A = Attack Immediately

- The insurance company returns an Explanation of Benefits (EOB)
- Sometimes it is paid correctly and sometimes not
- **ATTACK IMMEDIATELY!**

Explanation of Benefits

- Includes a detailed explanation of how the insurer/administrator determined the amount of reimbursement it made to the provider for a particular healthcare service.
- Also includes information on how to appeal or challenge the insurer’s reimbursement decision

Overview of EOBs

- Let’s walk through the steps of determining if a claim needs to be appealed
- Keep in mind the EOB tells us several important things like:
  - Lists payment amounts paid to provider, patient responsibility
  - Lists amount left of the deductible
Contracted Rate
Allowable Rate/Fee For Service

- Amounts that health insurance companies will pay to healthcare providers in their networks for services
- Negotiated and established in the insurers’ contracts with in-network providers

Your Fee For Service
\[ 98941 = 58.00 \]

Your Contracted Rate w/Ins. Company = 35.75

Your Write-off = 22.25

What to Look For

- Verify that all necessary information listed is correct:
  - Patient’s information
  - Primary insured information
  - Correct date of service
  - Correct codes

Sample EOB/ERA

- ERAs are just electronic EOBs
- Determine how each carrier sets their EOB
- Knowing how to read the codes is vital to EOB processing, posting payments

How to Read an EOB

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Code Billed</th>
<th>Amount Billed</th>
<th>Allowed Amount</th>
<th>Percentage Discount</th>
<th>Patient Responsibility</th>
<th>Amount Paid for This Code</th>
<th>Total Amount Paid</th>
<th>Remark Code</th>
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<td>$50.00</td>
<td>$32.00</td>
<td>$18.00</td>
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<td>$35.00</td>
<td>$5.00</td>
<td>$7.00</td>
<td>$28.00</td>
<td>$33.40</td>
<td>123</td>
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</table>

Total:
- $48.00
- $83.40
- $53.60

Is this really a write off per our contract?

What’s Wrong with this Picture?
Multiple Concerns

R = React Proactively

Reactive and Proactive Calls

- Phone calls are the name of the game
- You must set aside time for outbound calling
- Things will not always just come to you
- Both types of calls are necessary
  - Reactive Follow Up
  - Proactive Follow Up
Why Denials Occur

- Administrative
  - Incorrect ID number
  - Incorrect vital information of primary holder, patient, etc.
- Unsupported code
  - Therapy codes
  - Exam codes
- Medical necessity isn’t supported

Technical Errors

- Verify that all necessary information listed is correct:
  - Patient’s information
  - Primary insured information
  - Correct date of service
  - Correct codes

Coding Errors

- Are all the modifiers attached correctly?
- Is this service allowed for this patient per their benefit verification?
- What have you agreed to with your Provider Contract?

Medical Necessity Denial

- Has the insurance denied this service for medical necessity review?
- If so, you must prepare your documentation to send to them

Reactive Calls Include A/R Aging

- Not all money comes back in without any effort.
- Unpaid claims list must be worked
- Reasons bills go unpaid:
  - Never received
  - Pending information from the insured
  - Denied and you didn’t get the denial notice
Proactively Work it!

• Work the aging /unpaid claims list according to payer class
• Sort by carrier if you can
• Sort by highest balance if you’re just starting to work these lists
• Systematically move through these unpaid claims

Proactively Reconcile it!

• As you work through, reconcile all patient and insurance balances
• Apply any unapplied credit appropriately
• Strive to get through every aging within a month once you get caught up

Internal Financial Notes

• Find a place in your software where you can keep internal notes
• What if you win the power ball?
• Less is NOT more in this situation
• “And then I said, and then he said, and then I said…”

Proactively Mark it!

• Mark your aging report with cryptic notes
• Black “X” when you are complete
• Highlight those items you feel need attention
• DCs and managers should review this periodically/monthly

Helpful Scripting

• Get straight to the point: “I’m calling to follow up on an unpaid/incorrectly paid bill”
• “I’m unclear about the validity of this denial”
• “By when can I expect a check?”
• “What other options do I have to speed up the decision making process?”
• “Can I fax this directly to you so that you can give me an estimated date of payment?”
• “I’m sorry that we’re having difficulty communicating. May I please speak to your supervisor?”
Develop a Tickler System

- Follow up on your follow up
- This is the crux of a system
- It’s not person dependent
- It’s your brain in a box
- Electronic/Outlook
- Card file/hanging file

What Exactly is a Tickler File?

- A conventional physical tickler file consists of 43 folders or dividers: 12 for each of the months of the year and 31 for each of the days of the month.
- Uniquely designed to organize and keep pieces of paper or reminders
Why Appeal?

- Not appealing looks like you are billing fraudulently
- Appealing improves the practice’s bottom line
- Improves communication between providers and insurance companies
- Defends your services

Why Wouldn’t You Appeal?

- Washington – More than half of all Medicare claims denial appeals are overturned by administrative law judges according to a recent report by the Office of Inspector General.
- Examining some 40,000 Medicare appeals filed in the 2010 fiscal year, the OIG found about 35,000, or 85 percent, were filed by hospitals, physicians and other providers, with about one-third filed by 96 “frequent filers” appealing at least 50 claims. One unnamed provider filed more than 1,000 appeals.
- About half of all appeals made it to the third appeals level of administrative law judges, or ALJs, the penultimate authority on Medicare claims appeals, following two levels of Medicare contractors and preceding the Medicare Appeals Council.
- The OIG found ALJs reversed 56 percent of appeals in favor of appellants, overturning appeals rejections by qualified independent contractors (QICs).

