Convert Your Medicare Patients to Cash to Avoid the Penalties of MACRA!!

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CMS SHOULD USE TARGETED TACTICS TO CURB QUESTIONABLE AND INAPPROPRIATE PAYMENTS FOR CHIROPRACTIC SERVICES

Do You Feel Like This?

Under the Magnifying Glass

MACRA Section 514

PUBLIC LAW 114–10—APR. 16, 2015

"(A) PRIOR AUTHORIZATION MEDICAL REVIEW.—

(1) IN GENERAL.—Subject to clause (ii), the Secretary shall use prior authorization medical review for services described in paragraph (1) that are furnished to an individual by a chiropractor described in section 1861(r)(5) that are part of an episode of treatment that includes more than 12 services. For purposes of the preceding sentence, an episode of treatment shall be determined by the underlying cause that justifies the need for services, such as a diagnosis code.
Improvement Initiative

This Isn't Going Away Soon

Top Findings

Strategic Health Audit Finding 1

Strategic Health Audit Finding 2

Strategic Health Audit Finding 3
**Strategic Health Audit 4**

**Review Determination:**
The claim for chiropractic services was paid in error. Adjustment or denial of the claim has been recommended to the Centers for Medicare & Medicaid Services (CMS).

**Review Rationale:**
The submitted subsequent visit documentation did not meet the required Medicare guidelines. The documentation did not include the changes since the last visit or an assessment of change in the patient condition since last visit, and the documentation of treatment effectiveness. (CMS Pub 100-2 Medicare Benefit Policy Manual, Chapter 15, § 240.1.a)

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**You Can’t Opt Out!**

You must be enrolled with Medicare if you see Medicare patients.

Chiropractic is one of 3 specialties that cannot opt-out of the Medicare program:
- Chiropractors;
- Physical therapists in independent practice; and,
- Occupational therapists in independent practice

**You Must Bill Medicare**

- When a Medicare patient receives coverable, AT modifier-worthy care, the doctor must bill Medicare.
- When the patient is receiving maintenance care, s/he can elect through ABN whether or not to submit the bill.
- Non-covered care MAY have to be submitted as well.

**MN: Chiropractic Per CMS**

**Acute and Chronic Subluxation**

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.

The patient must have a subluxation of the spine as demonstrated by x-ray or physical examination (PART).

If above not met or exceeded = Not Medically Necessary!

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**How is Care Defined?**

**Clinically Appropriate Care**
- Maintenance care
- Supportive care
- Palliative care
- Life enhancing and wellness care
- Symptom relieving only
- Care that doesn’t have improved function and correction as its goal

**Medically Necessary Care**
- Acute problems
- Care that can provide measurable, functional improvement
- Chronic care with expected functional improvement
- Often defined by the carrier’s medical policy

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**Is All Care Medically Necessary?**
Is this visit AT or GA worthy?

- If the visit is inside a Treatment Plan/Active Episode of Care = AT
- If the visit is outside a Treatment Plan/Active Episode of Care = GA (and requires use of ABN form)

AT vs. GA Modifier

- Has to be a Doctor Decision
- Needs to be clarified in the Assessment
- Patient needs to understand the difference between the two
- Definitely Gray Areas

You Must Decide!

- It is up to the office, not the patient, to determine whether the visit is medically necessary or not
- It’s a clinical decision
- It’s not a money decision

Not Medicare Only...

The concept of medical necessity, active episodes of care, and maintenance care are the same for any type of third-party pay situation
Let’s Follow the Simple “YES” Path

Let’s Follow Alt. 1 “YES” Path

Let’s Follow Alt. 2 “YES” Path

I know they need care...now what?

This is the $64,000 Question

DCs Must Answer with Certainty!

If No....

In this circumstance, per Medicare coverage requirements, medical necessity cannot be established and therefore the condition is likely maintenance care.

If YES...it’s time to plan...

