Can I Really Be a Cash Based Practice?  
Have the Best of Both Worlds!  

Presented by:  
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What You Will Learn

- The true definition of a “cash” practice, and why some doctors’ missteps in this area are actually compliance liabilities.
- How to define medical necessity and clinical appropriateness.
- Why knowing this big difference is the key to third party payment vs. patient payment.
- How to work with insurance within their medical necessity definitions, and not a moment more.
- How to explain these important differences to your patient so they stay, pay, and refer!
KMC University’s Goal

• No scare tactics
• All the truth and nothing but the truth
• Actions speak louder than words
• We’re here to encourage, reassure, and support you in your efforts

if you’re making mistakes it means you’re out there doing something
Neil Gaiman
What Most THINK It Means to be a “Cash Based Practice”

• Third party payers are not billed directly by your office.
• Medicare patients are told that Medicare will not be billed.
• All inbound money from the practice is paid across the front desk.
• Oops, well, maybe we bill PI or WC.

Best of Both Worlds?

• Can you be a cash practice AND still say “Yes” to insurance?
• Is it possible to do both?
• Proper use of third party insurance AND proper patient education is the name of the game.

The Reality of a “Cash Based Practice”

• If you treat Medicare patients, you must bill Medicare on behalf of your patient for active treatment.
• If you allow patients to bill their own insurance, or you submit for them, you’re still bound by certain 3rd party rules of billing.
• If you bill PI or WC when you feel like it, you may be engaging in dual fee compliance concerns.
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, they can elect through ABN whether that is to be 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.
- More about HIPAA later.

Best Solution for Medicare in a “Cash Practice”

- Enroll in Medicare
- Keep “non-participating” status
- Submit AT care and GA care when requested
- Do not bill Medicare Advantage for Part C patients if you do not participate with the plan.
- Review your requirements on each plan
- Submit bills annually to stay enrolled

"Deemed Provider" Rule

- A provider is "deemed" if the following three conditions are met:
  - The service provided is covered under the PFFS plan and the provider is a Medicare provider.
  - The provider is aware in advance (before providing the service) that the individual is enrolled in a PFFS plan;
  - The provider has reasonable access to the plan's terms and conditions of participation, including provider notice and appeal rights. The Federal government defines "reasonable access" to this information as simply giving physicians access to the plan's phone, fax, email, and website. Obtaining this information is the provider's responsibility, whether or not s/he actually looks at this information and agrees to it before giving services does not matter.
- A deemed provider is required to accept the plan's payment amounts, and, similar to a contracted provider, may charge enrollees no more than the cost-sharing amounts that are permitted under the plan.
- Note: Being a "deemed" provider for one patient does not mean the provider is "deemed" for all her/his patients in a PFFS plan. Instead, a provider is considered "deemed" per patient, per episode. Yet, once a physician is "deemed" for one patient in a given plan, the physician is likely to be deemed to understand the plan's payment terms for all future patients in that plan. Therefore, the only way that a physician would not be deemed for every other patient enrolled in that plan to which s/he provides services is if the patient failed to present a current enrollment card.

Submitting Commercial Insurance

- Although you may not be “participating”, medical policy still applies.
- Your diagnosis and services are expected to be correct.
- Maintenance care should not be billed.
- When you “certify” that what’s on the bill is true and correct, you are bound.
Do Not Take This Lightly!

Fee Schedules Still Must Be Appropriate

- Accepting PI or WC patients and billing that fee schedule while allowing cash patients to pay significantly less is a violation of compliance policy.
- Use one common fee schedule for ALL in a cash practice.
- 5-15% discount may be appropriate
- Use DMPO like ChiroHealthUSA for legal cash discounts beyond this amount.
Best Solutions for Insurance in a Cash Practice

- Remain non-participating.
- Know the medical review policy of any carrier you allow patients to submit to.
- Use a super bill or receipt rather than 1500 form for your patient who wants to submit.
- Ensure that all services you allow to be billed have appropriate ICD and CPT codes.
- Clear communication with your patient about financial expectations up front.

Win-Win-Win

- Successful practices feel great about recommending the care their patients truly need and charging for it.
- They don’t allow managed care companies to intimidate them into prescribing a level of care that is inadequate to meet their patient’s needs.

Best of Both Worlds

- Understand the true benefit and use of third party payment for chiropractic care.
- Bill when appropriate.
- Discharge the patient when the episode is complete.
- Patient is a cash patient for all other care.

Who Knows KMC’s Favorite?

FRIDAY is my second favorite F word.

Medically Necessary vs. Clinically Appropriate Care

Medically Necessary
- Significant improvement in clinical findings and patient’s functionality

Clinically Appropriate
- Life Enhancing
- Symptom relieving
- Wellness care
- Supportive Care
- Maintenance care

The Guideline and Expectation

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 patients condition and provide reasonable expectation of recovery or improvement of function.”
Medical Review Policies

Aetna

BCBS

Acute

- 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."

