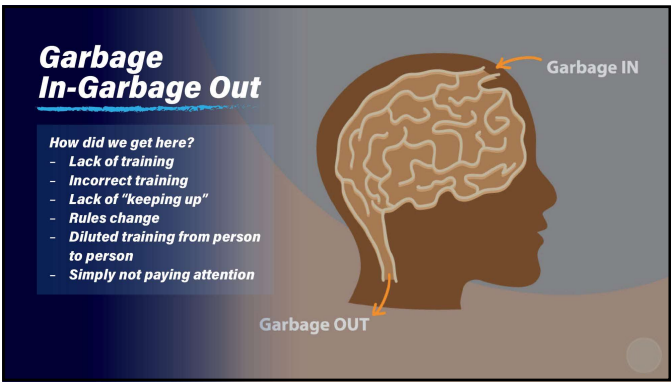




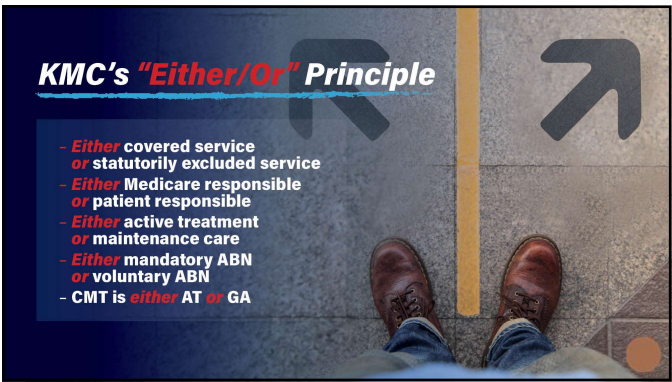
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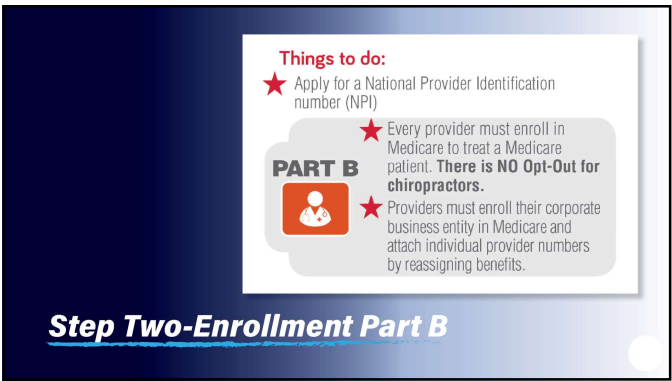
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4




5



6





Associate Doctors, be aware!
Physicians who reassign their right to bill and receive Medicare payments to their employer, by executing the CMS-855R application will still be held liable for false claims submitted by entities to which they have reassigned those benefits. Always know what is being billed under your provider number and name.

All Providers in the Group are Reassigned to One Tax-ID

7

Types of Medicare Coverage: Part B

THE FOUR PARTS OF MEDICARE

- Basic Medicare Part B coverage is what most of the senior population has
- Medicare Part B is optional
- Medicare Part B is usually the primary coverage

PART A
HOSPITAL INSURANCE

PART B
MEDICAL INSURANCE
Original Medicare or Medicare Part B coverage

PART C
MEDICARE ADVANTAGE PLANS (HMOs, PPOs)
Include Part A, Part B, and sometimes Part D coverage

PART D
MEDICARE PRESCRIPTION DRUG COVERAGE

8

Covers 80% Patient Responsible 20% plus deductible




The Traditional Medicare Card

- Beneficiary Name
- Medicare ID Number
- Medicare Coverage Start Date
- Type of Medicare Coverage

9

Filling in the Gap



→

Your doctor or medical service provider bills Medicare for your service or procedure

→

Medicare pays the approved portion and sends the excess amount to your Medigap plan

→

Your Medigap plan pays the excess amount according to the terms of the plan you chose

