KMC University's
Chronicles
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CELEBRATING KATHY (KMC) WEIDNER'S FOUR DECADES OF SERVICE TO OUR PROFESSION!

Documentation Through the Eyes of an Auditor

DC Insights

By Dr. Colleen G. Auchenbach, DC, MCS-P, CPMA

Ever wonder why an insurance company wants to see your documentation but not that of the doctor down the street? Although government and insurance carriers routinely perform audits as mandated through the Fraud, Waste, and Abuse program, it's important for providers to be aware of problems that could cause their clinic to be under investigation. For years, third-party payers, with Medicare taking the lead, have been telling chiropractors to step up their documentation, with little to no results. A high number continue to fail because key components are missing in documentation resulting in requests for money to be paid back. But why do payers request records in the first place? What triggers them to want to take a deeper dive into what a practice is billing?

Audit Triggers

It may seem like a small batch of claims on your end, but all data submitted to payers is used to assess and create coding policies and reimbursement limitations. It is the age of technology, and data mining is part of healthcare. A paid claim does not mean that you submitted a clean claim. Most payers analyze these claims even after payment has been made to determine if a take-back or audit is warranted. Some areas that can trigger an audit are listed below:

Billing Evaluation & Management (E & M) incorrectly. Some clinics choose the same level of E & M code for all patients regardless of their condition or complexity. As a result, some E & M procedures do not have the required documentation to support the level of E & M, while others should have been coded at a higher level. Some clinics ignore the required condition and documentation needed to perform an established patient exam, and as a result, the documentation does not meet all the E & M standards.

Excessive use of a CPT code or diagnosis code. This one is challenging since doctors of chiropractic have a limited set of procedure codes to choose from. Needless to say, payers can select a certain code for the code editing process, such as 98941 or 98942, or a certain diagnosis code, such as pain codes. We love our templates within the EHR (Electronic Health Records) system, but sometimes the documentation can look repetitive. For example, a patient that remains at level 98942 with little to no improvement might be a red flag. Each encounter should reflect the chief complaint, change in condition, and treatment rendered. The diagnosis should be assessed at each encounter, describing the condition of the patient at the time of the encounter and not be a copy and paste action within the EHR.

Lack of response from the provider. Ignoring a request for records will trigger an audit but ignoring denied claims can as well. In fact, when a service is denied, and the doctor stops billing the code or chooses a different code, it raises a red flag. For example, the provider bills 97124 and receives denials; the next month the provider bills 97140 for the same patient, instead. This can trigger an audit.

Billing patterns that classify you as an outlier. It is important to note that the procedure code may be valid but billing them too often or too long in comparison to your peers can trigger an audit. You might be an outlier if you adjust the full spine and bill for that adjustment rather than for what was documented as medically necessary. You might be an outlier for billing therapy services that closely approximate an adjustment, as well as using certain

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modifiers attached to those therapy codes. Even if you are doing everything by the book, you may still fall into the outlier category due to the nature of your technique. However, it does not automatically mean you are doing anything incorrectly. If you have properly documented and coded the services billed, you have nothing to worry about in the event of a records request.

It is vital that the **provider understands how choices for coding and documentation work together to tell a story.** That story should mirror the patient's presentation, the doctor's findings, and the services provided. The billing codes relay this information to payers in their language. If your documentation does not back up the billing code 'story', you have not justified your right to payment by the patient's insurance carrier. And they are well within their rights to ask for that money back. It's that simple.

Gone are the days when doctors could toss CMS-1500 forms into the air and expect them to rain money. In the age of electronic health care records, most doctors haven't even seen a 1500 claim form. Yet, they have signed it every time the office sends a bill. That signature verifies that the services billed were performed and documented in the patient record. **There must be a connection between the patient complaint, the treatment, and the billing codes on that claim form.**

Take the proactive approach and have your documentation reviewed in a safe environment with **KMC University's Proactive Chart Review.** Check it out here.

https://learn.kmcuniversity.com/product/proactive-chart-review-pcr/

Dr. Colleen Auchenbach graduated with a Doctor of Chiropractic from Cleveland University Kansas City in December of 1998 and enjoyed practicing for over 20 years. Her interest in Medical Compliance began when she earned the 100-hour Insurance Consultant/Peer Review certification from Logan University in 2015. She has been a certified Medical Compliance Specialist-Physician since 2016 and a Certified Professional Medical Auditor since 2022. Dr. Auchenbach joined the excellent team at KMC University as a Specialist in 2020, and as a part of this dedicated team is determined to bring you accurate, current, and reliable information. You may reach her by email through info@kmcuniversity or by calling (855) 832-6562.

