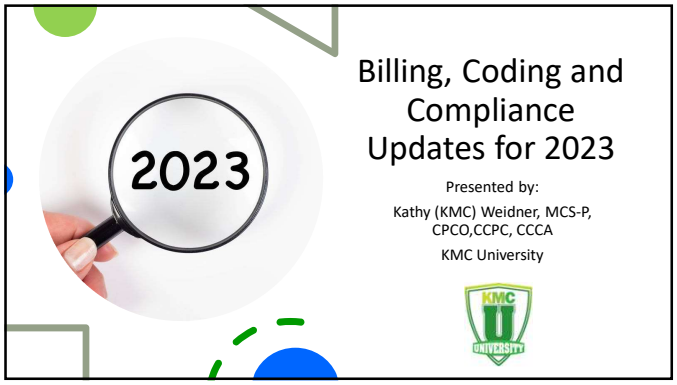
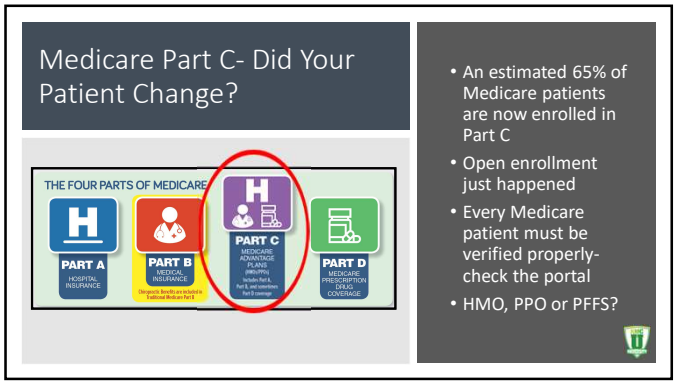

2023
Billing, Coding and Compliance Updates for 2023
Presented by:
Kathy (KMC) Weidner, MCS-P, CPCO,CCPC, CCCA
KMC University

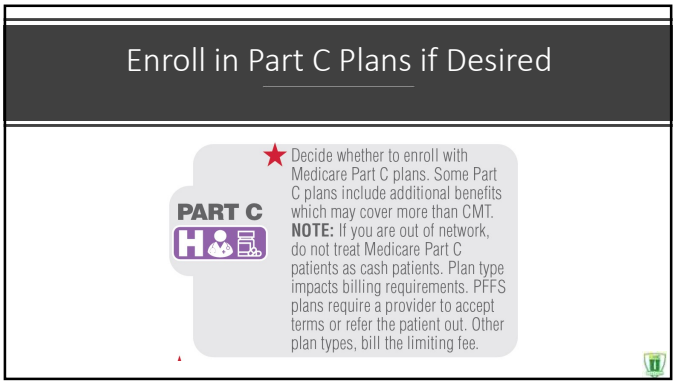
1


Our Plan for Today
Make
Make sure you're ready for an influx of Medicare Part C patients and what to do about them
Become
Become aware of the changes that the No Surprises Act brings for 2023, and refresh on 2022's rules that are being missed by most practitioners who see self-pay patients
Find out
Find out what changes occur in 2023 with the E/M coding guidelines and how they might apply to your practice
Review
Review a "beginning of the year" checklist to make sure 2023 is the best year yet
Be
Be aware of Comparative Billing Reports and what to do if you get one

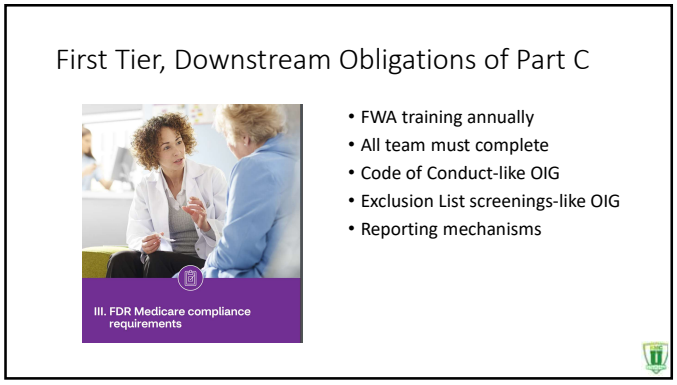
2


Medicare Part C- Did Your Patient Change?
THE FOUR PARTS OF MEDICARE
PART A
HOSPITAL INSURANCE
PART B
MEDICAL INSURANCE
PART C
MEDICARE ADVANTAGE PLANS
PART D
MEDICARE PRESCRIPTION DRUG COVERAGE
• An estimated 65% of Medicare patients are now enrolled in Part C
• Open enrollment just happened
• Every Medicare patient must be verified properly- check the portal
• HMO, PPO or PFFS?