10

Types of Medicare Coverage: Supplemental

Benefits	A	B	C	D	F*	G	K	L	M	N
Medicare Part A coinsurance and hospital costs (up to an additional 90 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospital care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part B deductible	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part B excess charges	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Foreign travel emergency (up to plan limits)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%

*Out of pocket limit in 2017: \$3,120 (in 2018: \$3,400)

Types of Medicare Coverage: True Secondary

- Resembles eligible group health plans (GHP)
- Could be from retirement benefits
- Often behaves like a GHP rather than a supplemental



12

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

Accept and Treat Medicare Part B Patients

The flowchart starts with a decision: 'Must be properly enrolled with Medicare'. If 'NO', it leads to 'Not enrolled in Medicare Part B', which then leads to 'Does not accept Medicare Part B patients for covered or non-covered services'. If 'YES', it leads to 'Must charge proper fee for enrolled services', then 'Must bill active treatment CPT on behalf of patient', then 'Patient specific documentation required', then 'Medical Necessity guidelines apply', then 'Coding is based on documentation', then 'Proper use of billing modifiers required'. From here, it branches into 'Non-Participating' and 'Participating'. 'Non-Participating' leads to 'Registered testing fee charged for CMT' and 'May accept assignment on case-by-case basis for CMT'. 'Participating' leads to 'Accepts assigned registered fee for CMT' and 'Always accept assignment for CMT'. A legend at the bottom indicates: Billing (yellow), Patient Finances (orange), Documentation (green), Compliance (blue), and Coding (purple).

13

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.

Step 3:
Enroll in Part C Plans if Desired

14

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

THE FOUR PARTS OF MEDICARE

The diagram shows four boxes: 'PART A HOSPITAL INSURANCE' (blue), 'PART B MEDICAL INSURANCE' (yellow), 'PART C MEDICARE ADVANTAGE PLANS' (purple, circled in red), and 'PART D MEDICATION COVERAGE' (green). Below the boxes, it says 'Part C, which includes Part B coverage'.

15

Medicare Part C

- Complete
- Advantage
- PPO
- HMO
- PFFS

The image shows two Medicare Advantage plan cards. The top card is for 'JANUS Medicare Advantage' and the bottom card is for 'aetna'. Both cards display plan details, including Health Plan, Member ID, and various benefits.

16

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

Accepts and Treats Medicare Part C Patients

The flowchart starts with a decision: 'Not enrolled in any Part C Plan'. If 'NO', it leads to 'Does not accept Medicare Part C patients for covered or non-covered services'. If 'YES', it leads to 'Charge Part B patients limiting fee for active CMT. Submissions may be required. See notification'. Then it branches into 'Non-Participating with Patient's Plan' and 'Participating with Patient's Plan'. 'Non-Participating' leads to 'May elect to treat and bill payer directly. May become "thermal" provider', then 'If submitting, must accept fee schedule', then 'Patient specific documentation required', then 'Medical Necessity guidelines apply', then 'Coding is based on documentation', then 'Proper use of billing modifiers required'. 'Participating' leads to 'Must bill on behalf of patient', then 'Must follow the contracted fee for payment. Patient may still be responsible for reduced services', then 'Patient specific documentation required', then 'Medical Necessity guidelines apply', then 'Coding is based on documentation', then 'Proper use of billing modifiers required'. A legend at the bottom indicates: Billing (yellow), Patient Finances (orange), Documentation (green), Compliance (blue), and Coding (purple).

17

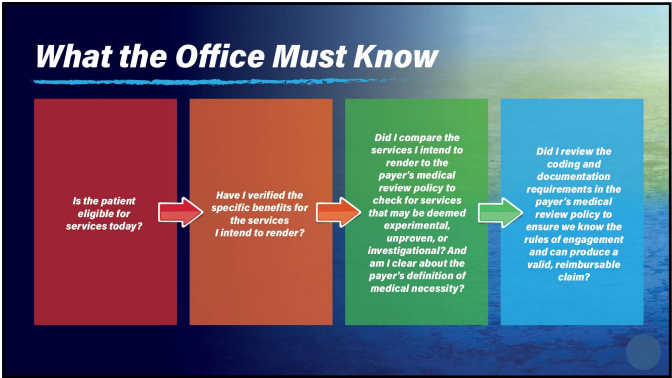
Foundations of the Reimbursement Process