The Importance of Financial Guardrails

When setting up a practice, a doctor might be eager to enroll in all the payer networks in the hopes of attracting more patients. Others may market free exams or other services that lead to different rates for different individuals. Neither of these is the best approach. In fact, navigating the payer world and setting practice fees without guidance can lead to serious violations and penalties. Even worse is to involve the patient without clear financial guidelines.

Setting Your Fee

Regulations that apply to financial matters in healthcare are provided to prevent a free-for-all in charges and collections. Healthcare entities should establish a fee system for the business, containing their actual fee, certain agreed upon contracted fees, and other elective discounts, if desired. It's so important that it is one of the four focus areas that the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) felt compelled to ask practices to audit and review regularly. A robust understanding of how your fee system should work is essential to set up a compliant fee system. Once established, the next step is communication with your patients.

A Policy that Protects Your Clinic

How often have patients come to your office, received quality care, and walked out without paying? Probably more times than you'd like to recall. Getting patients to pay is critical in the healthcare industry where the cost of doing business increases drastically each year. How can you avoid appearing unsympathetic or money hungry? How can you manage the subject of patient financial responsibility without offending patients or giving away the farm? Start by developing a written financial policy.

The movement towards consumer empowerment in healthcare means that the patient should be informed at all times about their financial responsibility, in most cases, prior to receiving care. In fact, there are federal regulations in place that require a good faith estimate for all individuals who are self-pay. Patients who ask questions or are hesitant to pay are not trying to be difficult or game the system, they simply need to be educated about covered and noncovered services. A financial policy lets your patients know what you expect of them and what they can expect of you.

Customized to Your Practice

The clearer you make your financial policy, the easier it will be to avoid disagreements with your patients and eliminate confusion for your team. When creating your policy, include all variables that could come into play in your practice. Some examples are:

- Level of participation with insurance carriers
- Options for payment plans
- Hardship policy and terms
- Fee for missed appointments
- Interest charges on past due or unpaid balances

A Financial policy is an educational process for patients. You may wish to include it on your website or post a copy near your front desk. You may want to review the policy with new patients before they see the doctor, or you may wish to review it at the end of the first visit while discussing their payment responsibilities. Be sure to have each patient read, sign, and date it. Then add it to the patient's chart. If patients are confused about their financial responsibility, direct their attention to the signed document, and they will likely comply. A financial policy clarifies the ground rules, creates less frustration for staff, and allows your clinic to be professional and compliant. Get started today by visiting the KMC University Library course titled **Fee System Set Up** for more information on actual and discounted fees. You will also find the Support Tool titled ***Financial Policy Questionnaire*** & ***Office Financial Policy Template*** in the module titled **Setting Office Financial Policy**. These tools will help you customize your own Financial Policy.

https://learn.kmcuniversity.com/courses/fee-system-set-up/

Throughout 2023, KMC University is celebrating our founder, Kathy (KMC) Weidner, for reaching an incredible milestone!

40 YEARS SERVING THE CHIROPRACTIC INDUSTRY!

(Continued from Part 2…)

https://kmcuniversity.com/kmc-celebrating-40-years-in-chiropractic

After relocating to Washington, DC, Kathy had the opportunity to serve the entire profession at a national level at the American Chiropractic Association (ACA). She served as the ACA's primary staff contact for coding, insurance, Medicare, and other practice management issues. During this time, Kathy gained tremendous knowledge about coding, Medicare, documentation, and other compliance issues from the leaders who formulate policy.

"I served as staff liaison to the Coding Committee, the group that works with the CPT Editorial Panel and supplies two DCs to sit on the committees that work with coding. Because we were a national association, we had to comment on any coding changes that could affect our profession. The research I did there and preparing for those committee calls elevated my knowledge of coding ten-fold.

I served as staff liaison to the Medicare and Senior Citizen's committees. I got to learn at the feet of the Governmental Relations department and attorney to see what goes on behind the scenes. I learned how the fees are determined and many other congressional activities that affect the profession.

I was responsible in my department for staying on top of the changes and making recommendations to the committees. I worked with the committee each year to compile the ACA's annual Coding and Billing Manual. It is where I honed my content development skills.

