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2023 Billing, Medicare, and Regulatory Updates Made Easy

Presented by:
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Education Director, KMC University

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Our Plan Today

- Have fun!
- Review of key issues with Medicare causing denials and cash-flow interruption.
- Differences between Medicare Part B and Part C.
- Did you master No Surprises Act in 2022? If not, you get another chance with new changes.

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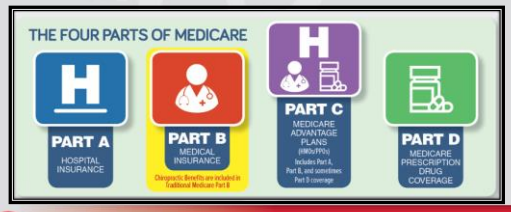
Types of Medicare Coverage

- Basic Medicare Part B coverage is what most of the senior population have but that is quickly changing
- Medicare Part B is usually the primary coverage



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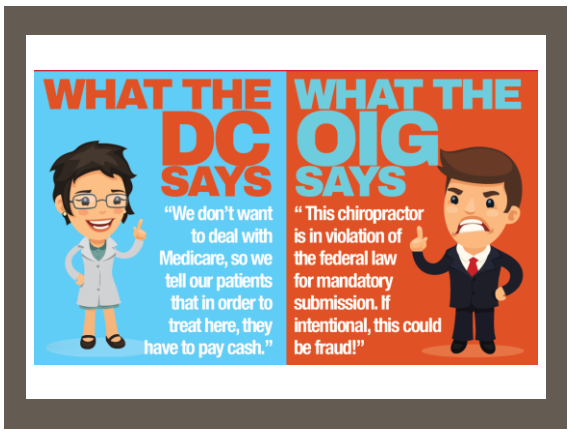

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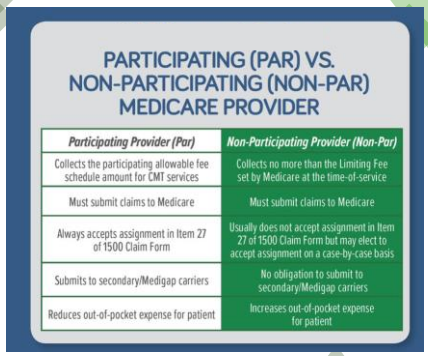

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**Dollar amounts for educational purposes only

Calculations for Spinal CMT in Part B			
Procedure Code	Par Allowable	Non-Par Allowable	Limiting Fee
98940	$28.93	$27.48	$31.60
98941	$41.55	$39.47	$45.39
98942	$49.18	$41.47	$53.19

80%

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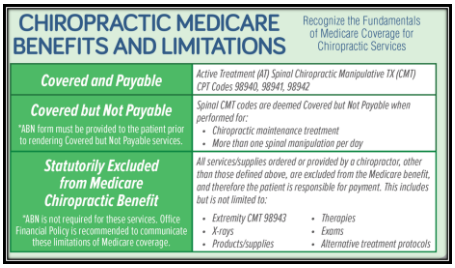
Must Know The Difference | Chiropractic is Different In Medicare



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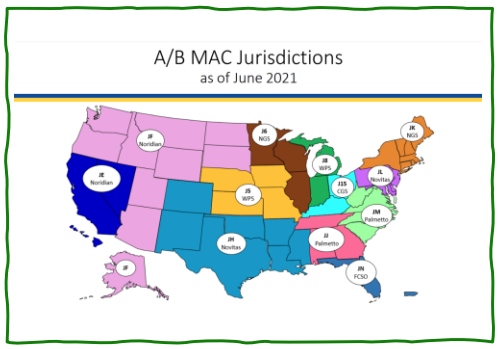

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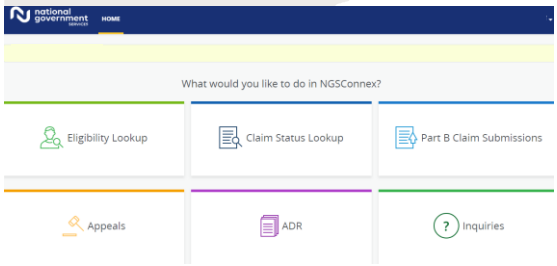
Part B MAC Provider Portal



