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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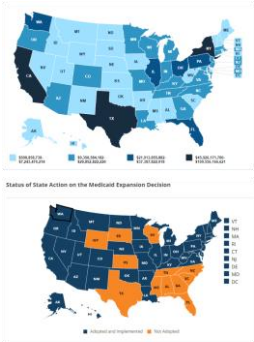
The Medicaid System



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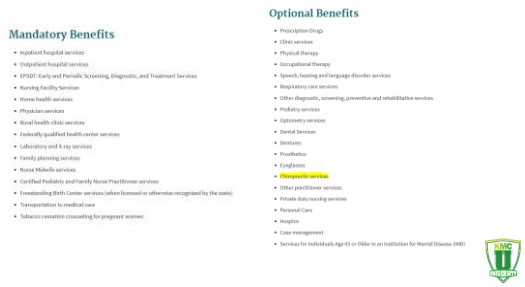
Chiropractic Coverage



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Find Your State Medicaid Status

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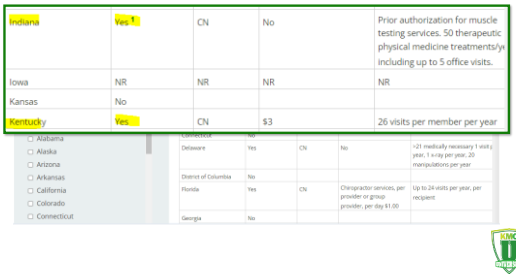
Not All Inclusive but a Good Start



Indiana	Yes [1]	CN	No	Prior authorization for muscle testing services. 50 therapeutic physical medicine treatments/yr including up to 5 office visits.
Iowa	NR	NR	NR	NR
Kansas	No			
Kentucky	Yes	CN	$3	26 visits per member per year

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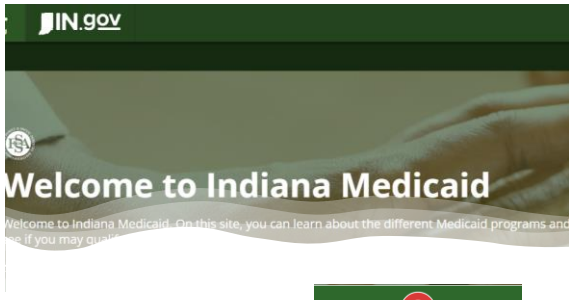
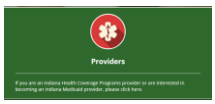


Google Search
'Medicaid Indiana'



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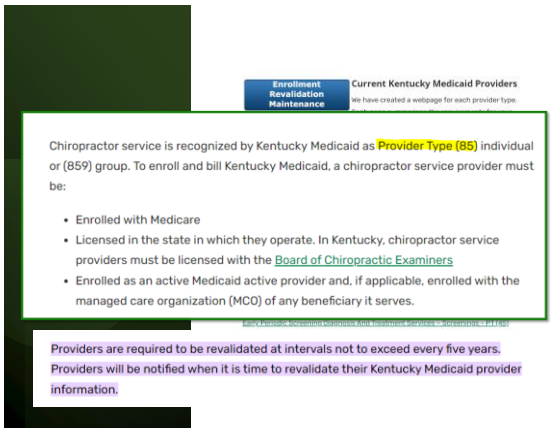

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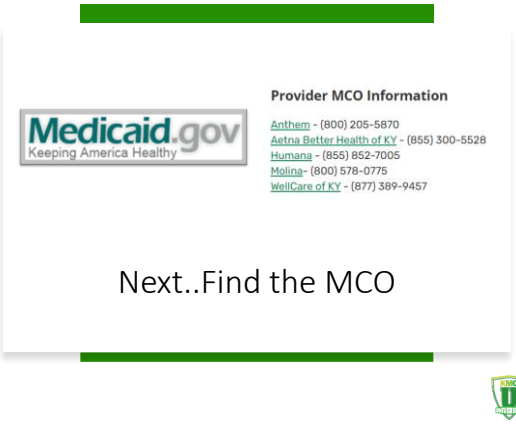

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Locate Profile

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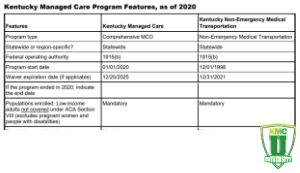
Locate the Managed Care Profile PDF



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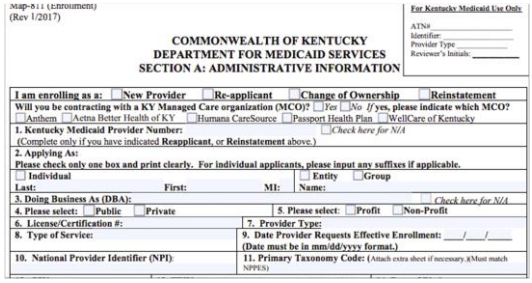
Provider Enrollment

Enroll in State Program

Confirm Enrollment with MCO



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Training Tools & Provider Forms

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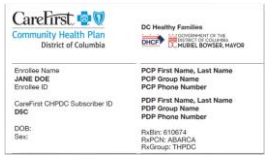
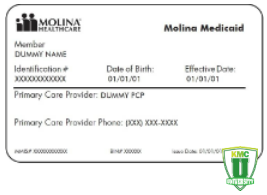
Keep an Eye Out for Medicaid Cards

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."