I was available to state associations as an expert speaker. Because I had national speaking experience, I was known to many of them. During this time, I became familiar with more executives at the state level and was honored to be a featured CE speaker at their events.

I was asked to present for the ACA at events like the annual House of Delegates meeting, and the National Chiropractic Legislative Conference (NCLC) each year. It was during one of those seminars that I met Dr. Mark Sanna. He approached me after the seminar and explained that he owned Breakthrough Coaching and said if I ever needed a job, I should let him know."

Another move brought Kathy to Denver, CO, and an opportunity that changed the course of her career. From 2001-2006, she served as a Senior Coach with Breakthrough Coaching (BTC) and worked directly with more than 100 practices throughout the country, training them with ethical and unique practice-building techniques. During this six-year period, Kathy spoke to and trained thousands of doctors and team members.

"After reaching out to Dr. Sanna, he hired me as a contractor for BTC. I became the first non-doctor, and non-former client to be a Senior Coach. Working at BTC, I helped create and build much of the content in the member learning area. I served on the recruitment team and as his liaison to The Strategic Partners. At one time, I coached as many as 70 practices on coding, documentation, billing, marketing, and practice management.

Because of my experience in multi-disciplinary practice (MDP), I also worked with many of these practices during my time there. It was during this time that the government introduced the Office of Inspector General (OIG) Compliance Guidance for Small and Group Practices. I became an expert on these laws and spoke at many state association conventions. At one point, I was speaking professionally 35-40 times a year. It certainly raised my national prominence and recognition. I became known as a national expert in Medicare, compliance, billing, coding, and documentation.

Because I was already working as my own business as a contractor, I began to explore whether I wanted to jump into the entrepreneurial pool myself. Dr. Sanna had graciously allowed my contractor agreement to include no provisions for non-competition for any of the knowledge I brought to BTC. It allowed me to consider forging out on my own. Although I loved my time coaching at BTC, I resonated much more with the documentation, compliance, and billing aspects of my coaching than with the general practice management areas. I'm proud that I made this move with integrity and preserve my friendship with Dr. Sanna to this day."

To be continued in the next edition of our
KMC University Chronicles…

Help Desk Frequently Asked Questions

TOP 40

In celebration of Kathy (KMC) Weidner's 40th Anniversary serving the profession, we will address the Top 40 Help Desk FAQs. Each issue in 2023 will address ten questions. We all can learn from the mishaps of others. This section will hopefully help clinics nationwide avoid frustration from misinformation and/or lack of understanding.

21 *I hear the ABN (Advance Beneficiary Notice) has expired as of June 2023. Will we need to have patients sign the new ABN form if they have the old one on file?*

Since the ABN expired on June 30, 2023, yes, you will need to have a new ABN (Form CMS-R-131 (Exp. 01/31/2026) signed by patients. The revised ABN templates are in the KMC University library along with scripting for team members. Check out the Medicare module titled ***The Mandatory Advance Beneficiary (ABN) Form.***

https://learn.kmcuniversity.com/courses/abn/lessons/mandatory-abn-for-spinal-adjustments/

22 *If a Medicare patient transitions into maintenance care, has signed the ABN form and selected Option 2, "I want the maintenance care listed above, but do not bill Medicare" and our clinic has a time-of-service discount, what fee should the Medicare patient be charged?*

If you wanted to give a time-of-service discount and you do not participate in a Discount Medical Program, a reasonable time of service discount on services that are patient responsibility doesn't violate any regulation **depending on the amount of the discount**, how your policy reads, and other factors. The discount must represent your true overhead savings for not filing a claim and Federal guidance seems to allude to a limit of 5-15%. State laws may vary and are not always well-defined. If your state law is different from the Office of the Inspector General (OIG) guidelines, follow whichever is most stringent. Consider how much more it costs to bill the patient or insurance rather than collect the fee at the time of service. Once the established percentage of savings is determined, create a written policy and procedure to be followed. Cover this option in your office financial policy to ensure patients are properly notified. Consider including such things as rules for payment, instructions for self-submission, if applicable, and reference the governing guidelines that the practice is following, to compliantly offer time-of-service discounts. Learn more in the KMC University Library Rapid Solution titled ***Three Payment Options for Medicare Maintenance Care.***

https://learn.kmcuniversity.com/rapid-solution/charging-for-medicare-maintenance-care/three-payment-options-for-medicare-maintenance-care/