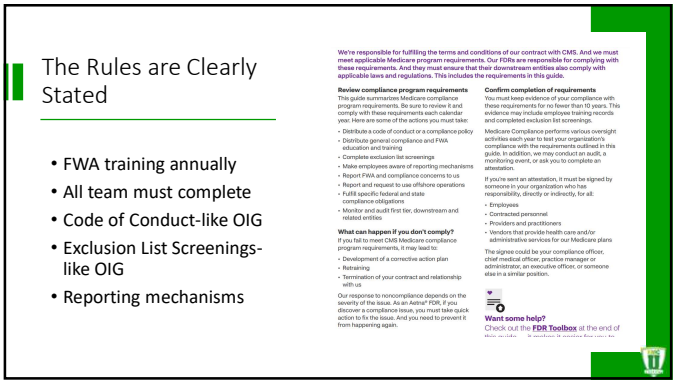
3


Enroll in Part C Plans if Desired
PART C
Decide whether to enroll with Medicare Part C plans. Some Part C plans include additional benefits which may cover more than CMT.
NOTE: If you are out of network, do not treat Medicare Part C patients as cash patients. Plan type impacts billing requirements. PFFS plans require a provider to accept terms or refer the patient out. Other plan types, bill the limiting fee.

4

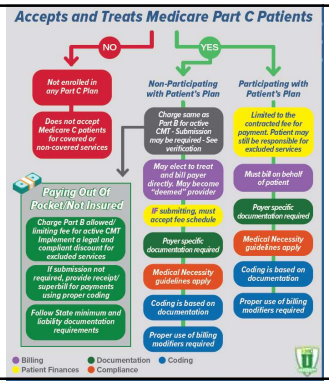

First Tier, Downstream Obligations of Part C
III. FDR Medicare compliance requirements
• FWA training annually
• All team must complete
• Code of Conduct-like OIG
• Exclusion List screenings-like OIG
• Reporting mechanisms

5


The Rules are Clearly Stated
• FWA training annually
• All team must complete
• Code of Conduct-like OIG
• Exclusion List Screenings-like OIG
• Reporting mechanisms

6

Obligations of DCs When Agreeing to Accept and Treat Medicare Part C Patients



7

New Year Checklist- Medicare Part C

- Re-verify every Medicare patient as they come in
- Double check ALL cards-they may not know
- Update your system depending on participation level
- Go through your Part B portal to confirm – if Part C participating, must verify as any other commercial plan
- Find the "Advance Notice of Non-Coverage" form your Part C payer requires—NEVER use Part B ABN
- Make sure your FDR obligations are met

8

Qualified Medicare Beneficiaries (QMB)

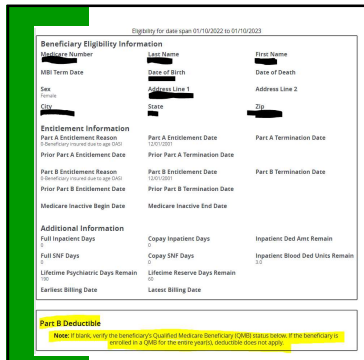
DUALLY ELIGIBLE BENEFICIARIES

"Dually eligible beneficiaries" generally describes beneficiaries enrolled in Medicare and Medicaid. The term includes beneficiaries enrolled in Medicare Part A and/or Part B and getting full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through the **Medicare Savings Program (MSP)**:

- **Qualified Medicare Beneficiary (QMB) Program:** Helps pay Part A, Part B, or both Program premiums, deductibles, coinsurance, and copayments
- **Specified Low-Income Medicare Beneficiary (SLMB) Program:** Helps pay Part B premiums
- **Qualifying Individual (QI) Program:** Helps pay Part B premiums but is limited to a first-come, first-served basis
- **Qualified Disabled Working Individual (QDWI) Program:** Pays Part A premiums for certain disabled and working beneficiaries under 65 not getting Medicaid and who meet certain income and resource limits set by their State