The diagram shows three main categories: 'Data Gathering', 'Billing', and 'Collections'. 'Data Gathering' includes 'New Patient Phone Call', 'Identify Case Type', 'Insurance Verification', and 'Complete Medical Review Policy'. 'Billing' includes 'CPT/ICD Coding', 'Charge Entry', 'Preparation of Electronic Submission', and 'Patient Billing'. 'Collections' includes 'Preparation of Electronic Remittance', 'Payment Posting', 'Follow Up on Active and Inactive', and 'Appeal & Reconciliation'. Each category is represented by a circular icon with a person or document.

18



19



20

A slide titled '1. Is the Patient Eligible for Services Today?'. It features the Availity logo and text: 'Online portals are useful here', 'Compliance Risk = using effective date on the card', 'Compliance Risk = not checking eligibility at all'. It also includes a quote: 'Streamlining your eligibility and benefits, claims management, and authorizations' and 'Availity is where healthcare connects. Payer-provider collaboration starts here!'.

21

A slide titled 'Eligibility: A Compliant Outcome'. It features a background image of a mountain range and a quote: 'A good process produces good results.' by Nick Saban. It also includes a list of bullet points: 'The correct payer is billed', 'Verification of the patient identity is completed', 'Basic information needed to further the next steps is gathered'.

22

A slide titled '2. Have I verified the specific benefits for the services I intend to render?'. It features a large yellow diamond-shaped sign with the text 'TRUST BUT VERIFY'.

23

A slide titled 'Benefit Verification: A Compliant Outcome'. It features a background image of a mountain range and a quote: 'A good process produces good results.' by Nick Saban. It also includes a list of bullet points: 'Services are clarified as covered or not covered', 'Patient financial obligations are made clear', 'Benefit verification leads to Medicare Review Policy comparison'.

24

3. Locate and Review Payer's Medical Review Policy

Did I compare the services I intend to render to the payer's medical review policy to check for services that may be deemed experimental, unproven, or investigational? And am I clear about the payer's definition of medical necessity?

Cigna Chiropractic MRP

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MRP Review: A Compliant Outcome

- Experimental, Unproven, and Investigational services are identified
- Clarification on whether patient can opt in
- Medical necessity rules are clarified
- Treatment planning can be customized

A good process produces good results.

Nick Saban

26

4. Understand and Implement Coding and Documentation Policy

Did I review the coding and documentation requirements in the payer's medical review policy to ensure we know the rules of engagement and can produce a valid, reimbursable claim?

Cigna Chiropractic MRP

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MRP Review: A Compliant Outcome

- Experimental, Unproven, and Investigational services are identified
- Clarification on whether patient can opt in
- Medical necessity rules are clarified
- Treatment planning can be customized

A good process produces good results.

Nick Saban

28

Why Verify Medicare?

- Is it so easy that it doesn't require verification?
- Everyone has the same coverage, right?

29

Eligibility is NOT the Same as Verification

30

✓


✓


Verify ALL Coverage


- Confirm Medicare Part B eligibility
- Confirm secondary or supplemental eligibility
- Confirm actual chiropractic benefits for any secondary or supplemental
- If Medicare Part C, confirm all benefits

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Intake Process


↓
Primary Medical


↓
Secondary Medical


↓
Prescription Coverage

32


Working Medicare Beneficiary

Individual	Condition	Pays First	Pays Second
Is age 65 or older, and covered by a Group Health Plan (GHP) through current employment or spouse's current employment	The employer has less than 20 employees	Medicare	GHP
Is age 65 or older, and covered by a GHP through current employment or spouse's current employment	The employer has 20 or more employees, or the employee is part of a multi-employer group with at least one employer employing 20 or more individuals	GHP	Medicare
Has an employer retirement plan and is age 65 or older	The individual is entitled to Medicare	Medicare	Retiree Coverage
Is under age 65, disabled, and covered by a GHP through his or her current employment or through a family member's current employment	The employer has less than 100 employees	Medicare	GHP
Is under age 65, disabled, and covered by a GHP through his or her current employment or through a family member's current employment	The employer has 100 or more employees, or the employee is part of a multi-employer group with at least one employer employing 100 or more individuals	GHP	Medicare