23 *I am new to billing and noticed the previous biller appended the modifier GA to all Medicare claims that have an exam, X-ray and/or procedure code 98943. Is this correct billing?*

The GA modifier reports to Medicare that the patient signed an ABN for services that are normally covered but would not be covered due to lack of medical necessity, such as maintenance care. Statutorily Non-Covered items, such as 98943, exams, X-rays would use the GY modifier when being billed to Medicare. GP Modifier would be used if they were having any type of physical therapy plan of care along with a GY modifier. Check out the helpful support tool titled ***Commonly Used Modifiers*** in KMC University library.

https://learn.kmcuniversity.com/courses/cpt-coding-according-documentation/lessons/coding-modifiers/topic/commonly-used-modifiers-quick-reference/

24 *Our office utilizes Microsoft Teams to communicate with staff. Could we use patient names on this platform and still be HIPAA compliant?*

Microsoft 365 Teams application is structured to meet guidelines and security requirements like any HIPAA-compliant application that houses PHI (Protected Health Information). They have done their part to make it HIPAA compliant and are willing to sign a Business Associate Agreement (BAA). Some providers are quick to sign the BAA without consideration of Microsoft 365's disclaimer. There is a shared responsibility approach to the compliance requirements for the BAA to be valid. Prior to utilizing any application that may process or store PHI, it is vital to review the HIPAA compliance standards and Terms of Use of the vendor. In order to meet the Microsoft 365 HIPAA requirements, you must track PHI through the entire workflow and identify areas of risk. Once you have tracked PHI, role-based access must be set up and documented, along with team training. All configurations to the application must be set exactly as Microsoft outlines in their security instructions. Based on the HIPAA guidelines, you could enter the full name if all the other settings and configurations are set correctly. For example, you may allow team members to utilize Teams on a personal device or a portable device at a home office. This additional risk must be evaluated, and protections established. Not sure if your office has a healthy HIPAA program? Feel free to check out our Library learning module titled ***Evaluate Your HIPAA Compliance Program.***

https://learn.kmcuniversity.com/courses/hipaa-compliance/lessons/evaluate-your-hipaa-compliance-program/

25 *If our clinic is non-par with Medicare, do new doctors that begin practicing at our clinic need to have a PTAN number with Medicare to practice?*

Any provider in your practice must have their own NPI (National Provider Identification) and be enrolled with the Part B carrier to see Part B patients. They must also be attached to your Practice Entity's registration with Medicare. If the provider is not enrolled with Part B, that needs to be done before they can see Part B patients. More information is available in the KMC University library module titled ***Mandatory Medicare Enrollment.***

https://learn.kmcuniversity.com/courses/medicare-basics/lessons/mandatory-medicare-enrollment/

26 *Currently, we have patients fill out an ABN every 12 months, is this correct? ?*

This is an incorrect usage of the ABN form. No need to do anything on a 12-month basis. A mandatory ABN remains effective after valid delivery as long as there is no change in:

- Care from what was described on the original ABN;
- The beneficiary's health status which would require a change in the subsequent treatment for the non-covered condition and/or;
- The Medicare coverage guidelines for the items or services in question (i.e., updates or changes to the policy of an item or service);
- The allowable/limiting charge since these fees change each year.

27 *We charge Medicare patients at time of service and let them know they will get a percentage of reimbursement from Medicare and/or their Secondary Insurance because we are non-par. If we get a payment from either Medicare or the Secondary (rare cases) we leave it as a credit on their account. Are we doing this correctly?*

Yes, you are charging the limiting fee at the time of service, submitting the claim and the patient will receive 80% of the non-par allowable, and then the secondary should pay them the 20% of non-par allowable. The difference between non-par allowable and Limiting Fee is never recouped by the patient. If the secondary accidentally pays you, it's okay to ask the patient how they'd like that to be handled; either as a credit for the next visit, or to be refunded to the patient. The KMC University Library module titled ***Medicare Charge & Fee Rules*** expounds on this topic.

https://learn.kmcuniversity.com/rapid-solution/medicare-charge-and-fee-rules/

28 *We have a patient who was in a vehicle accident and the patient never provided the accident claim information. We received a letter from a lawyer's office stating they are representing the patient. My question is, can we bill the patient directly?*