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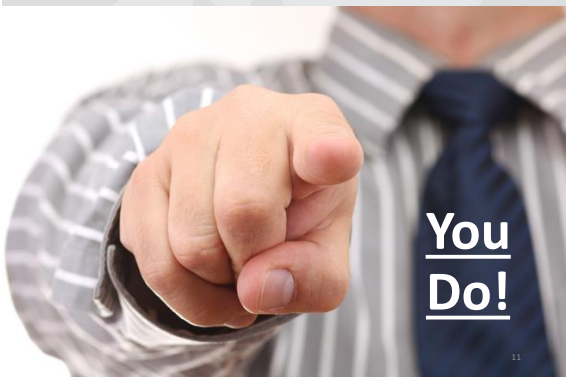
Who Determines Active vs. Maintenance?



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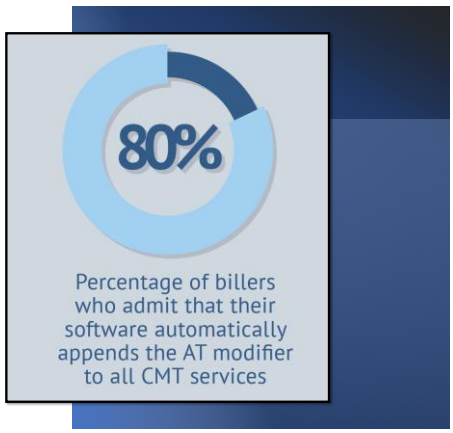

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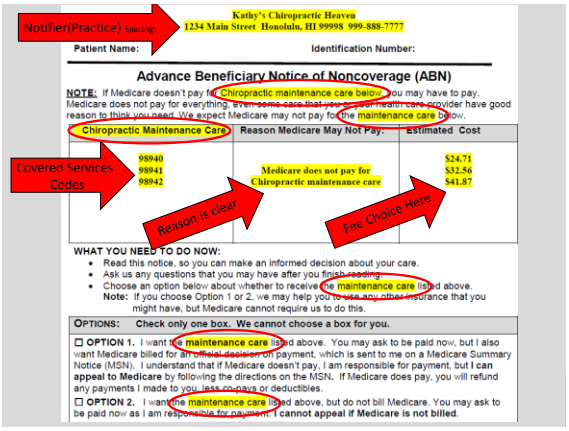

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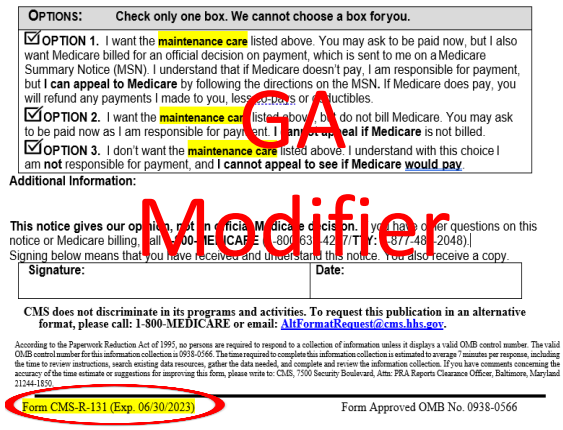

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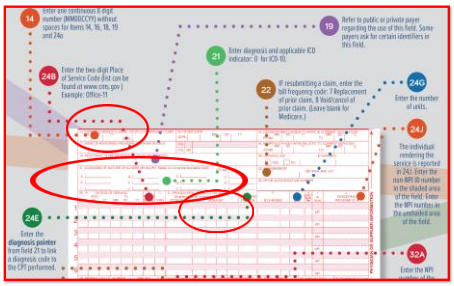
Common Billing Errors