- These patients must be handled properly
- Another reason Medicare verification is critical
- Even when Medicaid doesn't cover chiropractic, they must work with QMB patients for reimbursement

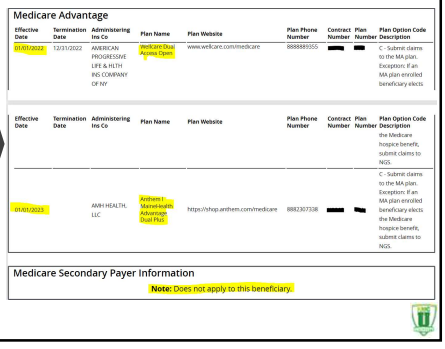
9



Verify QMB Status

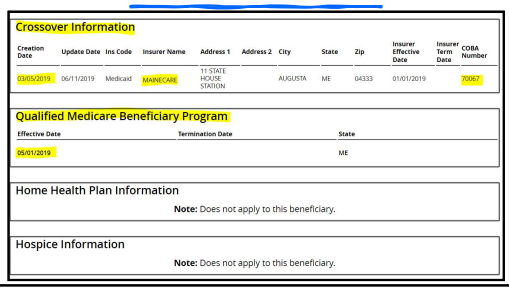
10

There's Your Sign!



11

It's Easy to Find When You Verify



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Sample EOB-Qualified Medicare Beneficiary

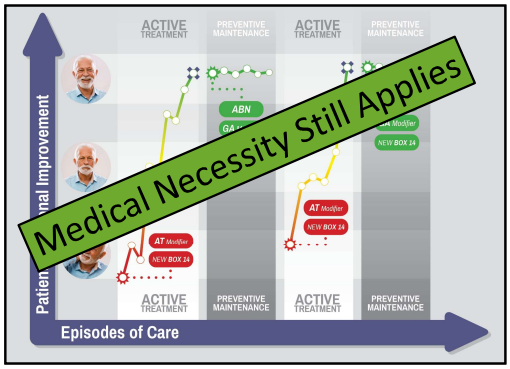
June 18, 2017
Dr. Susan Jones, M.D., (555) 555-1234
Brevard County Physical Therapy Center, 32 Main Street, Brevard, NC 28712-4187

Service Provided & Billing Code	Service Approved?	Amount Provider Charged	Medicare-Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minut (97110)	Yes	$45.00	$28.54	$22.83	$0.00	
Total for Claim #02-10195-592-677		$45.00	$28.54	$22.83	$0.00	A

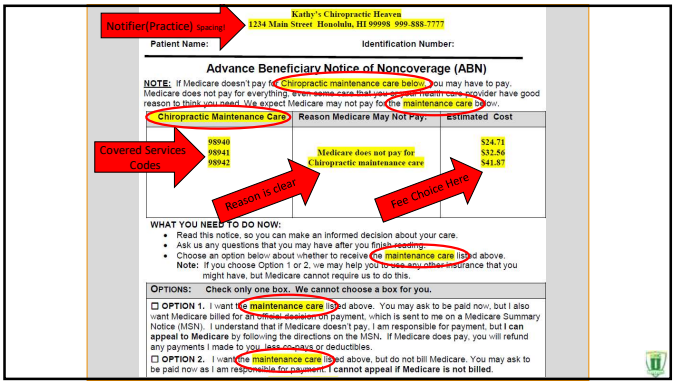
Notes for Claims Above

A You're in the Qualified Medicare Beneficiary (QMB) program, which pays your Medicare costs. Health care providers who accept Medicare can't bill you for the Medicare costs for this item or service, but you may be charged a small Medicaid copay.