Unless you are in a no-fault state, your patient owes you every penny for your bill. If you are electing to act as a bank and wait to be paid and assist them with billing an insurance company, then it is the patient's obligation to provide the information for you to do so. Essentially when you do not have this information you are taking on the role of a bank, giving out a loan without any collateral. It is a bad precedent to set. If the patient is being represented by an attorney and is putting you on notice, that attorney should be willing to accept a lien and ensure that your bill is paid. If there are medical payments or pip coverage that's available to pay the bills along the way, then the attorney's office should provide that to you so that you can bill it and receive your money along the way. If you wish not to do that, your patient can pay for the services, and you can provide a superbill at the end of each visit, and they can be reimbursed when their attorney settles with the other party's insurance. Additional information on billing personal injury claims can be found in KMC University library in the module titled ***Personal Injury Insurance*** in the Practice Finances course.

https://learn.kmcuniversity.com/courses/how-insurance-works/lessons/personal-injury-insurance/

29 *Can the doctor charge differently for after-hour appointments? If so, how do you code it?*

If it is during after hours, then you can charge an add on code in addition to the other services such as your CMT codes. That add on code would be CPT (Current Procedural Terminology) code 99050. Now, that being said, most third-party payers will not cover that code, so you will want to review the payer's non-covered service policy and procedures which may require advance notice to the patient using the payer's dedicated waiver form. If one is not available, be sure to initiate your own advance notice of non-coverage agreement prior to rendering the service. Check out the Helpdesk Video titled ***Can I Get Paid for After Hours or House Calls?***

https://learn.kmcuniversity.com/2021/03/18/can-i-get-paid-for-after-hours-or-house-calls/

30 *I want to utilize a consultation code for patients that come to the office to ask questions and determine if chiropractic care is indicated. I need the appropriate consultation code for billing.*

That is great that the patient is taking that approach, but it is important to understand what the Consultation codes are to be used for. Consultation codes are described by the AMA's Current Procedural Terminology (CPT) as Evaluation and Management (E/M) services *"performed by a physician* ***when another physician or another appropriate source has requested an opinion on an evaluation or for a recommendation of care*** *for a specific condition or problem. They are not to be used for consultations requested by the patient or a family member. There* ***must be an outside referral from another physician,*** *and a completed evaluation, and report must be sent to the referring physician."*

We would suggest initiating a New Patient Pre-Acceptance Interview. Offices can offer pre-acceptance interviews to patients at no charge if:1) this is a routine part of your initial visit procedure, 2) it is not advertised publicly, and 3) no evaluation or treatment has been given. Often, this is the best procedure for patients to come in and find out if they are in the right place and a suitable candidate for care while avoiding a claim of financial inducement. Additional information can be found in the KMC University Library Rapid Solution titled ***Compliant Marketing in the Chiropractic Clinic.***

https://learn.kmcuniversity.com/courses/student-training-compliance/lessons/compliant-marketing-in-the-chiropractic-clinic-2/

97110 vs. 97530

The Code Selection Challenge

A doctor must choose the code that best describes the service performed. Unfortunately, it can be challenging when the code descriptions are so similar, and the guidelines appear vague. It is even more difficult when payers send a mixed message on documentation and medical necessity requirements for these codes.

Is it Exercises or Activities?

Exercise is a way to strengthen muscles. It gives us the strength to perform activities. A provider may offer therapeutic exercises to a patient until they are strong enough to move on to therapeutic activities. When choosing one of these codes, focus less on what you are doing and more on **why** you are doing it.

If the primary goal is to develop **one functional parameter** like strength, endurance, range of motion, or flexibility, it is a therapeutic exercise (97110).

If the primary goal is to perform a **functional activity** that is dependent on **multiple parameters**, then this would be therapeutic activities (97530). Therapeutic activities typically are real-life movements or simulated activities of real life.

For example, the provider may focus on range of motion initially, then progress to strengthening. Once these exercises (97110) have helped the patient achieve the goal or outcome, the patient would move to a real-life activity such as lifting a box, walking up and down stairs, pushing a door open, or pulling an item. They are often referred to as 'ing' words or activities (97530). Think about Therapeutic Exercises as being the building block for Therapeutic Activities.

Choosing the Code

When choosing the best code, **consider the intention.** Does the procedure address multiple parameters? Will this procedure improve functional performance in daily life, work, or sport? Does it directly relate to a specific job function or sport task? If the answer to these questions is yes, you are most likely performing a therapeutic activity. Remember to document the specific relationship to a functional activity when documenting therapeutic activities. You must outline functional goals in a treatment plan that relate to a functional deficit where the patient is expected to improve.