QMB Management

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Get to Know What is Covered

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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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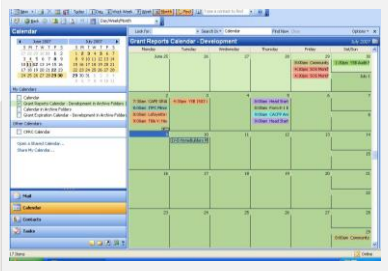

Appropriate Follow Up

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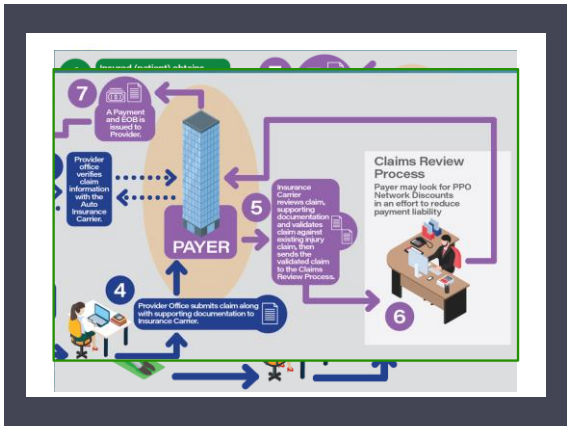

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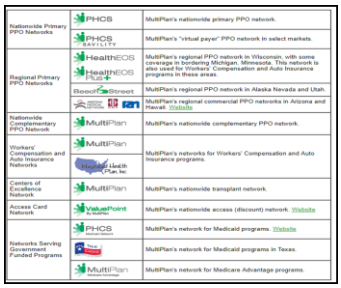
Silent PPO



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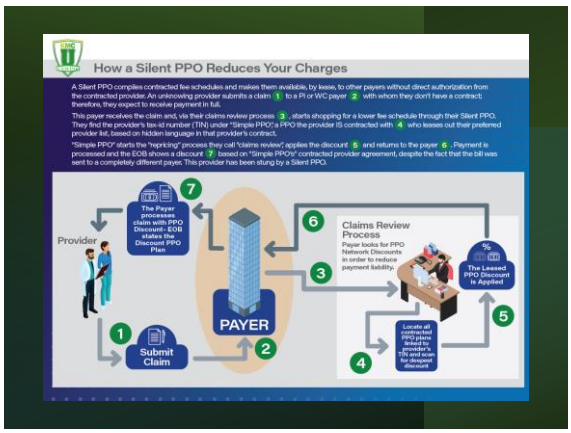

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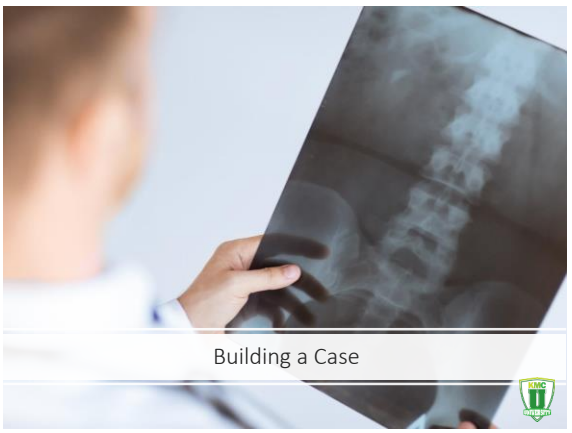

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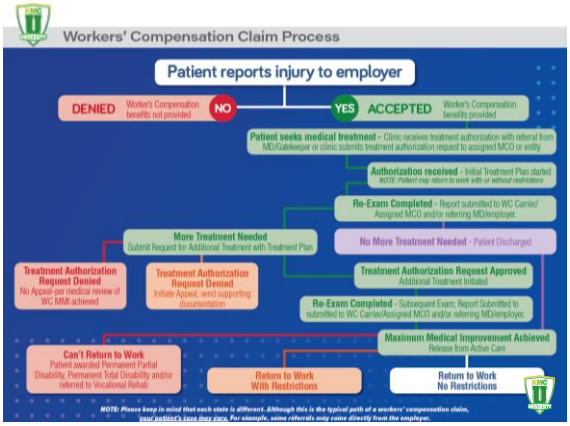

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Federal Workers' Compensation Claims

- 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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Summary

- 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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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.

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Partially Insured

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Advance Member Notice


BlueCross BlueShield of Montana

Advance Member Notice (AMN)

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

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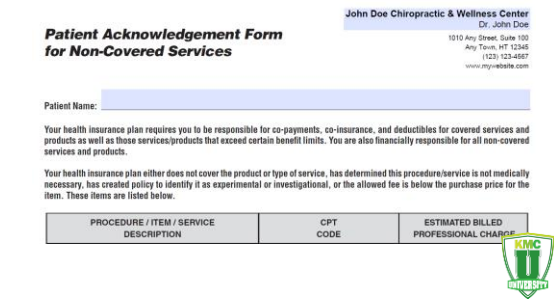
Customized Acknowledgement Form


John Doe Chiropractic & Wellness Center
Dr. John Doe
1010 Any Street, Suite 100
Any Town, HT 12345
(123) 123-4567
www.myuwebsite.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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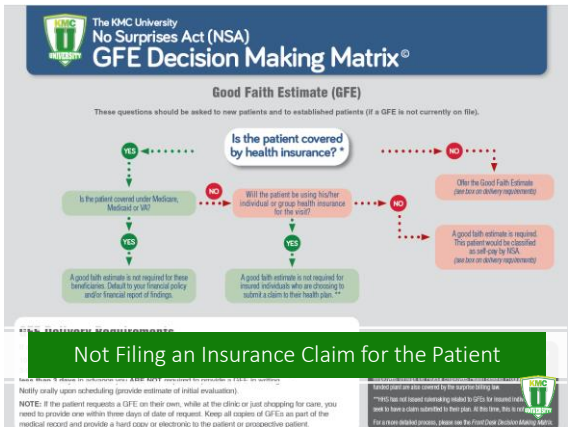

Not Filing an Insurance Claim for the Patient

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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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