13



14



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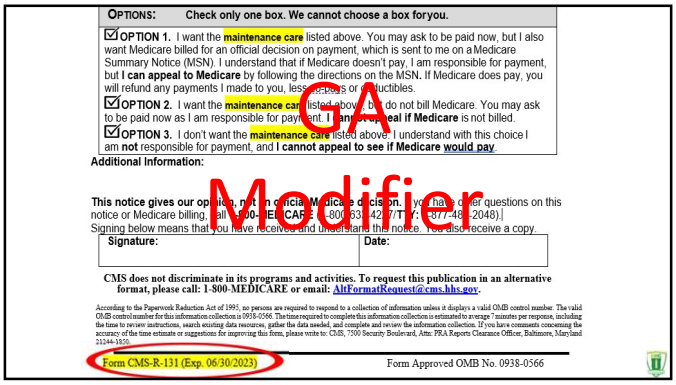

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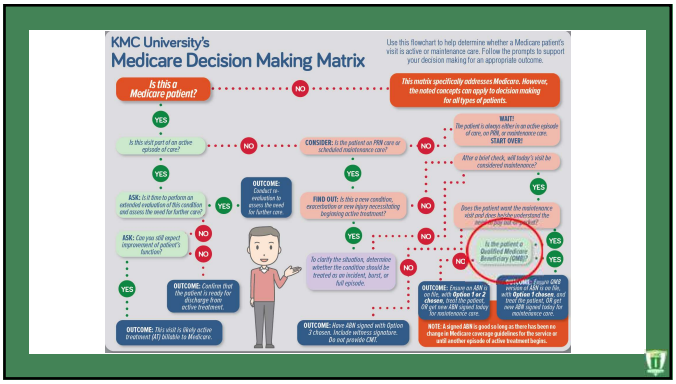

17

QMB Patients Must Choose Option 1

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

☐ **OPTION 1.** I want the **maintenance care** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a 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.

☐ **OPTION 2.** I want the **maintenance care** 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 **maintenance care** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

Additional Information:

18

New Year 2023 QMB and Medicaid Refresher

- Evaluate which patients may be QMB now, but not handled properly
- Update your verification in the MAC portal and gather info on all
- Determine whether they are Part B or Part C
- Make sure you have clarity on Medicaid benefits
- Confirm you have a proper QMB ABN form

19

Be Aware of Some Coding Changes and an Update

- E/M definitions clarifications
- Changes to prolonged services E/M codes
- UHC and others clarifying when 97140 can be used with adjustments
- Roller table traction – new policy

20

Clear Guidance on NP vs. EP … Finally!

New and Established Patients

► Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are

- This is finally in writing
- Remember, an EP has been in your office within three years
- Even if it's a new accident or condition

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Prolonged Services Coding Updates

- Deletion of Prolonged Services E/M codes 99354-99357
- Revision of guidelines for Prolonged Services E/M codes 99358, 99359, 99415, 99416
- Revision of Prolonged Services E/M code 99417 and guidelines
- Establishment of Prolonged Services E/M code 993X0 and guidelines
- Codes 99415-99416 are not payable by Medicare. Use appropriate G codes
- Remember, we only use these after exceeding 99205 or 99215 guidelines

22

A Number of Definition Changes for Clarity

► ***Stable, chronic illness:*** A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition.

23

Clarification and Updated Policy: 97012-Roller and Massage Tables

Coding Guidance

acatoday.org

Procedure Code 97012, Mechanical Traction

Introduction:

The American Chiropractic Association (ACA) receives numerous requests for coding clarification regarding mechanical traction.

Definition:

Current Procedural Terminology (CPT) code 97012 describes the "application of a modality to 1 or more areas: traction, mechanical"[1]. While third-party payer policies may differ regarding what constitutes mechanical traction, the CPT Assistant defines mechanical traction as follows: "The force used to create a degree of tension of soft tissues and/or to allow for separation between joint surfaces. The degree of traction is controlled through the amount of force (pounds) allowed, duration (time), and angle of pull (degrees) using mechanical means. Terms often used in describing pelvic/cervical traction are intermittent or static (describing the length of time traction is applied) or auto traction (use of the body's own weight to create the force)."[2]

The goals of mechanical traction typically include one or more of the following: re-establishing normal ranges of motion, reducing pain and/or muscle spasm, enhancing muscle relaxation, and improving blood flow to soft tissue.

Application:

The CPT Physical Medicine and Rehabilitation section does not have the granularity or distinction of identifying specific mechanical traction devices. When reporting physical medicine and rehabilitation modalities, the clinical necessity for the service and the therapeutic effect/how the treatment will achieve the goals of the care plan should be documented.

Roller Tables:

The American Medical Association (AMA) currently has no specific CPT or HCPCS code that reflects the act of a patient lying recumbent on massage or roller tables. Roller tables do not meet the definition of auto-traction according to the AMA CPT Assistant. They do not create a sufficient force to allow for the separation of joint surfaces. The appropriate reportable code would be CPT code 97139 (unlisted modality; specify type and time if used under constant attendance).[3]

24

What's Possible?