The Appeals Process

- Create and use template letters to send to the insurance company
- Have all of your documentation, research and other supporting records gathered and organized for easy review

Medicare Appeals At a Glance

<table>
<thead>
<tr>
<th>Appeal Level</th>
<th>Time Limit for Filing Appeal</th>
<th>Monetary Threshold to be Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIRST Redetermination</td>
<td>120 days from the date of the initial determination</td>
<td>None</td>
</tr>
<tr>
<td>SECOND Reconsideration by Qualified Independent Contractor (QIC)</td>
<td>6 months from the date of the Review determination</td>
<td>None</td>
</tr>
<tr>
<td>THIRD Administrative Law Judge (ALJ)</td>
<td>Must be filed within 60 days receipt of QIC decision</td>
<td>*$140.00</td>
</tr>
<tr>
<td>FOURTH Appeals Council Review</td>
<td>Must be filed within 60 days of receipt of the hearing decision / dismissal</td>
<td>None</td>
</tr>
<tr>
<td>FIFTH Judicial Review in U.S. District Court</td>
<td>Must be filed within 60 days receipt of the Appeals Council decision</td>
<td>*$1,400.00</td>
</tr>
</tbody>
</table>
Practice Makes Perfect

• The more confident you are in yourself and the policies and procedures of your office, the more effective you will be at collecting.
• Be confident, smile, be firm and look them in the eye.

Risk Areas To Avoid

• Giving away or discounting services to beneficiaries of federally funded programs is an inducement and can expose you to fines and penalties.

Ways to Collect

• Pay per visit
• Payment plans
• Billing after the fact

The Collections Process

Co-Pay or Deductible Waivers for Hardship

• The waiver is not offered as part of any advertisement or solicitation;
• Waivers are not routinely offered to patients;
• The waiver occurs after determining in good faith that the individual is in financial need;
• The waiver occurs after reasonable collection efforts have failed.

The Cash Practice 4-Step Process

Automate Payments
**Automate One-Time Payments**

- $29/mo Price for KMC Clients!

- www.bodzin.net/kmc29

**Automate Recurring Payments**

**Over-the-Counter Collections Matter**

- Strong collections procedures create a strong practice.
- Cash patients, delinquent accounts, insurance patients and even insurance companies all play a part in collections.

**How Much?**

- Are you collecting 100 percent of your fees?
- How much is walking out of the door
- How much time (which is money) is spent on collections after the fact?

**Over-the-Counter Collections**

- Collecting for services and products is very important.
- Any monies not collected at the initial encounter, only means more time spent collecting them after the fact.
- Reduces the chances of you getting payment at all.
- Do you have a strong plan of action for collections?
What is the First Step?

- Recognize what your over-the-counter products and services are.
- Pricing should be marked or posted.
- Create a fee sheet for an at-a-glance mastery of the pricing.
- Train all staff.

Overcoming Patient Excuses

- If your patients do not pay for the products and services provided, it is NOT THEIR FAULT.
- IT IS YOUR FAULT!!!
- Be one step ahead of them.
- Be prepared.

Cash Profit Collections

- Cash Profit items can be products and/or services.
- Each member of your team should know these. Do they?
- Review them in your team meetings to ensure they are known.

What About Insurance?

- Most all products are not covered by insurance.
- DME (durable medical equipment) is usually the only product possibly covered.
- Verification is needed for certainty about coverage.

Updating Financial Arrangements

**Existing Financial Plan**

- Duration and amount of plan?
- Is this plan completed or cut short?
- Is there a credit remaining?
- Cover the change in the existing plan with patient.

**Additional Service Financial Plan**

- Are any services the same as previous plan?
- When does the new plan become active?
- Overall cost with or without credits from previous plan.
- Cover this all with patient.

Sales Tax

- Each state varies in its application of sales tax.
- It may vary in percent even by County, Parrish or other division.
- Know how to appropriately calculate it.
- Know when and how to report collected sales tax.
Front Desk is your First Defense

Situations Happen
• Patient forgot wallet
• Patient gets paid Friday
• The insurance benefits were incorrect
• Front desk staff makes an error

Don’t Get Stuck
• No systems in place = loss of monies due
• Not enough time = time management issue
• Scared patient won’t understand = clarity needed

Don’t Delay!
• The longer a balance remains unpaid, the less likely you will be able to recover the balance due

Schedule a Time
• Schedule time in your calendar once a month to send patient statements of past due balances or pick a common day

Know Where You Stand
• Run an account receivable aging report to determine who currently has a balance
• Collector’s calendar
• Start where you’re at
Month One
• Start in the same place for everyone.
• Send bills to all account due
• Expect phone calls and be prepared to handle them

Month Two
• Affix stamp or sticker to all balances that were billed last month, but remain unpaid
• Keep track of who was billed with notice in a notebook or digital file
• Bill new balances with no sticker

Month Four
• Bill new balances with no sticker
• Follow suit with all unpaid balances sent previously
• Affix collections stamp or sticker to all balances that were billed both first, second & third month, but remain unpaid

Make Time for Contact
• Call patients to collect via telephone
• Develop scripts for common circumstances

Don’t Feel Bad 😌
• You had an agreement with the patient, and they are not sticking to their end of the deal.
• If they are avoiding you, they are not allowing you to work with them to pay down balance.

Streamlined Procedures = Success!
• Stay on top of your billing monthly
• No more writing off uncollected balances
• Collections confidence
Need Help?
Info@kmcuniversity.com