Medicare and Beyond!
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What We’ll Cover Today
• What’s really different about Medicare?
• Medicare’s procedure codes, diagnosis codes, and modifiers
• How your carrier shares special billing instructions
• Billing for non-covered services in Medicare
• Medicare’s Timely Filing rules

What We’ll Cover Today
• Secondary and supplemental policies for Medicare patients
• The rules that govern treating immediate family members
• The detailed Appeals Process that has been proven to overturn Medicare denials more than 50% of the time

What We’ll Cover Today
• Learn what the limitations are on fees charged to Medicare patients
• Know what you MUST charge them for, and how to do it properly
• Find out the best ways to handle those Medicare beneficiaries with true hardship situations
• Learn about the choices you have as you consider what you will charge for Medicare Maintenance Care
• Be clear when it’s necessary to bill Medicare as a secondary payer and what you’re allowed to charge

Medicare Assumes...
• The billing that you send is accurate
• Your doctor understands everything about Medicare maintenance definitions
• You are billing only medically necessary services

DOCTOR THINKING
• Doctor determines if treatment is needed
• Doctor determines if it is covered under Medicare
• Doctor should know the rules related to Medicare

In this Medicare patient...
• Is this the right patient for the treatment?
• Is this the right code?
• Is there a Medicare overpayment to be returned?
Where in the World is my MAC?

My Medicare Administrative Contractor (MAC)

What Does a MAC Do?

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.

What Does a MAC Do?

- 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
  - Make determinations regarding LCDs
  - Respond to provider inquiries
  - Establish local coverage determinations (LCDs)
  - Educate providers about Medicare FFS billing requirements
  - Coordinate with CMS and other FFS contractors
  - Review medical records for selected claims
Like Any Other Government Contractor

Summary of Section 509 of MACRA of 2015

The Medicare Access and CHIP Reauthorization Act of 2015, passed on April 16, 2015, included language in Section 509 that makes Medicare Advantage Contractors (MACs) liable for any harm. The legislation also requires the Agency to publish performance information on each MAC, to the extent that such information does not interfere with contract negotiations. This legislation applies to all contracts in effect at the time of enactment, meaning that current MAC contracts in place can be extended another 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.

DME Handled by Different MAC

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

Look Up for 98940
Chiropractic Lookups

Verification and the IVR

Partner with Your MAC

Objects

- 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

Requirements to Treat Medicare Patients

- Must be registered with Medicare carrier
- Choose participating or non-participating
- Maintain status, must re-verify
- May not “opt-out” to avoid billing Medicare

NPI Numbers
- National Provider Identifier: both personal and group
- A unique identification number for covered health care providers
- HIPAA established this number
- Is 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)

Provider Numbers and Medicare

- NPI
- PTAN
- UPIN
- TAX ID or EIN

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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

Medicare Replacement Plans

When an enrollee in a private fee-for-service (PFFS) plan offered by a Medicare Advantage (MA) Organization obtains services from a provider, then, for those services, the enrollee is considered to be a Medicare Advantage (MA) enrollee. However, the MA Organization is considered to be the provider, for all purposes, for those services. For more information, please refer to the MA Organization.

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

Verifying Crosswalk Claims

- EOMB will have code whose definition states “claim information transmitted to ….”
- Patient can verify with Medicare
- Verify on some carriers’ websites

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

Medicare as a Secondary Payer

- Personal Injury/Auto Accident
  - Must be billed to other parties first
  - 120 day wait rule
  - If paid by Medicare, lien on final settlement

Medicare as a Secondary Payer

- Work Injury
  - Wait until final disposition of case
- Group Policy
  - Only bill Medicare if the amount paid by Group Policy is below what Medicare payment would be based on Medicare allowable charge
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

• 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: 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? N/A

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

How Medicare Works with Chiropractic

History and Basics

- Chiropractic added to Medicare in 1972
- Under the auspices of Dept. of Health and Human Services (HHS)
- Administered by Center for Medicare and Medicaid Services (CMS)
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.

