



KMC University



Insurance & the Chiropractic Clinic

Not So Common Payers & Situations



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Our Discussion

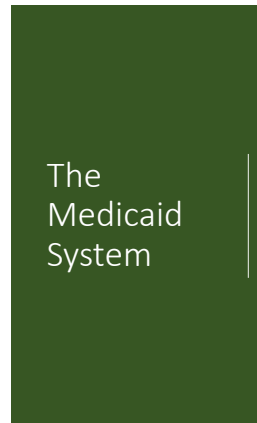
- Medicaid Chiropractic Coverage
- Personal Injury & Worker's Comp
- Self Pay



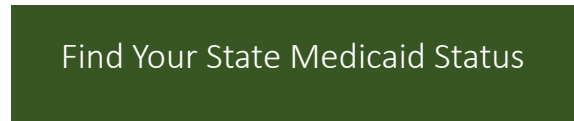
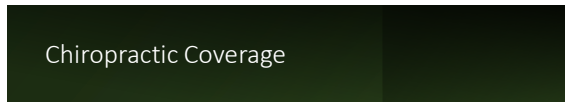
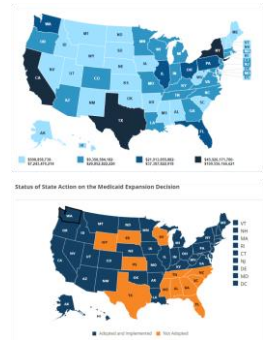
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Mandatory Benefits

- Inpatient hospital services
- Outpatient hospital services
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services
- Nursing Facility Services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and x-ray services
- Family planning services
- Nurse-Midlevel services
- Certified Pediatric and Family Nurse Practitioner services
- Federally Qualified Health Centers or other health extension or alternative recognized by the state
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

Optional Benefits

- Prescription Drugs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing and language disorder services
- Regulatory care services
- Other diagnostic, screening, prevention and rehabilitative services
- Prosthetic services
- Durable medical equipment
- Dental services
- Optometry
- Podiatry
- Eye services
- Chiropractic
- Other practitioner services
- Private duty nursing services
- Personal care
- Single
- Case management
- Services for individuals Age 65 or Older in institutions for Mental Diseases (IMD)



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KFF Medicaid Chiropractic Coverage

State Health Facts

Search: <https://www.kff.org/medicaid/state-indicator/chiro...>

Medicaid Benefits: Chiropractor Services - KFF

In Indiana, HIP Basic (coverage under Indiana's Section 1115 waiver) does not cover chiropractic services. HIP Plus offers only six chiropractic visits per year.

Location	Benefits Covered	Coverage Code	Government Required?	Limits on Services
IN				

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Not All Inclusive but a Good Start

Indiana	Yes	CN	No	Prior authorization for muscle testing services; 50 therapeutic physical medicine treatments/visits including up to 5 office visits.
Iowa	NR	NR	NR	NR
Kansas	No			
Kentucky	Yes	CN	\$3	26 visits per member per year

Delaware	Yes	CN	No	<25 medically necessary (1 visit/year, 1 x only per year, 20 manipulations per year)
District of Columbia	No			
Florida	Yes	CN		Chiropractor services, per provider or group provider, per day \$1,000; Up to 24 visits per year, per recipient
Georgia	No			



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Locate the Managed Care Profile PDF



Kentucky Managed Care Program Features, as of 2020		
Feature	Kentucky Managed Care	Kentucky Non-Emergency Medical Transportation
Program type	Community MCO	Non-Emergency Medical Transportation
Statewide or region specific?	Statewide	Statewide
Federal contracting authority	HRSA	HRSA
Program start date	01/01/2020	02/01/2008
Program expiration date (if applicable)	12/31/2025	12/31/2021
Has program ended in 2020, indicate the end date		
Programs available to individuals who are currently under ACA Section 1876(b) and have program review and comply with conditions	Medicaid	Medicaid

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Provider Enrollment
Enroll in State Program
Confirm Enrollment with MCO

0348P-011 (Enrollment)
(Rev 1/2017)

**COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
SECTION A: ADMINISTRATIVE INFORMATION**

For Kentucky Medicaid Use Only:
ATN: _____
Identifier: _____
Provider Type: _____
Reviewer's Initials: _____

I am enrolling as a: New Provider Re-applicant Change of Ownership Reinstatement

Will you be contracting with a KY Managed Care organization (MCO)? Yes No. If yes, please indicate which MCO:
 Anthem Actra Better Health of KY Humana CareSource Passport Health Plan WellCare of Kentucky