- Change this service to cash
- Consider using the premise that it's an acknowledgement to self-pay
- Make a description letter for the service to include if billing 97039

25

Refresh Yourself on Recent ICD-10 Coding Changes

- Cervicalgia is still being used incorrectly-M54.2
- Cervicalgia is always going to bounce due to Excludes 1 notes when M50 series is used
- Cervicalgia due to an intervertebral disc disorder already includes M54.2
- Lumbalgia M54.59 is the best code

26

New Year 2023 Coding Updates

- Review whether you have been using prolonged services codes and update them in your system
- Ensure all team members know the difference between NP and EP
- If you use Roller Tables or Aqua Bed Massagers, discuss coding and billing changes and update compliance policy if you are still using 97012
- Triple check that all DX codes are up to date in your billing system
- Refresh yourself on Excludes 1 and 2 for the codes billed most often

27

No Surprises Act Year 2

You must comply if you see any cash paying patient who is not using insurance

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Provider Impact

Improve
- Improve provider directories (PHSA 2799B-9)

Provide
- Provide **good faith estimate** in advance of scheduled services, or upon request (PHSA 2799B-6; 45 CFR 149.610 (for uninsured or self-pay individuals)

30

Payment Dispute Resolution Changes for 2023

Providers: what to expect when a patient starts payment dispute resolution

The "No Surprises" requirements are effective as of January 1, 2022, and protect uninsured (or self-pay) consumers from many unexpected high medical bills. If a consumer doesn't have health insurance, or doesn't plan to use that insurance to pay for health care items or services, they must be given a "good faith estimate" of what they may be charged, before they get the item or service. Once an uninsured (or self-pay) consumer schedules an item or service (like a medical device, a doctor's visit or a surgical procedure) with a health care provider or health care facility, that provider or facility must give them a good faith estimate of the amount it expects to charge for that item or service. A provider or facility must also give this good faith estimate when a consumer requests it (regardless of if they schedule the item or service).

A patient-provider dispute resolution process is now available for uninsured (or self-pay) consumers who get a bill from a provider that's at least $400 more than the expected charges on the good faith estimate. Under the patient-provider dispute resolution process, an uninsured (or self-pay) consumer, or their authorized representative, may initiate the dispute process. This process brings in an independent third-party called a dispute resolution entity to determine the appropriate amount the consumer must pay.

If a consumer chooses to dispute a charge for an item or service, the provider will be asked to provide:

- The good faith estimate they provided their patient.
- The bill they sent to their patient.
- Any supporting documents that help to explain why the bill is higher than the estimate.

Providers will be emailed a link to the federal dispute resolution portal where they can upload the requested documents. The dispute resolution entity will contact the provider if any additional information is needed. Once a determination is made, the

31

Provider Directories

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Provider Requirements

Must submit provider directory information to a plan or issuer:

- at the beginning of a network agreement with a plan or issuer
- if the provider terminates a network agreement with a plan or issuer
- when there are material changes to the content of provider directory information of the provider
- at any other time (including upon the request of plan or issuer) determined appropriate by the provider, health care facility, or the Secretary of Health and Human Services (HHS)

33

CMS Scenario..

- A doctor of chiropractic recently began a network agreement with a new health plan. **Is the DC required to submit provider directory information to the plan?**

  Yes, under the No Surprises Act, the DC is required to submit provider directory information (i.e. the provider's name, address(es), specialty, telephone number(s), and digital contact information) to a plan or issuer when they begin a network agreement with a plan or issuer with respect to certain coverage.

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Keep Information Up to Date

Names, addresses, specialty, telephone numbers, and digital contact information of **individual health care providers**; and

Names, addresses, telephone numbers, and digital contact information of each medical group, clinic, or health care facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved.

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Must Notify Patient of Availability of GFE

OMB Control Number [XXXX-XXXX]
Expiration Date [MM/DD/YYYY]

Appendix 1

Standard Notice: "Right to Receive a Good Faith Estimate of Expected Charges" Under the No Surprises Act

(For use by health care providers no later than January 1, 2022)

Instructions

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage **both orally and in writing** of their ability, upon request or at the time of scheduling health care items and services, to receive a "Good Faith Estimate" of expected charges.