Basics of Medicare

- 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...
  - 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.

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

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
**Opting Out of the Medicare Program**

Q: Are chiropractors allowed to Opt-Out of the Medicare Program?

A: No. By definition of the CMS CR 5426 the term “physician” is limited to doctors of medicine; doctors of osteopathy; doctors of dental surgery or of dental medicine; doctors of podiatric medicine; and doctors of optometry who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the State in which such function or action is performed; no other physicians may opt out.

“The opt-out law does not define “physician” to include chiropractors; therefore, they may not opt out of Medicare and provide services under private contract. Physical therapists in independent practice and occupational therapists in independent practice cannot opt out because they are not within the opt-out law’s definition of either a “physician” or “practitioner.” (Rev. 82, issued: 12-22-08, Effective: 11-13-08, Implementation: 04-02-07).


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**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.”

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**Active and Maintenance Care**

Incidents, bursts, and episodes of care will happen throughout the patient’s experience in your office

**FINANCIAL RESPONSIBILITY OF Chiropractic CARE**

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**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.”
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

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

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/misalignment 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

MEDICARE DOCUMENTATION

MEDICARE MEDICAL NECESSITY DOCUMENTATION REQUIREMENTS

SUBLUXATION PROOF VIA PART DOCUMENTATION

MEDICARE MEDICAL NECESSITY DOCUMENTATION REQUIREMENTS
Entering Provider Information

- Box 31 – Physician Signature
- Box 32 – Service Facility Information
- Box 33 – Provider of Service Information

CMS Requirements

- Onset Date for Medicare
- Use Box 14
- Date of treatment for this episode

Modifiers

- Use in Box 24D
- Multiples may be used
- Pricing modifiers in first place

Chiropractic Services CMS Basics

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  - All Exams, Therapies, X-rays, DME, Etc.

AT Modifier

- AT: Active treatment
- Supporting documentation
- Declares the covered service
- Absent modifier will trigger denial

Procedure Codes on Claims

Box 24 contains

- Date
- CPT Code
- Diagnosis Pointer
- Charge
Non-Covered Services

- Statutorily Non-Covered
  - Every other service provided except CMT
- Non-covered in this instance
  - Maintenance CMT

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

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

Advance Beneficiary Notice of Noncoverage (ABN)
From the Horse’s Mouth!

WHAT IS AN ABN?

An ABN, Form CMS-R-131, 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 Healthcare 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.

AdvanceBeneficiaryNotice

- 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

WHEN MUST I ISSUE AN ABN?

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); or
- 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).

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 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.

- If Option 2 is chosen:
You will not violate mandatory claims submission rules under Section 1544A 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.
Modifiers Required When Billing With An ABN

• Any procedures provided that require an ABN must be submitted with one of the following Medicare modifiers:
  – 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.
  – 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.
  – 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 included.
  – 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.

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 issuance, 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;
• Provided far enough in advance of potentially noncovered items or services to allow sufficient time for the beneficiary to consider available options;
• Explanations in its entirety with all questions related to the ABN answered; and
• Signed not dated by the beneficiary or his or her representative after he or she selected one option box on the ABN.

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.

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
A Simple Solution

Patient Friendly Medicare Education

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

www.patientmedia.com/medicare

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

But Do I Need One for Non-CMT Services?

Voluntary Use = “MAY I?”

WHEN MAY I ISSUE AN ABN?

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 Claim Reporting Modifiers Do I Use?” section at the end of this booklet for information on claim modifiers associated with voluntary ABN use.

ABN for Voluntary Use

You should only provide ABNs to beneficiaries to indicate your acceptance or refusal to bill a specific service. Medicare does not require you to issue an ABN in order to bill a non-CMT service. Medicare does not cover non-CMT services. Medicare does not require you to issue an ABN in order to bill a non-CMT service. Medicare does not cover non-CMT services.

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

Aha!
Your Options for Advance Notice for Statutorily Excluded Services in Medicare

Option One: Do Nothing

Option Two: Use Medicare’s Official Form

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)
Option Three: Make Your Own Notice

DO IT YOURSELF

Option Four: A Better Way

BETTER WAY

Patient Friendly Medicare Education

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

www.patientmedia.com/medicare
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?