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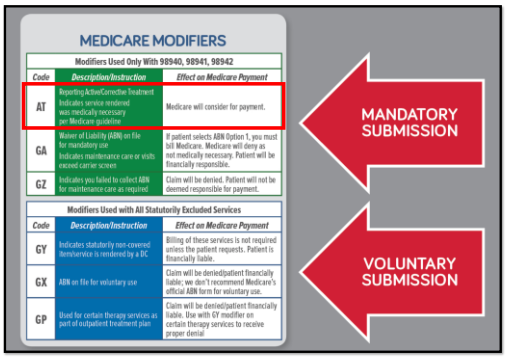

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You Must Understand

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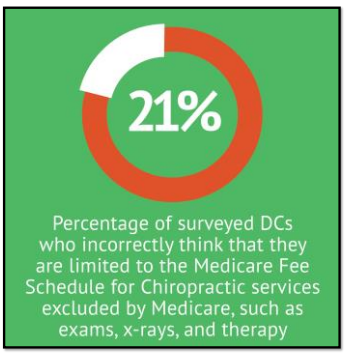
Silly Errors Cost Your Practice Money!



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Bad News Either Way!

42% of DCs surveyed admitted to automatically writing off Medicare statutorily excluded services like exams, x-rays or therapy.

31% of DCs surveyed admitted to not prescribing statutorily excluded services to their patients because they didn't want to charge them.

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Northern District of Iowa

FOR IMMEDIATE RELEASE — Tuesday, March 6, 2018

Oelwein Chiropractor and Clinic Agree to Pay Nearly $80,000 to Resolve False Claims Act Allegations Involving Free Electrical Stimulation

Bradley Brown, D.C., from Oelwein, Iowa, and his clinic, Brown Chiropractic, P.C., have agreed to pay $79,919 to resolve allegations Brown violated the False Claims Act by improperly billing Medicare and Medicaid for chiropractic adjustments after providing free electrical stimulation to beneficiaries to influence those beneficiaries to receive chiropractic adjustments from Brown. The government alleged that this conduct violated the Anti-Kickback Statute and, in turn, the False Claims Act. The claims at issue were submitted between January 1, 2012, and September 30, 2016.

The Anti-Kickback Statute's purpose, in part, is to protect patients and federal healthcare programs from fraud and abuse by limiting the influence of money or improper incentives on healthcare decisions. It is intended to ensure, among other things, that improper financial incentives do not compromise providers' medical judgments and that inappropriate considerations do not cloud beneficiaries' decisions when determining which providers to utilize and which services to obtain.

"Our office takes seriously our responsibility to safeguard taxpayer dollars and to ensure a level playing field for healthcare providers," said Peter E. Deegan, Jr., United States Attorney for the Northern District of Iowa. "We appreciate Dr. Brown's cooperation in the investigation and hope this settlement sends a message to all providers that they must comply with all applicable rules and regulations or face consequences."

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Four Possible Fee Structures For Excluded Services

- Charge your actual fee
- Charge a reasonable time of service discounted fee (5-15%)
- Use a network-based, legally discounted fee of choice
- Allow for a legal hardship/indigence fee the patient qualifies for

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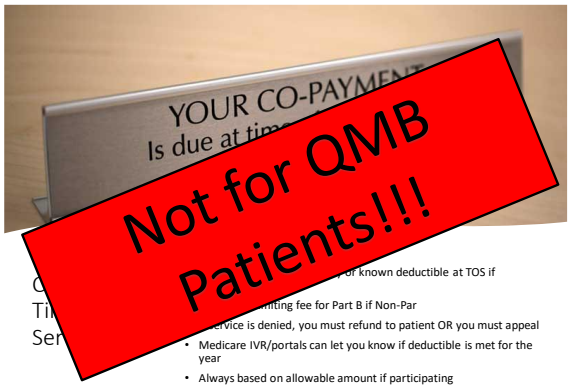

- Medicare IVR/portals can let you know if deductible is met for the year
- Always based on allowable amount if participating

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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

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Verify QMB Status

OPTION 1: Since July 2018, original Medicare providers and suppliers have been able to readily identify the QMB status of patients and billing prohibitions from the Medicare Provider Remittance Advice which contains new notifications and information about a patient's QMB status.