Acute

- New injury, identified by x-ray or physical exam
- Expected improvement in, or
- Expected arrest of progression of, the condition

Chronic

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 continue 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."

Chronic

- Not expected to significantly improve or resolve with treatment
- BUT continued therapy can result in some functional improvement.

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."
Maintenance

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

FINANCIAL RESPONSIBILITY OF CHIROPRACTIC CARE

The Foundational Visit of the Episode

1-2 VISITS
MAY OR MAY NOT INCLUDE SEPARATE IDENTIFIABLE E/M CODE

3-9 VISITS
NEEDS E/M AT beginning of BURST of CARE

0+ VISITS
NEEDS E/M AT beginning of EPISODE of CARE
**GA Modifier**

**A Better Way!**

**A Simple Solution**

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

www.patientmedia.com/medicare

**A Simple Script: At the Return of Paperwork**

“I’m going to review your paperwork now and prepare your file so we can get you in to see Dr. ____. This is a brochure that explains how Medicare works with Chiropractors. (hand brochure to patient) Please take a moment while I’m working with your paperwork to review it. During your consultation, Dr. ____ will be happy to answer any questions you have about it.” (Leave the patient to review the brochure while you prepare to take the patient back to the consultation room.)

**Episodes of Care**

Expect Payment from Medicare!
Maintenance

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

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PATIENT IS FINANCIAL RESPONSIBLE
Maintenance Care

INCIDENT

1-2 VISITS
MAY OR MAY NOT INCLUDE SEPARATE IDENTIFIABLE E/M CODE

BURST

3-9 VISITS
NEEDS E/M AT BEGINNING OF BURST OF CARE
The Foundational Visit of the Episode

Transition to Cash Based Or MORE Cash Based

- Add more cash based services by billing insurance ONLY when it's appropriate
- Education will be your saving grace
- Use insurance when you must; transition to cash when appropriate

Begin With Patient Education

- Start with New Patients
- Re-educate returning patients
- Clean up existing relationships that are overdue to discharge
- Expect mild attrition
- Declare your practice style to all patients and the culture of your practice
Goals of a New Patient Phone Call

- Schedule the appointment
- Did I mention, Schedule the appointment?
- Address financial issues if they bring them up
- Determine if they wish to use third party assistance
- Collect data for pre-verification if possible
- Oh by the way: Schedule the appointment!
Goals at End of Day One

- Patient understands that they’ve come to the right place
- Patient understands their financial responsibility for today’s visit and that details will happen after ROF visit
- Patient pays something toward their financial responsibility today
- Patient joins CHUSA if they wish to access discounted fee schedule, if appropriate
- Patient signs general office financial policy

Goals at Day 1.5

- Doctor has completed diagnosis and treatment plan
- CA has received all pertinent info so the patient’s responsibility can be determined
- The calculator you choose to assist you can be prepared in advance and ready for the FROF
Clinical ROF

- Doctor gets agreement on "4 yesses"
- Last "yes" is agreement to pay for care
- Transition by passing baton to team member performing FROF
- Make the private conversation public
- Exit so team member can begin FROF

4 Yesses...4 Agreements

- Yes doctor, I understand I have a problem and want to get it fixed.
- Yes doctor, I understand that healing takes time and I will keep all of my appointments.
- Yes doctor, I want to fully participate in getting well and I will attend at least one Healthy Lifestyles Workshop
- Yes, I’m aware I’m financially responsible and will pay “X” dollars over “Y” period of time.

FROF

- Review the benefits or lack thereof
- Review the plan they just got from the doctor
- Estimate to the best of your ability
- Explain your processes
- Visit by Visit vs. payment plan

Automation

- Scheduling and payments should be handled
- Every time one must stop at the front desk, it’s an opportunity to make a choice
- Front Desk CAs need to be able to serve, love, and nurture
Healthy Lifestyle Workshop (HLW)

- The Healthy Lifestyle Workshop is the continuation of the ROF/FROF process.
- It gives you the opportunity to share the chiropractic story, get family support for your new patient/new practice member.
- Your relationship is strengthened when a patient understands the importance of their Nervous System …to their health, well-being and day to day functioning.

The Financial Touch Base

- When we initially speak to the patient in the Financial ROF, we must remember they are in pain.
- When a patient is in pain, their ability to remember is impaired.

Proactive Communication

- Master the dance
- Communication is key
- Get in front of problems before they come up
- Pre-empt by working the plan
Available here or at KMCUniversity.com

ICD-10 Intervention!
Time is running out! Get step-by-step ICD-10 training paired with an expert to help keep you on track.

Questions?
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