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

Special Code Restrictions In Medicare

- 97010 – Bundled into CMT code, not billable to secondary/supplements
- 97014 – not recognized, replaced by HCPCS code G0283

Other Special Requirements

- Billing x-ray codes for denial
- Box 17 - Ordering physician
- Box 17b - NPI of ordering physician

Diagnosis Driven

- Medicare covers only treatment by manual manipulation for a subluxation of the spine
- Local carrier determines how you report
- Except Florida, M99.0 will be primary diagnosis

Diagnosis Driven

- Supporting neuromusculoskeletal diagnosis
- Supporting diagnosis list available from carrier
- Two diagnoses for each segmental level billed
- At least two diagnoses on a claim
What About S8990?

- The Health Care Procedure Coding System (HCPCS) is developed and maintained by CMS and consists of a letter followed by a series of numbers. The codes are categorized by the letter prefixes. The "S" codes are Private Payer Codes. The introductory paragraph of the Private Payer section states: "HCPCS "S" codes are temporary national codes established by the private payers for private payer use. Prior to using "S" codes on insurance claims to private payers, you should consult with the payer to confirm that the "S" codes are acceptable. "S" codes are not valid for Medicare use."

- S8990 is defined as "physical or manipulative therapy performed for maintenance rather than restoration". Maintenance care is not a covered service for Medicare beneficiaries. As such, we are not required to bill Medicare for maintenance care and would not require a specific code for that purpose.

- Not a single Medicare Administrative Contractor lists code S8990 in a Local Coverage determination. If this code is not listed in the LCD then it is not acceptable to use when billing chiropractic services.

**Different Names for Different Fees**

- Allowable fees – Fees permissible by health plans, or mandated programs such as Medicare, Medicaid or Workers Compensation and PIP

- Approved Amounts – The amount Medicare determines is reasonable for a service covered under Medicare Part B. It may be less than the actual charge.

**Advantages of Participating**

- Fee schedule is 5% higher than non-par provider

- Collections from patients are much easier

- Medicare will automatically forward Medigap claims to the proper secondary insurer

- Participation makes it easier for Medicare patients to see you since they don't have to pay full fee up front
Charges: Participating Providers

- For (AT) Spinal CMT Codes Only
  - May submit full fee and write-off down to allowable fee
  - May submit allowable fee
    - Actual Fee: 98940 = $40
    - Allowable Fee: 98940 = $25
    - Medicare pays 80% = $20
    - Coinsurance = $5
    - Write Off = $15

Advantages of Non-Participation

- Function more like a “cash based” practice
- Accept assignment only when you choose to
- Zero to limited A/R for Medicare
- Might discourage Medicare patients
- Attract patients ready to pay up front

Charges: Non-Participating Providers

- For (AT) Spinal CMT Codes Only
  - Must charge and submit limiting charge
  - Equal to 115% of fee schedule
  - Will be reducing to non-par fee if taking assignment on individual basis

What Do I Charge in 2015

- Looking up your fee is much more complicated for 2015
- PQRS and EHR both affect which column you will look to for your fee schedule

Tools for Finding Your Fee

- Tools to confidently and accurately determine your fees
- Use your MAC website
- Know your status
  - PQRS in 2013?
  - EHR in 2013?

Medicare Charges

- Charges while in active care
- Charges while in maintenance care
- Medicare policies dictate compliance
Poor Morris Medicare!

- Medicare is highly regulated
- How you deal with Medicare patients is highly scrutinized
- Make sure that “helping out poor Morris Medicare” doesn’t put you, your license, and your practice at risk

You Must Bill Medicare

- When a MC patient receives covered (-AT modifier) care, the doctor must submit to MC.
- When the patient receives maintenance care, they can elect through ABN whether they want it submitted.
- Non-covered care MAY have to be submitted as well.