OPTION 2: Providers can verify beneficiaries' QMB status online through his/her state of residence's Medicaid eligibility systems.

OPTION 3: Ask beneficiaries for other proof such as their Medicaid identification card (look for the QMB) or some other documentation—issued by the State—that proves the patient is enrolled in the QMB program.

Medicare

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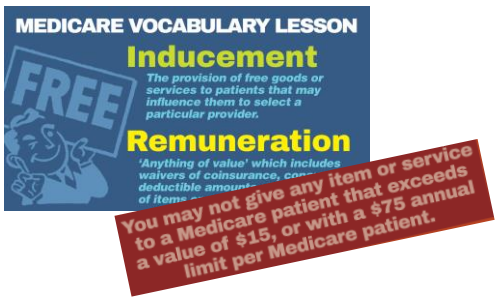
Your Obligation is to Know the Rules



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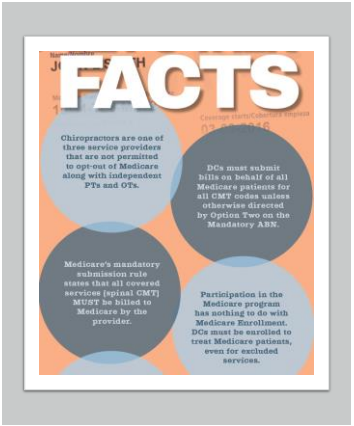
Know the Facts!

- Not allowed to Opt-Out
- Mandatory Submission rule applies to all covered services (CMT)
- Participation in Medicare is not the same as enrollment
- Claim submission required unless directed otherwise by the patient via the Advance Beneficiary Notice (ABN)



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Steps to Minimize Risk with Medicare

- Recognize the risks of not being enrolled and properly billing Medicare according to mandatory submission rules
- Distinguish active, billable treatment from not-medically necessary maintenance care
- Complete Medicare's documentation requirements flawlessly
- Prepare patients to be aware of the difference between covered and excluded services
- Apply proper Medicare rules to financial transactions with Medicare patients

Medicare

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Types of Medicare Coverage: Part C

- Also known as Medicare Advantage Plans or Replacement Plans— "Managed Care Medicare"
- Redirects benefits to a private carrier
- No Part A or B

Medicare

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Different Plan Types

2022 Humana Medicare Advantage Health Maintenance Organization (HMO) plan

The following documents contain information about HMO and HMO point-of-service (HMO-POS) plans and HMO special Needs Plans (SNPs).

HMO electronic claims flyer

HMO FAQs

2022 Humana Medicare Advantage Preferred Provider Organization (PPO) Plan

PPO electronic claims flyer

PPO FAQs

2022 Humana Medicare Advantage full and partial networks private-fee-for-service (PFFS) plans

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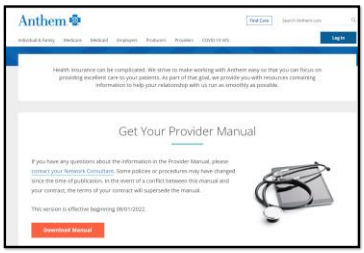

Find the Specific Provider Manual or Medical Review Policies

- Resources available online
- Simple Google Search "Medicare Advantage Provider Manual'

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Identify the Plan Type & Your Network Status

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Mandatory Submission

A provider is not required to agree to accept a PFFS plan's terms and conditions of payment or agree to treat a PFFS plan member. If a provider does not agree to accept the plan's terms and conditions of payment or refuses to treat the member, then the member will need to find another provider that will accept the plan's terms and conditions of payment. PFFS plans should assist members to locate another provider in the member's area who will accept the plan's terms and conditions of payment. For example, if there are providers in the area that the PFFS plan knows have accepted its terms and conditions of payment it should identify those providers to its members who are seeking a provider willing to be deemed as possible sources of care.