HINT: Setting internal treatment protocols keeps you from reinventing the wheel with each new condition

Is there a subluxation present, capable of causing a significant neuromusculoskeletal (NMS) condition, and does the patient have a documented loss of function that can be improved?

If No....

If Yes...
Incident Protocols
- Documentation within CMT
- May not be necessary to provide E/M
- Keep up your PQRS
- Beware of incidents that happen once-a-month like clockwork

Typical Episode of Care
- Likely to require at least one re-evaluation
- Chronic diagnosis and significant lack of function

Burst may be the most commonly used

It has to be one or the other...

HINT: All team members should understand what it means to be “in an active episode of care” in order to facilitate in-processing

Let’s Go Down the “YES” Path
Let's Go Down the "NO" Path

Part One

Let's Go Down the True Non-AT (GA) Path

Part Two

No Thank You
Clarify Once and For All...

**Do I Need a Signed Advance Beneficiary Notice (ABN)?**

An ABN is mandatory when a service is denied because Medicare does not cover it. It’s important to note that an ABN form must be signed and dated in order to be in compliance with Medicare regulations. Follow the prompts to support your decision making in the correct outcome.

**Hint:** ABN forms are mandatory when a CMT service may not be medically necessary.

**Routine use of the ABN form is strictly forbidden.** If you use it incorrectly, you could invalidate all of your ABN forms.

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**As with the previous discussion, it has to be ONE or the OTHER!**

**It is up to the doctor to direct the team member on when the visit may be considered maintenance rather than active treatment (AT).**

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**Keep in mind that not every patient will agree to pay for GA care.**

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**When Should We Release?**

- **Obvious Example:**
  - Patient is treated
  - They got better
  - Patient starts maintenance care
  - Great Job Doc!
  - Patient is adjusted for life!

  Sadly 3rd party payers don’t think like this!
When to Release from Active Care

• At scheduled re-evaluations, review patient’s progress towards:
  • ADL goals
  • Functional goals
  • Symptom free goals
• Within active treatment if the results warrant
• Reschedule evaluation earlier

When to Release from Care

Per CCGPP: When the patient arrives at Final Plateau (maximum therapeutic benefit)
• Complete or partial resolution of the condition and all reasonable treatment and diagnostic studies have been provided
• Patient is unlikely to improve further

Clinical Discharge

• Releasing from Medically Necessary Care
  • The patient doesn’t need treatment to improve function anymore
  • Release them so they can fly on their own
  • Be the place where they can maintain safety
  • Discharge puts a “pin” in this active episode

Final Discharge Checklist

- You’ve finished a course(s) of treatment
- The patient has met or is not likely to move closer to reaching goals
- You have effectively attempted therapeutic withdrawal or written down why it is not indicated
- The patient has been given educational and self-management tools about his/her condition
- Written discharge is placed in chart

Maximum Improvement Achieved

Re-Evaluation Assessment:
- Current status: Overall, Mary feels the complaint has improved significantly. She states that her ability to sleep through the night, without being aware of pain, has improved without residual symptoms
- Treatment Effectiveness: Six-week follow-up (6 weeks post-treatment) showed a 75% improvement in cumulative satisfaction and an 80% reduction in pain, resulting in a significant improvement based on her meeting all short-term and long-term goals, and based on her final evaluation.
- Treatment Effectiveness: Line-Back Disability Questionnaire (LBDQ), was utilized indicating a 50% change since beginning care. Initial score: 75.0% - Current Score: 58.6% - Goal Score: 100.0% or better
- Continuation of Care: In consideration of the findings from today’s reevaluation, continued active chiropractic treatment is unnecessary for this condition and will be discontinued because maximum clinical improvement has been reached. See the complete discharge summary.