Medicare Patient Rights Rule

- You must bill when they ask you to, even non-covered services.
- Regardless of your participation level, the patient decides whether you bill Medicare.
- They can change their mind and you must comply.

Charges: Statutorily Excluded Services

- Medicare patients must be charged your ACTUAL fee for the services they pay for out of pocket
- If they qualify for a discount due to another program available in your office, they can be charged that fee
What is the PQRS System?

- Physician Quality Reporting System
- Established by Tax Relief and Health Care Act 2006
- Pay for reporting program
- Only eligible professionals can report
- Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) made the PQRI program permanent

Quality Codes for CMT

1. Functional Outcome Assessment: Was it performed? Was a treatment plan formed as a result? Measure #182
2. Pain Scale: Was it performed? Was it positive or negative? Was a follow-up plan created because of it? Measure #131
What to Collect from Patients

- Participating Physicians
  - Limited to allowable charge on covered CMT
  - May have to wait until all insurances process
  - May collect full fee on statutorily non-covered
  - May collect full fee on incidental non-covered services (maintenance CMT)

What to Collect from Patients

- Non-participating Physicians
  - Limiting charge amount when not accepting assignment
  - May collect at time of service
  - May collect full fee on statutorily non-covered
  - Limiting charge on incidental non-covered services (maintenance CMT)
  - Reduce to non-par allowable when accepting assignment

Limits on How You Charge Medicare Patients

What You May Not Do:

- Waive charges to induce Medicare patients
- Give away any service or item of value greater than $10 up to 5 times per year

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.

Simple, Clean and Legal

- Do you ever NOT recommend therapy because you know they have to pay?
- Would the patient get more complete health care if financial concerns were removed?
- They qualify for the discounted, network based fee schedule that YOU set.
Many Medicare Patient Legitimately Need Help

Clear Understanding of Hardship and Discounted Fees

- 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

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.

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
Treating and Billing Family Members

The following is taken directly from CMS Policy Manual 102011 Medicare Benefits Policy Manual.

Members of the Patient's Household

- Immediate Family
  - Spouse and self
  - Children (biological, adopted, step, foster)
  - Grandchildren (biological, adopted, step, foster)
  - Parents (biological, adoptive, legal)
  - In-laws (mother-in-law, father-in-law, brother-in-law, and sister-in-law)
  - Grandparents and grandchildren

- Other Family
  - Brother or sister in-law (i.e., in-law related to the patient's spouse)

NOTE 1: A brother or sister in-law who is not related to the patient's spouse must be excluded from coverage.

NOTE 2: A brother or sister in-law is not related to the patient's spouse if the patient's parent dies before the birth of the brother or sister in-law.

We Recommend ChiroHealthUSA

- Membership discount plan
- Used for statutorily non-covered services
- No submission to insurance
- You set your office fee for all patients
- Can be used for incidentally non-covered services (maintenance CMT)

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

But, I Want to Give Medicare Patients a Break on Fees!

- Office of Inspector General has been clear about this
- Never routine, never advertised, avoid inducement
- Look for legal and clean but simple ways to have your cake and eat it too

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 Reconciliation 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>$14,900.00</td>
</tr>
<tr>
<td>FOURTH Appeals Council Review</td>
<td>Must be filed within 60 days of receipt of the hearing decision (denial)</td>
<td>None</td>
</tr>
<tr>
<td>FIFTH Judicial Review in U.S. District Court</td>
<td>Must be filed within 60 days of receipt of the Appeals Council decision</td>
<td>$1,000.00</td>
</tr>
</tbody>
</table>
25,000 Foot Overview

- Most denials will be for Medical Necessity or Screen violations
- There are five distinct steps to the Appeals process
- Sometimes, you may not have to appeal, but simply correct errors and resend
- Creating a system of appeals makes it easy to do
- System can also be used for MM denials and appeals

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).

Level Zero

- You might not need to appeal
- There may be simple errors to correct
- The appeals process is more suited to MN denials
- Review the Reference Tool that will allow you to get the steps for level zero

Should You Be Appealing?