A provider that decides not to accept the plan's terms and conditions of payment should not provide services to a member, except in emergencies. If the provider nonetheless

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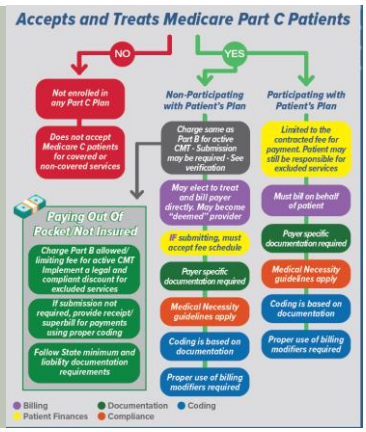
Obligations of DCs When Agreeing to Accept and Treat Medicare Part C Patients



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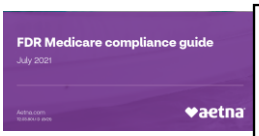
FDR Compliance- AMA Requirement



Review compliance program requirements

This guide summarizes Medicare compliance program requirements. Be sure to review it and comply with these requirements each calendar year. Here are some of the actions you must take:

- Distribute a code of conduct or a compliance policy
- Distribute general compliance and FWA education and training
- Complete exclusion list screenings
- Make employees aware of reporting mechanisms
- Report FWA and compliance concerns to us
- Report and request to use offshore operations
- Fulfill specific federal and state compliance obligations
- Monitor and audit first tier, downstream and related entities

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Watch For Open Enrollment for Medicare

- Approximately 65% of Medicare enrollees choose Part C over Part B
- Sometimes, they don't even know what they have
- New deductibles
- Different plans
- Must verify all insurance again in the new year…not on policy year

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Summary

- Confirm your Medicare participation status
- Identify your network status with all Medicare Advantage Plans
- Locate Payer Policies & Agreements
- Make a list of network plans and plan types
- Locate the FDR Requirements for each plan
- Establish a Notification & Consent Process for out-of-network services

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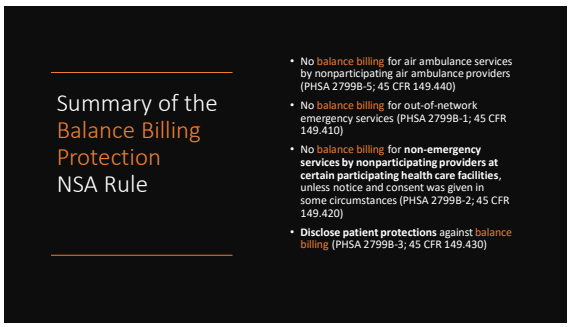

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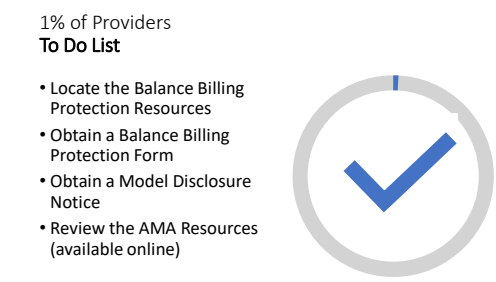

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What About Good Faith Estimates?

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"Health care providers and health care facilities are required under PHS Act section 2799B-6 to furnish a **notification of the good faith estimate of expected charges to an uninsured (or self-pay) individual** who schedules an item or service…"

Good Faith Estimate

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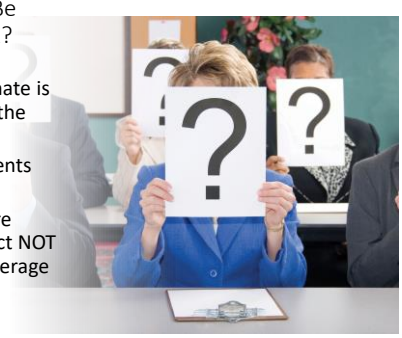
Who Should Be Offered a GFE?