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When Medicare is Secondary

- I'm 65 or older and have group health plan coverage based on my own current employment status or the current employment status of my spouse
- If the employer has 20 or more employees, then the group health plan pays first, and Medicare pays second
- If the employer has less than 20 employees and isn't part of a multi-employer or multiple employer group health plan, then Medicare pays first, and the group health plan pays second



34



Minnie Medders

Our Medicare Part B Avatar

35

Minnie Medders' Data Gathering


Traditional Part B Medicare

Eligibility Check completed

Located MAC Portal and confirmed the following:

- Medicare Primary Status (MSP)
- QMB Status
- Not a Medicare Advantage Plan

Located the Local Coverage Article for this beneficiary



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John Doe Chiropractic Office
1234 Any Street
Anytown, AS 12345
(850) 732-4499

Medicare Verification Form

Section A: Beneficiary Information

Beneficiary Name: _____
Phone Number: _____
Subscriber ID#: _____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Other _____
Effective Date: _____
Maximum per day if any: _____
Follows Medicare guidelines? ☐ Yes ☐ No ☐ No
Covers (includes non-covered services)? ☐ Yes ☐ No
If no or (standing on appeal) on coverage inquiry verification form to complete verification

Section B: Medicare Coverage

Service Name: _____
Phone Number: _____
Subscriber ID#: _____
Coverage for QPPT? ☐ Yes ☐ No ☐ Not
When is provider enrollment required for QPPT enrollment? ☐ Yes ☐ No
Are there any changes to QPPT in your state and/or at the time of enrollment? ☐ Yes ☐ No
If yes, please list changes to QPPT in your state and/or at the time of enrollment

Section C: Medicare Enrollment

Initial Enrollment: ☐ Yes ☐ No ☐ Other
Part B Effective Date: _____
Name and Address Match Confirmed? ☐ Yes ☐ No
Part B Enrollment Remaining This Year? ☐ Yes ☐ No
Supplement/Secondary Information Available? ☐ Yes ☐ No
Automatic Coverage Established? ☐ Yes ☐ No
QMB Status Confirmed? ☐ Yes ☐ No ☐ If yes, list type of QMB
Is coverage established for Medicare QMB related services? ☐ Yes ☐ No
If no, are there any other factors?

Notes

Number Called: _____ Date: _____ Reference #: _____
Time: _____ Date: _____ Mark appropriate boxes:

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Demographics

Overview Clinical Documents Billing Insurance (1) Ledger Claims Worksheet Cases (1)

Demographics

Medical Record Number: 123456789
Status: Active
Employment Status: Not Employed
Preferred Location: Anytown, AS 12345
Email: john.doe@gmail.com

Insurance

Plan Name: Medicare
Insured ID: 123456789

Active Beneficiaries

Name: John Doe
Relation: Self
Balance: \$0.00

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MAC Portal

Eligibility Look Up Tool

What would you like to do in NGSConnect?

Eligibility Lookup Claim Status Lookup Part B Claim Submissions

Appeals ADR Inquiries

39

Findings

Medicare Secondary Payer Information

Note: Does not apply to this beneficiary

Crossover Information

Contract	Update Date	Ins Code	Insurer Name	Address 1	Address 2	City	State	Zip	Effective Date	Contract Termination Date	QMB
											70007

Qualified Medicare Beneficiary Program

Effective Date: _____ Termination Date: _____

Findings:

- No Medicare Secondary Payer (does not apply)
- No QMB status listed
- Effective Date not listed

40

Finding the Coverage Documents

Medical Policy Articles

Article Title: Chiropractic Services - Medical Policy Article (A57889)
Article #: A57889
Related CPT/HCPCS Codes: 98940, 98941, 98942

1 to 1 of 1 records (filtered from 36 total entries)

Findings:

- LCDs
- Medical Policy Articles

41

Article - Chiropractic Services - Medical Policy Article (A57889)

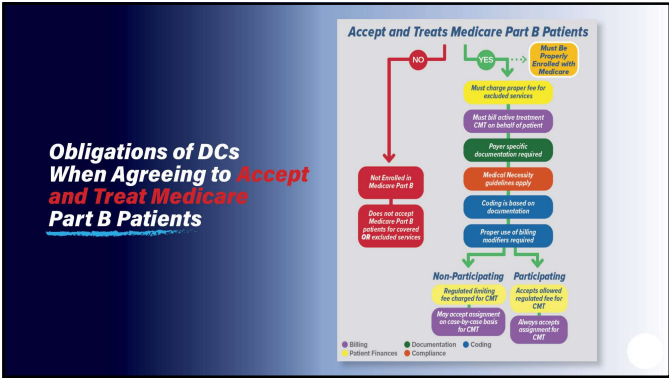
Contractor Information

Contractor Name	Contract Type	Contract Number	Subsidiary	Status
National Government Services, LLC	HAC - Part A	05102 - HAC A	1 - 06	Steady
National Government Services, LLC	HAC - Part B	05103 - HAC B	1 - 06	Steady
National Government Services, LLC	HAC - Part A	05101 - HAC A	1 - 06	Steady
National Government Services, LLC	HAC - Part B	05102 - HAC B	1 - 06	Steady

General Information

Article ID: A57889
Article Title: Chiropractic Services - Medical Policy Article (A57889)
Article Type: Policy
Original Effective Date: 1/1/2010
Revised Effective Date: 1/1/2010

42



43

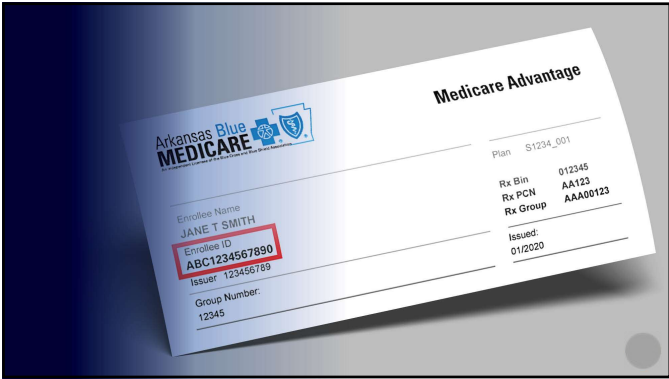
Types of Medicare Coverage: Part C

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

THE FOUR PARTS OF MEDICARE

Part A: HOSPITAL INSURANCE
Part B: MEDICAL INSURANCE
Part C: MEDICARE ADVANTAGE PLANS (Managed Care Medicare)
Part D: MEDICARE PRESCRIPTION DRUGS COVERAGE

44



45

Medicare Part C

- Complete
- Advantage
- PPO
- HMO
- PFFS

46

PFFS Aware!

- 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 furnishes non-emergency services, then the provider will become a deemed provider under the plan for that specific visit and be subject to the plan's terms and conditions whether the provider agrees to them or not.
- A deemed provider can decide whether or not to accept the PFFS plan's terms and conditions of payment each time the provider sees one of the plan's members. **However, the provider cannot change his or her mind about accepting the terms and conditions of payment after providing services to the member.**

47

Our Medicare Part C Avatar

Henry Humes

48

49

50

51

52

53

54

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57

58

59

60

You will receive the following eligibility information if applicable:

- When a Health Insurance Claim number is provided, the IVR will advise caller if an MBI has been n
- Enrolled in MDPP – If the beneficiary is eligible to receive MDPP services from an MDPP supplier
- Medicare Part A and B effective dates
- Qualified Medicare Beneficiary (QMB)
- Date of Death
- Part B deductible
- PT/OT amounts
- Medicare primary or secondary status (based on the date provided) - Reason Medicare is secondar
- Effective and Termination Dates
- Medicare Advantage Information - Name and Contractor ID; Type of Plan; Address and Telephone
- Termination Dates
- Home Health Information - Name and Address of the Home Health Provider
- Hospice Information - Name and Address of the Hospice Provider