This form may be used by the health care providers to inform individuals who are not enrolled in a plan or coverage or a Federal health care program (uninsured individuals), or individuals who are enrolled but not seeking to file a claim with their plan or coverage (self-pay individuals) of their right to a "Good Faith Estimate" to help them estimate the expected charges they may be billed for receiving certain health care items and services. Information regarding the **availability of a "Good Faith Estimate" must be prominently displayed** on the convening provider's and convening facility's website and in the office and on-site where scheduling or questions about the cost of health care occur.

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Providers Urged to Update Information

Hi Jill,

Your patients (and people who want to be your patients) rely on insurance companies' provider directories to find physicians that are right for them.

Under the No Surprises Act, your payers are **required** to have processes in place to remove providers who have not verified their directory information. Our records show that **as of September 16, at least one of your providers' information has not been verified** in more than 90 days.

It's essential that you complete this critical task today. Log in to the Availity Portal (now known as Availity Essentials) and check your providers' information.

Remember, even if nothing has changed, the No Surprises Act requires verification of your directory information every 90 days.

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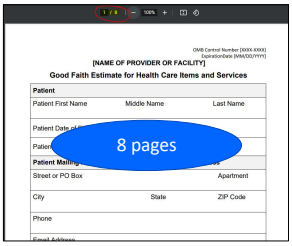
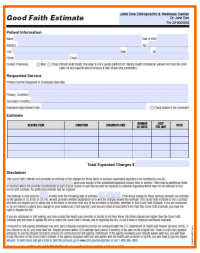
Government Form vs. KMC University





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Initial Visit GFE Customization

Good Faith Estimate

John Doe Chiropractic & Wellness Center
Dr. John Doe
TIN 20-0000000

Patient Information

Name: Judy Jones | Date of Birth: 04-02-1997
Address: 1 Paradise Lane | Apt.
City: Simplicity | State: KY | Zip: 41000
Phone: 555-555-1111 | Email: contactme@gmail.com

Estimate

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Exam (Evaluation)	low back, shoulder, neck, midback		1	145.00	145.00
Imaging	diagnostic		1-2	105.00	210.00
Electrical Stimulation	muscle spasm		1	36.00	36.00

Total Expected Charges $ 521.00

Exam (Evaluation)	low back, shoulder, neck, midback		1	145.00	145.00
Imaging	diagnostic		1-2	105.00	210.00
Electrical Stimulation	muscle spasm		1	36.00	36.00

Total Expected Charges $ 521.00

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New Patient Visit Customization

Estimate

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Exam (Evaluation)	Pain		1	145-230.00	230.00
Imaging	diagnostic		1-2	65-105	215.00
Electrical Stimulation	muscle spasm		1	36.00	36.00

Total Expected Charges $ 481.00

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Second Step of the GFE Process

Financial Report of Findings
Good Faith Estimate

John Doe Chiropractic & Wellness Center
Dr. John Doe
TIN 20-0000000

Patient Information

Name: Judy Jones | Date of Birth: 04-02-1997
Address: 1 Paradise Lane | Apt.
City: Simplicity | State: KY | Zip: 41000
Phone: 555-555-1111 | Email: contactme@gmail.com

The following is a list of items and services which the provider/clinic anticipates you will need once your initial exam or re-exam has been completed.
The recommended treatment is to begin on 05 / 03 / 22 and is projected to completed by 06 / 15 / 2022.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Spinal Manipulation 3 areas	Cervical Dysfunction,Thoracic Dys., Lumbar Syndr	M9900,M9902,S335xxA	15	65.00	975.00
Manual Therapy	Shoulder pain	M7541	12 units/6 visits	45.00	540.00
Exercise Therapy	Cervical Dysfunction/ Lumbar Dysfunction	M9900,M9903	20 units/10 visits	65.00	1300.00
Re-Exam	spine & shoulder	N/A	2	85.00	210.00