1. Kentucky Medicaid Provider Number: _____ (Complete only if you have indicated Reapplicant, or Reinstatement above.)
2. Applying As: Individual Entity Group
3. Doing Business As (DBA): First: _____ MI: _____ Name: _____ (Check here for N/A)
4. Please select: Public Private 5. Please select: Profit Non-Profit
6. License/Certification #: _____ 7. Provider Type: _____
8. Type of Service: _____ 9. Date Provider Requests Effective Enrollment: _____ (Date must be in mm/dd/yyyy format.)
10. National Provider Identifier (NPI): _____ 11. Primary Taxonomy Code: (Attach extra sheet if necessary. Match most NPPES)

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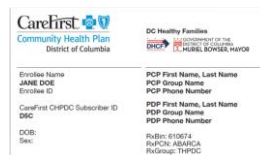
Training Tools & Provider Forms



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Keep an Eye Out for Medicaid Cards

Look for words: Community Plan; Community Health; Home State Health; Department of Social Services



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Locate QMB Status for the Dual Eligible Patient

- Local MAC
- The Medicare Advantage Payer Portal
- Medicaid Payer Portal
- Remittance Advice (Medicare)

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Identify QMBs	To avoid improper billing, you must get familiar with the different types of QMBs. Identify all QMB patients during the verification process prior to charge entry.
Avoid Billing the Patient	In most cases, the QMB patient is not legally obligated to pay Medicare providers for cost-sharing services. You should avoid billing a QMB for any cost-sharing (covered) services. It is illegal. This includes Medicare Advantage Plans. This 'no billing protection' normally applies only to covered CMT procedures but you shouldn't assume that.
Consider Enrollment Requirements	In order to receive payment for the Medicare cost-sharing amount owed by your State, the provider may need to enroll in the local Medicaid system. You must reach out to your state Medicaid office to confirm.
Create a Process	Once you identify a QMB, create a procedure for processing these beneficiaries to include verification, charge entry, secondary billing, payment posting, and patient statements. According to CMS, "Coverage for dually eligible beneficiaries varies by State. Some States offer Medicaid through Medicaid managed care plans, while others provide Fee-For-Service Medicaid coverage. Some States contract with health plans that include all Medicare and Medicaid benefits."

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QMB Management



Get to Know What is Covered



"The doctor will be with you in a few minutes. He's trying to figure out what disease goes with your insurance."

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In Review

Medicaid **MAY** or **MAY NOT** cover Chiropractic Services.

Medicaid is Secondary to Medicare if patient has **dual eligibility**. **Identify QMB status** for all patients.

A provider **MUST** be enrolled as a Medicaid Provider with the State to render covered services (and Revalidate every 5 years).

Front Desk, Billing and Credentialing Staff should be familiar with all Medicaid MCO websites in order to monitor changes and updates.



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Personal Injury



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Automobile Accidents



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Steps to Success

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First-Party vs. Third-Party Claims

- First-Party- The patient's insurance. Direct pay to the provider.
- Third-Party- The adverse party is at fault. Bills are paid after settlement of the claim.

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Tort vs. No-Fault States

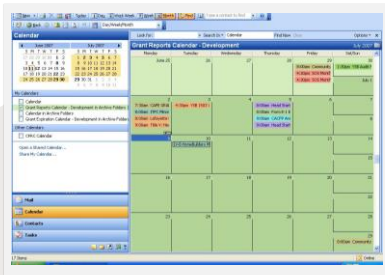
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Case Management Relationships

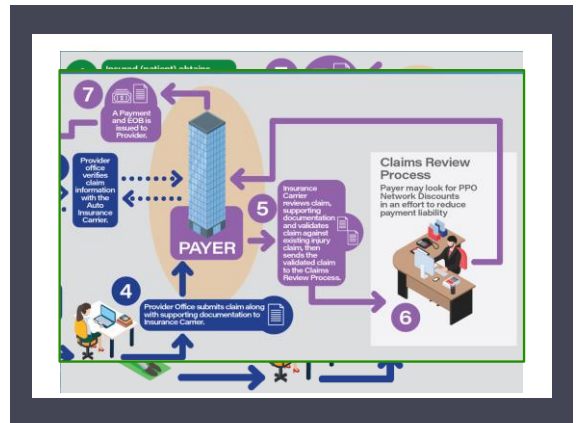
- Identify the Claims Adjuster for the Injury [Medical Side of the Claim]
- Communicate with the Attorney [if applicable]

