Preventing Errors
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Decrease Risk, Increase Reimbursement

So What is Medical Necessity?

CMS Medical Necessity Definition

“Items or services which are for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member”

- All provider types must follow this rule
- Each service (CPT) gets a more detailed explanation as it relates to this

Chiropractic as a CPT

- All carriers see Chiropractic Services as a set of CPT codes used by a provider type
  - Medicare sees 98940-2
  - Others may see more
- MN is determined for the code set

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!
Is All Care Medically Necessary?

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

**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

Active Vs. Maintenance Care

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

**Acute Care**
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 Care**
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**
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."
Episode at a Glance

• Episodes are easy!
• There is a clear delineation of:
  • The beginning
  • The middle
  • And the end of care
• They are Black & White

Who Determines Medical Necessity?

You Do!

Are You an Outlier?

• Statistics tell us that the improper coding of full-spine treatment can cause you to appear to be an outlier
• You therefore can be subject to more scrutiny, red flags, and even an audit

• Look at your CMT coding ratios to evaluate code usage
• Is it realistic that your diagnosis warrants 98941 or 98942 so frequently?
  • 98943
    – Are you over or under utilizing?
    – Are you doing but not billing?
CMT Ratios

- What is expected/typical
  - 98940: 40-60%
  - 98941: 40-60%
  - 98942: 1-10%
  - 98943: 15-20% of the total number of spinal CMTs

- How would your office look?
- Run Your Ratios!

98942 Issues

- Potentially Upcoded Claims: A high average “physician work relative value unit” for a chiropractor’s claims suggests billing for services at a higher level than warranted. Only about 10 percent of all paid chiropractic services are for the highest CPT code, 98942. Previous OIG work found that almost half of chiropractic services with CPT code 98942 were upcoded.

98942 is A Red-Flag

- Medical necessity definition dictates that you must prioritize each area of complaint
- Every visit:
  - S + O (P + ART) for every region treated
  - 2 DX codes for each region
  - Treatment plan for each/short and long term goals

The $64,000 Question

- Is the subluxation you found creating a secondary, neuromusculoskeletal condition?
- Or is it a subluxation that simply needs to be corrected?
Executive Summary: CMS Should Use Targeted Tactics to Curb Questionable and Inappropriate Payments for Chiropractic Services

Under the Magnifying Glass

August 2016

“Establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary, correctly coded and adequately documented.”

Compliance

MN: Chiropractic Per CMS

Acute and Chronic Subluxation

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Compliance

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
- 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
I know they need care...now what?

Is the condition likely to be treated as an INCIDENT, BURST or EPISODE?

- NO
  - If not, is the condition likely to recur within 3-6 months?
  - If not, is the condition likely to recur within about a month?

- YES
  - If yes, consider if the condition likely require treatment beyond a month?

This is the $64,000 Question

DCs Must Answer with Certainty!

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....

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

 Incident Protocols

- Consider: Will the condition likely be resolved within 1-3 visits?

- Document:
  - History/Chief Complaint
  - Mechanism of injury
  - ODI/visual analog score
  - Exam/Physical findings/FRAT
  - Measurable functional deficits
  - TX plan, including STRATEGIES
  - Estimated discharge or re-evaluation date

- Formal EMR service necessary to establish medical necessity for this much care

Typical Episode of Care

- Consider: Will the condition likely require treatment beyond a month?

- Document:
  - History/Chief Complaint
  - Mechanism of injury
  - ODI/visual analog score
  - Exam/Physical findings/FRAT
  - Measurable functional deficits
  - TX plan, including goal setting
  - Date of next re-evaluation (no less than every 30 days)

- Formal EMR service necessary to establish medical necessity for this much care

Burst may be the most common used

- Likely to require at least one re-evaluation
- Chronic diagnosis and significant lack of function
Meanwhile, back on the other side...

**CONSIDER:** Is the patient on PRN care or scheduled maintenance care?

**FIND OUT:** Is this a new condition, exacerbation or new injury necessitating beginning active treatment?

**STOP**

**YES**

After a brief check, will today’s visit be considered maintenance?