Good Faith Estimate is to be offered to the following:

- Uninsured patients (self-pay)
- Patients who are insured but elect NOT to use their coverage



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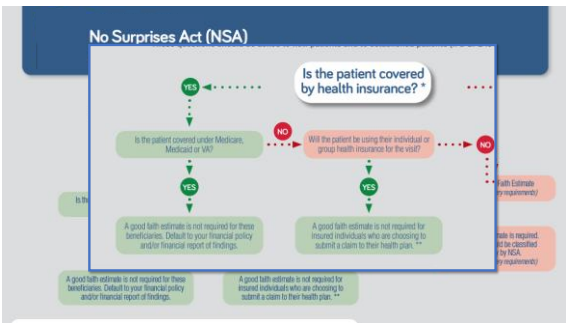

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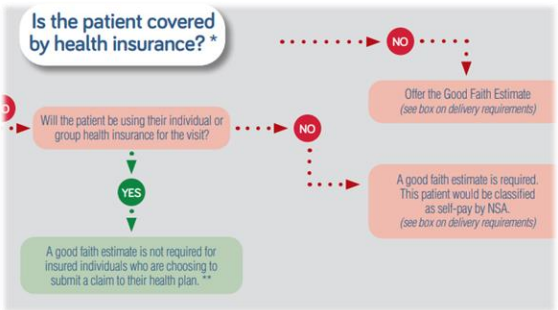

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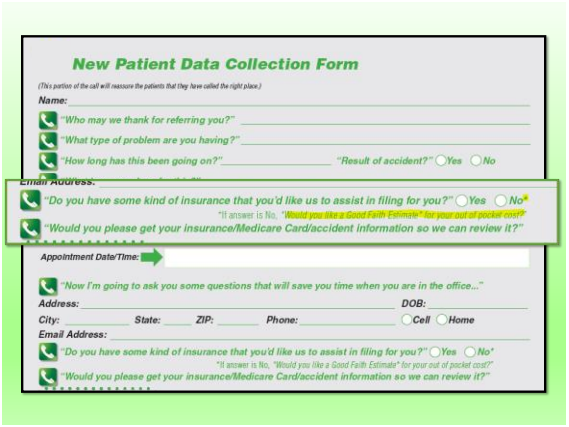

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GFE Delivery Requirements

- **10 business days** in advance, the GFE must be provided **within three business days**
- **3-9 business days** in advance, the GFE must be provided **within one business day**
- **Less than 3 days** in advance you ARE NOT required to provide a GFE in writing. Notify orally upon scheduling, provide estimate at initial evaluation if requested.

HEADS UP!

If patients request a GFE on their own, you need to **provide one within three days of the date requested. Keep all copies of GFE's as part of the medical record and provide a hard copy or electronic to the patient or prospective patient.**

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Must Contain

- Patient name
- Patient date of birth
- Description of the services that will be provided, in understandable language
- Itemized list of goods or services reasonably expected to be provided in connection with the scheduled services
- Diagnostic codes, service codes, and expected charges associated with each of those goods or services
- Provider name, NPI and/or tax ID number
- Office location where services will be provided

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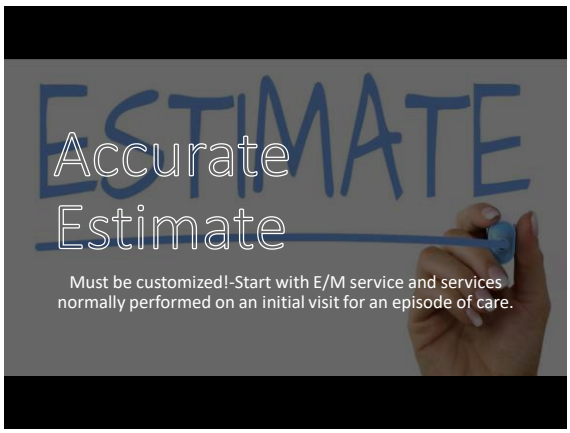

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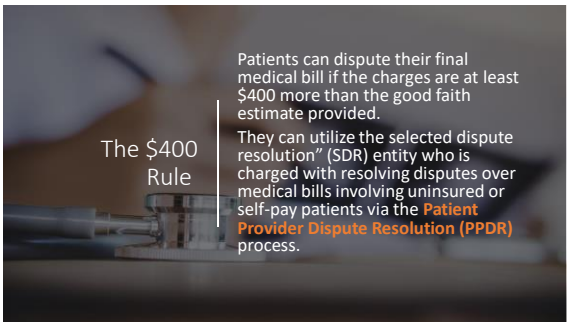