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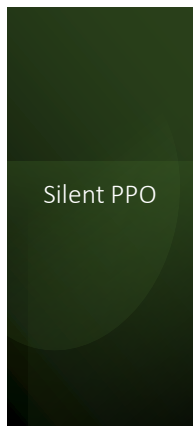


Appropriate Follow Up

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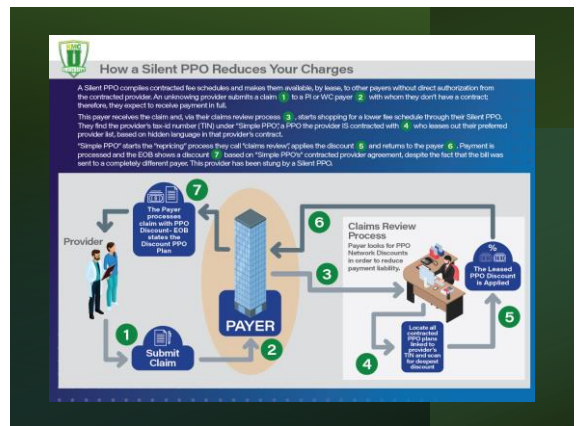


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Nationwide Primary PPO Networks	PHCS HealthNEOS HealthNEOS	MultiPlan's nationwide primary PPO network MultiPlan's "virtual payer" PPO network in select markets MultiPlan's regional PPO network in Wisconsin, with some coverage in Kentucky, Michigan, Minnesota. This network is also used for Workers' Compensation and Auto Insurance programs in these areas.
Regional Primary PPO Networks	HealthNEOS Benevolent	MultiPlan's regional PPO network in Alaska, Nevada and Utah
Nationwide Complementary PPO Networks	MultiPlan	MultiPlan's nationwide complementary PPO network.
Workers' Compensation and Auto Insurance Networks	MultiPlan	MultiPlan's networks for Workers' Compensation and Auto Insurance programs.
Networks of Excluded Providers	MultiPlan	MultiPlan's nationwide transplant network.
Access Card Network	MultiPlan	MultiPlan's nationwide access (discount) network. Details
Networks Serving Government-Related Programs	PHCS MultiPlan	MultiPlan's network for Medicaid programs in Illinois MultiPlan's network for Medicare Advantage programs.

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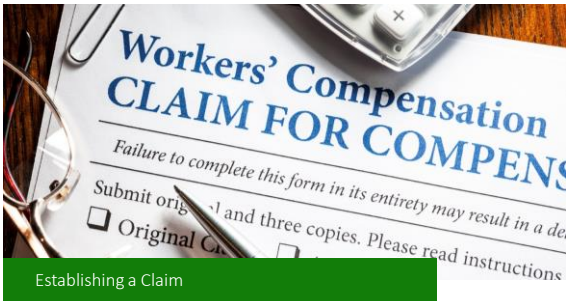
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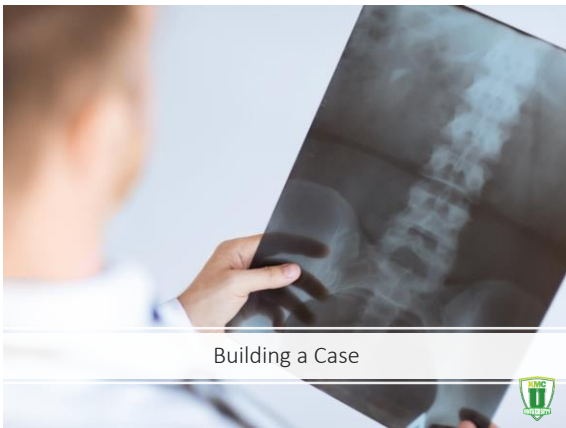
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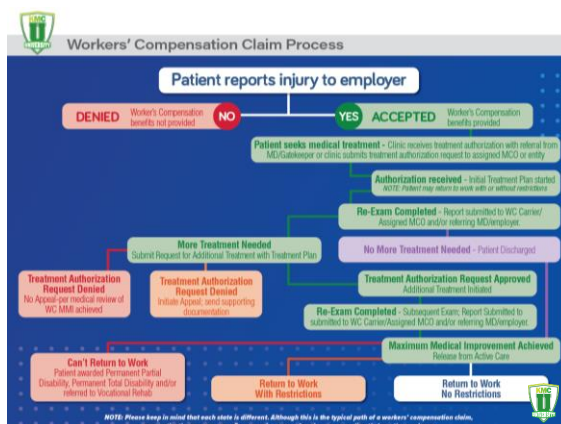


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Fee Schedules- OMFS

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Federal Workers' Compensation Claims

- DCs are recognized as physicians
- Services limited to one condition- subluxation of the spine
- Must be based on X-ray findings (taken shortly after the injury)



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Future Medical Benefits

- Permanent Impairments do not mean forever treatment allowed
- Must communicate with carrier to confirm the claim is 'open'
- Be sure to stick to treating only the allowed diagnosis (injury).