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Treatment Plan from

The following is a list of items and services which the provider/clinic anticipates you will need once your initial exam or re-exam has been completed.
The recommended treatment is to begin on 05 / 03 / 22 and is projected to completed by 06 / 15 / 2022.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Spinal Manipulation 3 areas	Cervical Dysfunction,Thoracic Dys., Lumbar Syndr	M9900,M9902,S335xxA	15	65.00	975.00
Manual Therapy	Shoulder pain	M7541	12 units/6 visits	45.00	540.00
Exercise Therapy	Cervical Dysfunction/ Lumbar Dysfunction	M9900,M9903	20 units/10 visits	65.00	1300.00
Re-Exam	spine & shoulder	N/A	2	85.00	210.00

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Treatment Plan

The following is a list of items and services which the provider/clinic anticipates you will need once your initial exam or re-exam has been completed.
The recommended treatment is to begin on 04 / 19 / 2022 and is projected to completed by 06 / 19 / 2022.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Adjustment 2 Regions	Neck		20		
Re-Evaluation 99213	Neck		2		
Muscle Stim 97014	Neck		12		
Laser	Neck		12		
Exercises	Neck		4		

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Maintenance Plan

The following is a list of items and services which the provider/clinic anticipates you will need once your initial exam or re-exam has been completed.
The recommended treatment is to begin on 06 / 19 / 2022 and is projected to completed by 06 / 18 / 2023.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Adjustment S8990	Maintenance		24		

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Financial Hand Off

The following is a list of items and services which the provider/clinic anticipates you will need once your initial exam or re-exam has been completed.
The recommended treatment is to begin on 06 / 05 / 22 and is projected to completed by 06 / 16 / 2022.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Spinal Manipulation 3 areas	Cervical Dysfunction Thoracic Dys., Lumbar Spine	M9900,M9902,S335xxA	15	65.00	975.00
Manual Therapy	Shoulder pain	M7541	12 units/6 visits	45.00	540.00
Exercise Therapy	Cervical Dysfunction Lumbar Dysfunction	M9900,M9903	20 units/10 visits	65.00	1300.00
Re-Exam	spine & shoulder	N/A	2	85.00	210.00

Total Expected Charges $ 3025.00

Disclaimer

This Good Faith Estimate only provides an estimate of the charges for those items or services reasonably expected to be furnished to you by Dr John Doe upon your receipt of the scheduled/requested primary item or service. There may be additional items or services which the provider recommends as part of your course of care that you will be required to schedule separately which may not be reflected in this Good Faith Estimate. An additional estimate may be required.

The estimate is only valid for 6 months from the following date of estimate 5 / 03 / 22. If the actual charge for these services exceeds our estimate

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New Year 2023 –No-Surprises Act

- Make sure all your provider directories including out of network are up to date
- Review your NP phone call process for proper scripting
- Make sure your GFE process is working properly along with providing the necessary information at visit 1
- Refresh on this process if needed
- Watch for new Advance EOB rules to come out

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What's a Comparative Billing Report from Medicare?

RELI Group
7125 Ambassador Drive, Suite 100
Windsor Mill, MD 21244

January 31, 2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CBR #: CBR202201
Chiropractic Manipulative Treatment (CMT) of the Spine
[redacted]

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Not Everyone Gets One

The criteria for receiving a CBR are that a provider:

1. Is significantly higher compared to either state or national percentages in any of the three metric calculations (i.e., greater than or equal to the 95th percentile), and
2. Has at least 60 beneficiaries with claims submitted for CMT of the spine, and
3. Has at least $20,000 in total charges for CMT of the spine.

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Only When Considered an Outlier

Table 2: Summary of Your Utilization of CPT® Codes for CMT of the Spine Between Jan. 1, 2019, and Dec. 31, 2019

CPT® Codes	Allowed Charges	Allowed Units	Beneficiary Count
98940 Without Modifier AT	$0	0	0
98940 With Modifier AT	$31,296	1,129	168
98941 Without Modifier AT	$0	0	0
98941 With Modifier AT	$0	0	0
98942 Without Modifier AT	$0	0	0
98942 With Modifier AT	$0	0	0
Total	$31,296	1,129	168

*A beneficiary is counted once per row of CPT® code level. The total "Beneficiary Count" is not the sum total; it represents unique beneficiaries for all the CPT® codes for the 12-month period.

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Now is the Time to Prepare!

- Go through your notes and make a plan; everything doesn't have to be done all at once
- This is part of the role of the office manager, biller, and/or compliance officer
- Note this training in your compliance manual as this can count as your annual required training
- Don't let your notes sit and wonder why you didn't get this done next January

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