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Patient's Rights

Patient-Provider Dispute Resolution Form

Find out if you qualify for the dispute resolution process

This form is only for people who do **not** have health insurance or who decided not to use insurance for their medical care.		
Did your health care provider give you a Good Faith Estimate for the item or service?	Yes ☐	No ☐
Is the bill for your health care provider at least $400 more than the Good Faith Estimate?	Yes ☐	No ☐
Is the **date on the top of the bill** within the last 120 calendar days (about 4 months)?	Yes ☐	No ☐

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Payment Dispute Resolution

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

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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
Contact Preference: ☐ Mail ☐ Email (Patient understands that email is not a secure platform for sharing health information and will not hold the clinic liable for any unauthorized disclosure if they choose this preference)

Requested Service

Primary Service Requested or Scheduled (describe): Examination (evaluation)
Primary Condition: Low back strain
Secondary Condition: shoulder impingement syndrome (cervical and mid-back pain)
Scheduled Appointment Date: May 3, 2022 ☐ Check bubble if not scheduled

Estimate

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Exam (Evaluation)	low back, shoulder, neck, midback	M54.5	1	145.00	145.00
Imaging	diagnostic	M54.5	1-2	105.00	210.00
Electrical Stimulation	muscle spasm	M54.5	1	36.00	36.00

Total Expected Charges $ 521.00

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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 06 / 19 / 22 and is projected to completed by 06 / 19 / 2023.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Spinal Manipulation 3 areas	Cervical Dysfunction; Thoracic Dys.; Lumbar Dysfu	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

Second Step of the GFE Process

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Treatment Plan from the DC

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 / 22 and is projected to completed by 06 / 19 / 2023.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Spinal Manipulation 3 areas	Cervical Dysfunction; Thoracic Dys.; Lumbar Dysfu	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

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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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 / 19 / 2023.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Adjustment S8990	Maintenance	Z00.00	24		

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What About Hardship Arrangements?

Q: Do providers or facilities need to factor in financial assistance an uninsured (or self-pay) individual may receive when calculating the expected charges for items or services included in the GFE?

A: Yes. The GFE must reflect the expected charges, including any expected discounts or other relevant adjustments that the provider or facility expects to apply to an uninsured (or self-pay) individual's actual billed charges. For example, certain tax-exempt hospital organizations are required to meet certain Financial Assistance Policy (FAP) requirements; for purposes of this example, any adjustments expected to be applied under the FAP would be factored in and reflected in the amount reported in the GFE.

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Document Delivery
It is part of the medical record

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Audit Your Current Process

Gather	Gather with your team and review your current intake process
Train	Train staff on the expectations of the newer regulations such as No Surprises Act
Make	Make note of areas that are lacking

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Non-Compliance Penalty

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Changes on the Horizon

- **Current** -a GFE is required for uninsured/self-pay patients or insured patients who are not using their insurance and includes only the expected charges from the provider who is actually providing the estimate
- **Future-** the departments are going to enforce a requirement that it includes the **expected charges of other providers** and other facilities that **may be involved in the service** other than the one that's scheduling the service
- **Future**- GFE will be required for **all patients- insured**, uninsured, and those opting not to use their insurance

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Be Prepared

- Focus on Payer Relationships
- Register Online Portals and Availity
- Medical Review Policies
- Identify Non-Covered Services
- Create a list of network payers on your website

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Recommendations

Stay Alert to Educational Opportunities	**Know Your Fees & Compliance Obligations**	**Build a Financial Report of Findings Process**
Include a Good Faith Estimate in the Intake Process	Patient Rights Posted in the Clinic	Patient Rights on Surprises Act Posted on Your Website

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Medicare Can't Be Taught in an Hour

- Come visit my team at Booth XXX
- Get some swag goodies
- Request a private consultation
- Sign up to connect post-Parker
- info@kmcuniversity.com

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