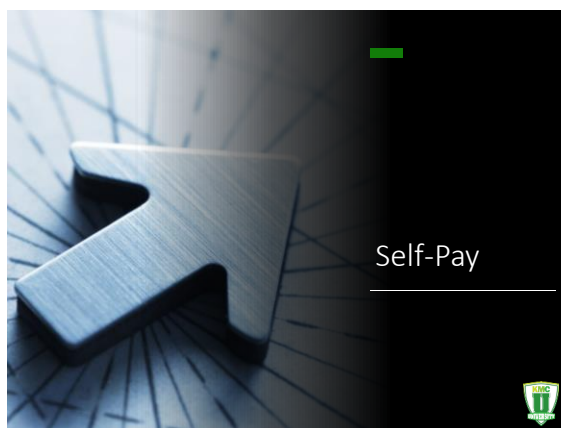


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- Confirm your status as a workers' comp provider in your state
- Obtain copy of Injury Report prior to rendering service
- Confirm with claim adjuster the validity of the claim
- Be sure to follow federal guidelines if the case is a federal work injury
- Follow the carrier's guidelines and reporting expectations
- Only render service to the allowed condition/injury

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Self-Pay



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Our Discussion

- Self-Pay Defined
- Be Aware- Deemed Provider
- PFFS Requirements
- Advance Notice of Non-Coverage
- Good Faith Estimate Requirements

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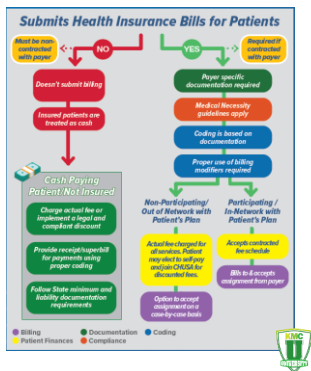
The Self-Pay Patient

Uninsured
Partially Insured
Not Utilizing their Insurance



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Uninsured – Provider Out of Network



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Heads – Up Deemed Provider

3. What does it mean for a provider to be deemed by a PFFS organization?

under Original Medicare. The non-contract provider can only collect from the PFFS enrollee **the amount allowed by the plan's terms and conditions** of participation. If a provider **mistakenly collects more** from the enrollee than the plan allows than the provider **must refund the difference to the enrollee**.

It is important to note that a provider is not required to furnish health care services to enrollees of a PFFS plan. However, when a provider chooses to furnish services to a PFFS enrollee and the deeming conditions have been met the **provider is automatically a deemed provider** (for that enrollee) and must follow the PFFS plan's terms and conditions of participation.

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Example of Deemed Contracting

An enrollee visits the office for the first time, advises the physician that s/he is a member of a PFFS plan and presents the appropriate enrollment card. Since the provider **had the opportunity to call the phone number on the enrollee card**, the provider is considered deemed contracting as soon as s/he provides services, even if the provider did not actually check the terms and conditions of payments.

Partially Insured

MEMBER CONSENT FOR FINANCIAL RESPONSIBILITY FOR UNREFERENCED/NOT-COVERED SERVICES
 Applied to all benefit programs in New Jersey and Pennsylvania

MEMBER INFORMATION
 MEMBER NAME _____
 MEMBER'S ID # _____

PROVIDER INFORMATION
 PROVIDER NAME _____
 PROVIDER'S ID # _____
 SPECIALTY OR DEPARTMENT _____
 TYPE OF SERVICE _____

MEMBER MUST COMPLETE THIS SECTION
 As a member of: Amerihealth HMO Amerihealth PPO Amerihealth OS HMO (check the appropriate box)

I understand that...
 (Check the appropriate box)
 A referral from my Primary Care Physician is required for any and all non-Emergency inpatient hospital specified services. I acknowledge that I do not have a referral with me at this time, but I choose to receive the services without the required referral. I understand that without the appropriate referral, I will be held responsible for any payments required for these services. (HMO)
 I understand that only in an emergency period for which my insurance carrier will not make payment (or I agree to be financially liable for any payments required for these services) I understand that I have the right to appeal this determination. (ANY)