If the primary goal is to develop one functional parameter, it is more than likely an exercise. Using procedure code 97110 may encompass techniques such as the use of a treadmill to improve endurance, isokinetic exercises to improve range of motion (ROM), lumbar stabilization exercises to improve flexibility, or a stability ball to improve the patient's stretch or strength. The **therapeutic exercise code is not considered a dynamic code.** It typically involves looking only at one parameter being measured.

Are You Equipped for Activities?

Most chiropractic clinics have the equipment to support therapeutic exercises. However, it is rare to find clinics with equipment or activities that represent daily living, sports activities, or work tasks. A therapeutic activity must incorporate multiple parameters (balance, coordination, power, strength, and range of motion) into a single activity. For example, lifting a weight off the floor and placing it on an overhead shelf would improve shoulder strength which would allow the patient to place an item in an overhead cabinet without pain. You can bend to improve range of motion, but bending, twisting, and reaching with a weight is an activity of daily life like putting away groceries or clothing, etc.

Take a Closer Look

Is your coding based on guidance from your peers? Do you find yourself coding procedures according to reimbursement amount rather than the code description? When was the last time you reviewed the CPT (Current Procedural Terminology) definitions for the procedures you perform in your clinic? Asking yourself these questions is the first step to proper coding. Find out more about coding according to documentation in the KMC University course titled **CPT Coding According to Documentation** where you will find detailed documentation samples and specific coding guidance.

https://learn.kmcuniversity.com/courses/cpt-coding-according-documentation/

Documentation Drives Coding

What was first... the chicken or the egg?
When it comes to chiropractic, the answer is simple;
documentation ALWAYS drives coding.

1

The patient meets with the doctor in consultation. A history and examination is performed, and the health record is assembled. This is the initial visit that establishes the foundation for the episode of care.

2

Now the "doctor thinking" is performed by assessing the data gathered in the history and exam, assigning diagnoses, and formulating a treatment plan.

Only now can we begin to code!

3

By reviewing the initial visit documentation, the correct Evaluation and Management (E/M) code is assigned. Treatment rendered on a given visit is coded according to the procedures performed (adjustment, EMS, exercise)

4

CMT coding is derived from medically necessary spinal regions established, documented and adjusted. Compensatory spinal segments addressed as clinically appropriate are documented, but not billed.

Navigating Financial Risk with Non-Covered Services

In the age of consumer empowerment, most payers are placing the patient in the driver's seat as it relates to financial obligations. Patients are to be well informed of any out-of-pocket medical cost prior to receiving services. Years ago, a provider could render services to a patient and the obligation to know their benefits fell on the patient, not the provider. The clinic may have included a statement in their financial policy such as "we will file your claim as a courtesy but are not responsible for verifying your coverage and benefits." If a service was considered non-covered, the provider would simply refer the patient to the financial policy that they signed in the clinic and transfer the balance to patient responsible.

On the other hand, some clinics have a solid verification process in place and from the first visit, they identify all the non-covered services and other limitations outlined by the patient's insurance plan. Normally this is conducted in a financial report of findings where the patient signs an acknowledgement of non-covered services and is well informed of their financial obligations. Normally, we would say that this is the best approach but sadly **providers are skipping an especially crucial step** and it is costing them.

The Patient Waiver

Payers have started to classify services within their Medical Reimbursement Policies and once classified, there are specific directions with regard to patient financial responsibility. **Ignoring the rules of the policy can lead to take-backs, investigation, and possible termination from the payer's network.**

Most payers will list a service as one of the following, **Non-Covered Experimental/Investigationa**l or **Content of Service.** If a service is considered 'content of service' then the insurance will not reimburse both procedures on the same encounter or day. A perfect example is CMT with an established patient E/M. BCBS of Kansas views the established E/M as being part of the CMT and will not reimburse even if modifier 25 is appended. This service, if rendered on the same day, cannot be billed to the patient if denied by the payer. On the other hand, a procedure such as cold laser, dry needling, or aqua massage therapy may be considered experimental and investigational. If the patient chooses to have the service, the provider must **FIRST locate the Limited Patient Waiver** or patient acknowledgement form from the payer and have the patient sign it.

Each payer has their own process, their own forms and specific billing and filing requirements. Some simply require you to use their form, have the patient sign it and keep it on file. Others require the provider to bill with a GA modifier, attach medical records and the limited patient waiver to the claim form. For example, select BCBS plans require the aforementioned documents for any 97139 procedures (unlisted therapeutic procedure). A select few payers restrict the patient from paying out of pocket for any service including massage, products and/or supplements without a designated advance notice form signed by the patient.