- Does the documentation in the record support your appeal?
- Do the definitions apply to this claim for necessity?
- Perform a mini-audit of the records first!

Level 1: Redetermination

- Within 120 days from original denial
- Use special form that is a part of this lesson
- Will be reviewed at the CARRIER (MAC) level
- Attach supporting documentation with the cover sheet we provide

Level 2: Reconsideration by Qualified Independent Contractor (QIC)

- Reviewed by independent third party
- Must be filed within 180 days of the denial from level one
- Two different QIC depending on state you live in
- Another special form must accompany
- Review the materials sent to Level One
Level 3: Administrative Law Judge (ALJ)

- If $140 from all claims remains outstanding, you can escalate to ALJ.
  (2013)
- Can be on phone or in person.
- Within 60 days of QIC decision
- QIC letter gives instructions on how to do this and fill out corresponding form
- You want to really make your case here

Level 4: Review by Medicare Appeals Council

- Request submitted in writing within 60 days of ALJ decision
- No additional monetary threshold.
- Should issue a decision within 90 days
- At this level, you must have your collective ducks in a row
- Arguing points that must be clarified with data

Level 5: Judicial Review in Federal District Court

- Amount in controversy needs to be at least $1400 in 2013.
- Must file within 60 days of Medicare Appeals Council decision
- Your literal “day in court”

Maintenance

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.”

Three Choices for Fees in Maintenance Care

- Charge Medicare allowable fee or limiting fee
- Charge your actual fee
- Charge a discounted fee for maintenance if the patient qualifies and you offer this to ALL types of patients
- Codify this in your compliance policy

Option One: Medicare Allowable/Limiting Fee

- Continue to charge the allowable or limiting fee in maintenance care
- Charge that fee when billing for active treatment
- Set policy that says THIS is your fee for all phases of care: acute, chronic, or maintenance
Should I Consider This Option?

**Pros**
- Super simple for the front desk and the patient
- Much easier to explain when maintenance care begins
- Doesn’t feel confusing to the patient since the fee is the same all the time

**Cons**
- The doctor won’t be able to collect actual fee, even for maintenance care CMT

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Sample Policy: Option One

It is the policy of this office to charge the published, regulated fee schedule for the spinal Chiropractic Manipulative Treatment (CMT) codes delivered to Medicare patients, whether the treatment is for acute, chronic, or maintenance care. If a Medicare patient elects to receive Chiropractic Manipulative Treatment services that the provider deems are likely to be denied by Medicare, this patient will indicate their choice on the appropriate Medicare Advance Beneficiary Notice (ABN) form, and will be informed of the fee for the service prior to treatment. This office will continue to charge our full and actual published fee schedule for these services. If the patient qualifies for discounts under our available Hardship Policy or a Discount Medical Plan Organization (DMPO) we may participate in, the fee schedule will be extended to the patient. In addition, this office will charge and attempt to collect any and all deductible and co-insurance due from the patient.

This office’s providers are (participating/non-participating) with Medicare. We locate the published, regulated fee schedule applicable to our office on our Medicare carrier’s website on an annual basis, and update our fees accordingly. As a participating provider, we bill the Medicare Participating Allowable fee for each of the three spinal CMT codes during active treatment. OR As a non-participating provider, we bill the Medicare Limiting fee for each of the three spinal CMT codes during active treatment.

Should I Consider This Option?

**Pros**
- The doctor can collect actual fee, rather than this limited fee schedule for maintenance care.

**Cons**
- Patients may have difficulty understanding the increase
- They may already have confusion around the maintenance concept, and could have pushback around increased fee
- Confusion can lead to calling Medicare raising a flag
- Par providers may go from as small a copayment as $25 all the way to $50

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Collect Actual Fee for Maintenance CMT

- As the manual states, it’s OK to begin charging ACTUAL fee during maintenance with ABN signed
- Requires carefully worded PRO and discharge discussion of fees
- We recommend Par providers BILL actual fee
- Non-Par Providers must bill Limiting Fee
Option Three: Publish A Maintenance Fee Schedule Anyone Can Access