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Advance Member Notice

BlueCross BlueShield of Montana
Advance Member Notice (AMN)

Patient Name	Patient Health Plan ID	Patient Date of Birth
Provider Name	Provider NPI Number	Provider Phone
Address/Location	Provider NPI Number	Provider Fax
Address/Location	Provider NPI Number	Provider Phone
Address/Location	Provider NPI Number	Provider Fax

You Need to Make a Choice About Receiving These Health Care Items or Services

Your health care provider has decided to provide services that Blue Cross and Blue Shield of Montana (BCBSMT) may not cover under your health plan. You may not be responsible for payment for these services. To avoid any out-of-pocket costs, you must make a choice about receiving these services. You must also give your health care provider your choice. If you do not make a choice, your health care provider will assume you want to receive these services. If you do not want to receive these services, you must tell your health care provider and you have responsibility to receive services that BCBSMT may determine are not medically necessary or



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Customized Acknowledgement Form

John Doe Chiropractic & Wellness Center
Dr. John Doe
1010 Any Street, Suite 100
Any Town, MT 12345
(123) 123-4567
www.jdoe-wellness.com

Patient Acknowledgement Form for Non-Covered Services

Patient Name: _____

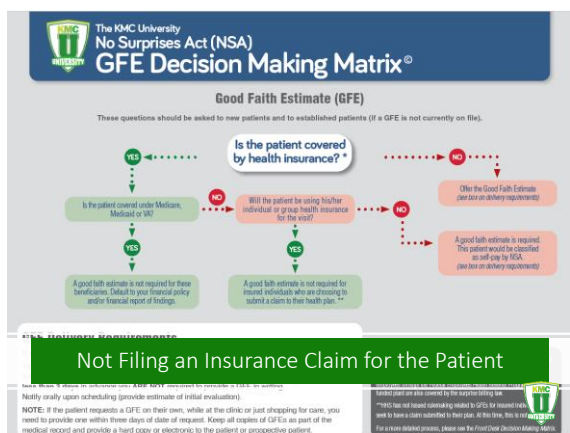
Your health insurance plan requires you to be responsible for co-payments, co-insurance, and deductibles for covered services and products as well as those services/products that exceed certain benefit limits. You are also financially responsible for all non-covered services and products.

Your health insurance plan either does not cover the product or type of service, has determined this procedure/service is not medically necessary, has created policy to identify it as experimental or investigational, or the allowed fee is below the purchase price for the item. These items are listed below.

PROCEDURE / ITEM / SERVICE DESCRIPTION	CPT CODE	ESTIMATED BILLED PROFESSIONAL CHARGE
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Good Faith Estimate Requirements

- Need to post notice of patient's right to receive a GFE (in clinic and on website)
- Need to OFFER a GFE to all patients who are uninsured or insured but not filing a claim with their insurance
- GFE must be customized according to the recommended treatment and within \$400.00 of actual billed charges- AVOID Price List documents

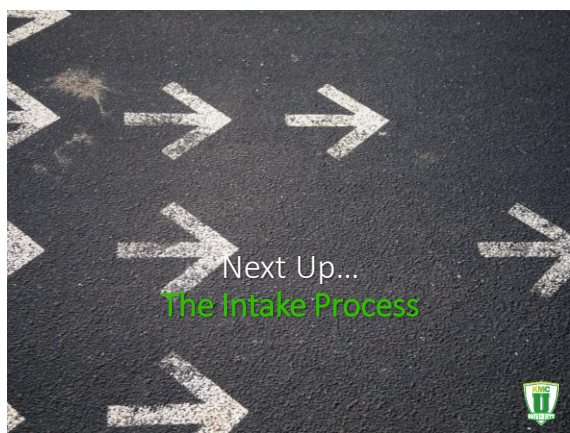
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Summary

- Identify the type of Self Pay patient at the time of the appointment.
- Offer GFE to all patients who are uninsured or not utilizing their insurance-REQUIRED
- Best practice is to offer some type of estimate of cost to all patients (insured and uninsured)
- If insured but service offered is not covered, notify and obtain consent to bill the patient
- Work closely with payers to identify their requirements and forms for patient billing
- Consult state laws for any rule that is more stringent than federal
- Be aware of PFFS plan obligations- Deemed Provider and Mandatory Claim Submission



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