**YES**

Does the patient want the maintenance visit and does he/she understand the need to give out of pocket?

**OUTCOME:** Have PRN appeal and Option B chosen. Include witness signatures. Do not provide CMT.

**OUTCOME:** Ensure an ACR is on file with Option C chosen, stated within previous 12 months, and treat the patient.

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 assist with in-processing.

Let’s Go Down the “NO” Path

Let’s Go Down the True Non-AT (GA) Path Part One
Let's Go Down the True Non-AT Path “Part Two” No Thank You

Compliance

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the D__ listed above. You may ask to be paid now, but I also want Medicare billed for an office decision on payment, which is sent to me on an Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ OPTION 2. I want the D__ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ OPTION 3. I don’t want the D__ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4225), TTY: 1-877-486-2047.

Signature: ____________________________
Date: ____________________________

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Form CMS-R-381 (Exp. 03/2020)
Form Approved OMB No. 0938-0358

Meanwhile, on the other side...

Compliance

Analyze the ABN Forms for...

- Are all the "D" categories filled in properly?
- What fees are included on the ABN?
- Was the appropriate option selected with the appropriate outcome? Billing?
- Does it include services excluded by Medicare? 
- Stay tuned!
CLARIFY ONCE AND FOR ALL…

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

An ABN is mandatory when a service results in Medicare’s Committee for Treatment and Management (CMT) that is overturned may not be covered today. This is usually because the code will not meet medical necessity guidelines and the adjustment may not be covered. Medicare patients also agree to pay for maintenance care if they want it. Medicare does not require an ABN form for advance notice for statutorily excluded services. Use this (and others) to help determine when an ABN should be signed and on file in order to be in compliance with Medicare regulations. Follow the prompts to support your decision making in the normal course.

**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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**Is the service a spinal CMT?**

**Outcome:** The patient is in an acute episode of care.

**Determine:** Is the service a spinal CMT? If the service is a spinal CMT, the ABN is not required in an acute episode of care.

**Outcome:** The patient is in a maintenance care episode.

**Determine:** Is the service a spinal CMT? If the service is a spinal CMT, the ABN is not required in a maintenance care episode.

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

**Let’s Follow the “YES” Track**

**Outcome:** Ensure an ABN is on file, with Option 1 or 2 chosen, dated within previous 12 months, and that the patient, or their ABN signed buddy, for maintenance care. **Note:** A signed ABN is good for up to 12 months or until another episode of active treatment begins.

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**All team members should understand when a CMT may not be considered medically necessary... therefore maintenance care that is the responsibility of the patient.**

**Outcome:** Ensure an ABN is on file, with Option 1 or 2 chosen, dated within previous 12 months, and that the patient, or their ABN signed buddy, for maintenance care. **Note:** A signed ABN is good for up to 12 months or until another episode of active treatment begins.

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**ABN discussions with the patient should be clear, concise and in plain language.**

**Outcome:** Ensure an ABN is on file, with Option 1 or 2 chosen, dated within previous 12 months, and that the patient, or their ABN signed buddy, for maintenance care. **Note:** A signed ABN is good for up to 12 months or until another episode of active treatment begins.
Keep in mind that not every patient will agree to pay for GA care.

The Illusive Voluntary ABN

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.

Aha!

ABN for Voluntary Use

You should only provide ABNs to beneficiaries enrolled in Original (Fee-For-Service) Medicare. The ABN allows the beneficiary to make an informed decision about whether to get services and accept financial responsibility for those services if Medicare does not pay. The ABN serves as proof that the beneficiary knew prior to getting the service that Medicare might not pay. If you do not issue an ABN to the beneficiary when Medicare requires it, you cannot bill the beneficiary for the service and you may be financially liable.

The ABN also serves as an optional (voluntary) notice that you may use to forewarn beneficiaries of their financial liability prior to providing care that Medicare never covers. Medicare does not require you to issue an ABN in order to bill a beneficiary 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.
Although not required, good office and financial policy includes making sure patients understand their financial responsibility... preferably in writing.