Discharge Summary: Mary Murphy
Condition Treated: Neck pain
Treatment: Chiropractic, Physical Therapy, moist heat, electric muscle stimulation
Functional Goals Achieved: Sleeping without being awakened by pain - Mary can now sleep 8 hours without awakened with pain
Final Status: Active TK Discharged - return as needed for maintenance and/or wellness care
**Patient-Friendly Medicare Education**

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

www.patientmedia.com/medicare

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**Simple Explanation**

“Mrs. Jones, great news. Today is the day we’ve been planning for. You’ve met all the goals we set several weeks ago, your pain level is reduced significantly and you’re back to sleeping through the night without waking up due to your neck pain. I’m discharging you from active treatment for this episode of care now and we’ll let Medicare know that you’ve reached the finish line!

As we discussed, now you move into the supportive phase of care. We’ll see you (insert schedule for maintenance/wellness or PRN) to help ensure that you don’t have this kind of a flare-up again. It’s always better to maintain rather than to fix things when they break.”

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**Here’s the Great News!**

Good News

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**Graduation to Maintenance Care**

- Medicare patients will move in and out of active treatment while a patient in your office
- The doctor is in control of this: it’s called Case Management!
Now It’s Time for Hip-Pocket National Bank!

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

We Recommend ChiroHealthUSA

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

We Recommend ChiroHealthUSA

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

Option Two: Charge Actual Fee for Maintenance Care

50.7.3 - Effects of Lack of Notification, Medicare Review and Claim Adjudication
(Rev. 2/01, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Beneficiary Liability

A beneficiary who has been given a properly written and delivered ABN and agrees to pay may be held liable. The charge may be the supplier/provider’s usual and customary fee for that item or service and is not limited to the Medicare fee schedule. If the beneficiary does not receive proper notice when required, he is relieved from liability.

Notify may not issue ABNs to shift financial liability to the beneficiary when full payment is made through bundled payments. In general, ABNs cannot be used where the beneficiary would otherwise not be financially liable for payment for the service because Medicare made full payment. See 50.13 for information on collection of funds.

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 that is a member can access that fee schedule

Out Gift to You

Compliance Policy for Medicare Charges and Fee Schedule
Select only ONE (1) of the Three (3) Options Below

Option One: Medicare Allowable/Limiting Fee

It is the policy of this office to charge the published, regulated fee schedule for spinal Chiropractic Manipulative Treatment (CMT) codes delivered to Medicare patients, whether for acute, chronic, or maintenance care. All other treatments rendered in the office are considered statutorily non-covered under Medicare, so this office charges the full and actual published fee schedule for these services. If the patient qualifies for a discount under our Medicare Policy or through a Discount Medical Plan Organization (DMPO) we participate in, that fee schedule is extended to the patient. In addition, this office charges and attempts to collect an deductible and/or co-insurance due from the patient.

This office is not participating in Medicare. We post the published, regulated fee schedule for our services on our Medicare center’s website and update it monthly. (Please visit the following). As a participating provider, we bill the Medicare Participating Allowable fee for each of the three spine CMT codes during active treatment. As a non-participating provider, we bill the Medicare Limiting Fee for each of the three spine CMT codes during active treatment.

Fact Sheet

Simplify Medicare Financial Discussions with Helpful Scripting

Medicare-eligible patients may present to your office confused about how much it costs to see a Chiropractor. If they are covered by Medicare, they may have seen another chiropractor who did a “test that didn’t work” job of explaining how the chiropractic treatment plan would work. Even if they did not receive a chiropractic treatment plan, they may not realize that those services were medically necessary. This can create a big problem when we try to explain “out of pocket”. This may be a bittersweet pill for you to give your non-covered patient because the message you are delivering is completely different from what they heard before.

You may be faced with a patient who has a co-pay amount that covers the deductible and co-insurance for the adjustment, but that isn’t covered for the statutorily non-covered services. Then again, you may have a patient with a great secondary insurance that covers almost all of the services rendered in your office. We need to have the courage to ask our patients to make those discussions clear and efficient while managing to show how affordable the care can be for those patients.
Need Help?
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