Another example is when a patient transitions to maintenance care, most payers require the provider to locate the Limited Patient Waiver and have the patient sign it **before** rendering care. If this step is skipped, the provider cannot collect from the patient. If they do collect, the insurance can open an investigation and require the provider to refund the patient.

It is vital that your billing team make it a priority to locate the policy, procedure, and form for all patient responsible services from **each of your payers**. Sadly, the naming is different for each payer. For example, American Specialty Health calls it the Member Billing Acknowledgement Form (MBAF), others call it the Limited Patient Waiver, Waiver of Liability Statement, Patient Billing Acknowledgement Form Non-Covered Services, or Advance Notice of Non-Covered Services.

To complicate matters even worse, is that most Medicare Advantage plans do not allow you to charge a beneficiary for non-covered services unless the member receives a **pre-service organization determination.** It usually requires the provider to obtain a Notice of Denial of Medical Coverage from the payer **before services are rendered** and the member must elect to receive the non-covered services.

In Summary

Although a financial policy as well as a Patient Acknowledgement Form for Non-Covered services is recommended for all chiropractic clinics, it is not enough. Your verification process should be focused on identifying all procedures rendered in your clinic that may be considered non-covered by the payer. Once you have determined that a service is considered non-covered, find the form and the process for each payer. Train your staff in the process and have copies of the forms available. Check back often to the payer's site for updated policies and procedures (every three months at a minimum). Keep the patient in the know while abiding by the payer's acknowledgement process.

Need more information? Check out KMC University's Rapid Solution titled **Patient Acknowledgement for Non-Covered Services.**

https://learn.kmcuniversity.com/rapid-solution/patients-acknowledgement-to-self-pay/self-pay-for-non-covered-services-products/

2023 Updates

Payer Updates

Medicare enrollment and revalidation process is getting a makeover with PECOS 2.0 this summer. The process will be much more efficient and less burdensome to providers who need to update their information, add a new location, enroll a new physician, or revalidate. Check out all the information at the following link:

https://www.cms.gov/medicare/provider-enrollment-and-certification/introducing-pecos-20

Cigna's Modifier 25 Policy on Hold

The role out of a pre-payment audit for all E/M services billed with modifier-25 has been placed on hold due to extreme push back from the AMA (American Medical Association) with support of medical associations nationwide, including the American Chiropractic Association. Read more at:

https://www.ama-assn.org/practice-management/cpt/cigna-s-modifier-25-policy-burdens-doctors-and-deters-prompt-care

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Upcoming Events, Seminars, and Webinars

CE Webinar| August 8 | 11:00 AM MST
Social Media & HIPAA Compliance - Identifying & Managing Risk
Presented by Jill Foote, Certified Healthcare IT Specialist

August 12-13, 2023
Chiropractic Association of Louisiana Annual Convention

Saturday, August 12 | 9:00 AM – 4:00 PM
CA's: Be Brilliant In Your Office: The Key to Higher Reimbursement and Lower Risk

Sunday, August 13 | 8:30 AM – 3:30 PM
DC's: Coding, Billing and Documentation Compliance for Chiropractic–Made Easy

The Symposium Live CE Event/Epic Clinic | September 7-9
Compliance Implications of a Cash-Based Practice and Specialty Practice
Presented by Kathy (KMC) Weidner, MCS-P, CPCO, CCPC, CCCA

CE Webinar| September 12 | 11:00 AM MST
Avoiding Medicare ABN Pitfalls- Establish a Compliant Process
Presented by Kathy (KMC) Weidner, MCS-P, CPCO, CCPC, CCCA

Michigan Association of Chiropractors
Fall Convention | September 16
Compliant and Consistent Cash Flow is Everyone's Job
Presented by Kathy (KMC) Weidner, MCS-P, CPCO, CCPC, CCCA

NCHS 2023 Alumni Weekend | October 6
Self-Auditing: Making Your Documentation Work for You
Presented by Kathy (KMC) Weidner, MCS-P, CPCO, CCPC, CCCA

American College of Chiropractic Consultants Seminar
October 12-14
Evaluation and Management (E/M) Documentation and Coding Workshop
Presented by Kathy (KMC) Weidner, MCS-P, CPCO, CCPC, CCCA