- The safest, and cleanest way to do this is to join a DMPO like ChiroHealthUSA
- Within that fee schedule, post a fee for maintenance CMT, regardless of levels
- Anyone who is a member can access that fee schedule

Sample Policy: Option Three

This office's providers are (participating/non-participating) with Medicare. We locate the published, regulated fee schedule applicable to our office on our Medicare carrier's website on an annual basis, and update our allowable fee accordingly. (Choose one): As a participating provider, we bill our published, actual fee for each of the three spinal CMT codes during active treatment submitted to Medicare. When payment is allowed by Medicare, we take the appropriate contractual write-offs as directed on the Explanation of Medicare Benefits, charging the Medicare patient ONLY the applicable co-insurance or applied deductible fees. OR As a non-participating provider, we bill the Medicare Limiting fee for each of the three spinal CMT codes during active treatment.

All other treatment rendered in the office is considered to be statutorily non-covered under Medicare. Therefore, this office charges our full and actual published fee schedule for those services. If the patient qualifies for discounts under our available Hardship Policy or a Discount Medical Plan Organization (DMPO) we may participate in, that fee schedule will be extended to the patient. In addition, this office will charge and attempt to collect any and all deductible and co-insurance due from the patient.

If a Medicare patient elects to receive Chiropractic Manipulative Treatment services that the provider deems are likely to be denied by Medicare, this patient will indicate their choice on the appropriate Medicare Advance Beneficiary Notice (ABN) form, and will be informed of the fee for the service prior to treatment. This office has a published “maintenance” fee schedule that is offered to any patient receiving maintenance or wellness based care that is not covered by their applicable third party payer, including Medicare. Medicare beneficiaries wishing to continue in Maintenance care will be made aware of this fee schedule in conjunction with our network-based, ChiroHealthUSA fee schedule. The patient will direct the office whether to submit this maintenance care to Medicare by their choice on the ABN form. If it’s billed to Medicare, the fee will be represented as the amount of the maintenance fee actually charged, and not any other fee.

Should I Consider This Option?

Pros
- Patient has likely already joined DMPO for excluded services—easy transition
- Much easier to explain when maintenance care begins
- Doesn’t feel confusing to the patient since the fee is for “maintenance”

Cons
- Lots of confusion in this area about whether one can assign a maintenance fee outside of a DMPO
- Requires LOTS of explanation to the patient about who decides what is maintenance
- Maintenance adjustments cost the same as active treatment to the practice

The Three Most Important Considerations

- You must CHARGE correctly...use the correct fee schedule
- You must BILL it correctly...use the right fee whether billing patient OR carrier
- You can COLLECT according to your policies

What Makes a Payment Plan Compliant?

- Use of proper fees to calculate patient responsibility
- Appropriate estimate of medically necessary care to be paid by 3rd party
- Automated payments from credit card handled properly
- No discounts given on 3rd party reimbursable portion of care

Medicare Payment Plans

- Once you have charged and billed correctly, you may collect according to your written policy
- OK to allow them to pay their portion on a monthly payment plan
- OK to incentivize excluded services 5-15% if prepaid...but we discourage this
Payment Plans = Opportunities

- Patients on payment plans:
  - stay under care longer
  - tend to get all the care they need, including rehab and other items
  - are more likely to have family under care

Mastery of Medicare Charges and Fees

- Understand and implement these options into your Fee System
- Write appropriate policy based on your decision
- Practice explaining these fees at the various touch points necessary
- Make Medicare one of the easiest demographics in your practice!

HIPAA and OIG Compliance Training Program

Our HIPAA and OIG Compliance Training is a monthly membership program that walks you step-by-step through installing your required HIPAA and OIG Compliance programs. You'll learn how to:
- Avoid common documentation errors and omissions
- Code when you address compensatory areas vs. treat primary subations
- Install necessary HIPAA and OIG compliance policies

More info? KMCUniversity.com/LibraryPlusCompliance

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info@kmcuniversity.com