Interactive Voice Response (IVR)

61

You will receive the following eligibility information if applicable:

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- Enrolled in MDPP – If the beneficiary is eligible to receive MDPP services from an MDPP supplier
- Medicare Part A and B effective dates
- Qualified Medicare Beneficiary (QMB)
- Date of Death
- Part B deductible
- PT/OT amounts
- Medicare primary or secondary status (based on the date provided) - Reason Medicare is secondar
- Effective and Termination Dates
- Medicare Advantage Information - Name and Contractor ID; Type of Plan; Address and Telephone
- Termination Dates
- Home Health Information - Name and Address of the Home Health Provider
- Hospice Information - Name and Address of the Hospice Provider

IVR DISCONTINUED

Interactive Voice Response (IVR)

62

You will receive the following eligibility information if applicable:

- When a Health Insurance Claim number is provided, the IVR will advise caller if an MBI has been n
- Enrolled in MDPP – If the beneficiary is eligible to receive MDPP services from an MDPP supplier
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- Effective and Termination Dates
- Medicare Advantage Information - Name and Contractor ID; Type of Plan; Address and Telephone
- Termination Dates
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- Hospice Information - Name and Address of the Hospice Provider

USE PART B MAC PORTAL

Interactive Voice Response (IVR)

63

Both Doctor and Patient Must Know When It's Active and When It's Maintenance

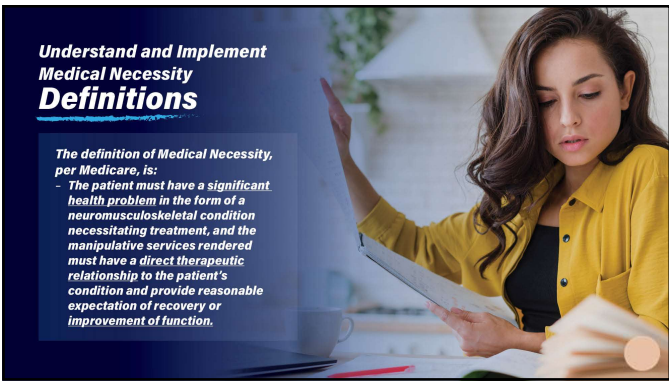


64

Understand and Implement Medical Necessity Definitions

The definition of Medical Necessity, per Medicare, is:

- The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function.



65

AT = Active Treatment

- By definition meets medical necessity
- Billed and expected to be paid
- Follows MAC screens
- Should not be automatic



66

Code

Description/Restriction

Effect on Medicare Payment

AT

Reporting Active/Function Treatment
Indicates service rendered was medically necessary Medicare guideline

Medicare will consider for payment.

Code

Description/Restriction

Effect on Medicare Payment

GA

Indicates maintenance care or visits required under a plan

Medicare will deny if not medically necessary. Patient will be financially responsible.

Code

Description/Restriction

Effect on Medicare Payment

GZ

Indicates you failed to collect A/R for maintenance care as required

Claim will be denied. Patient will not be deemed responsible for payment.

Code

Description/Restriction

Effect on Medicare Payment

GY

Indicates statutorily non-covered (denied by a DC)

Billing of these services is not required unless the patient requests. Patient is financially liable.

Code

Description/Restriction

Effect on Medicare Payment

GX

ABN on file for voluntary use

Claim will be denied/patient financially liable. Use with AT modifier on certain therapy services for routine proper denial.

Code

Description/Restriction

Effect on Medicare Payment

GP

Used for certain therapy services in part of subsequent treatment plan

Claim will be denied/patient financially liable. Use with AT modifier on certain therapy services for routine proper denial.

MANDATORY SUBMISSION

VOLUNTARY SUBMISSION

67

DCs Must Answer with Certainty!

Is there a subluxation present, capable of causing a significant neuromusculoskeletal (NMS) condition, and does the patient have a documented loss of function that can be improved?

If No...
In this circumstance, per Medicare coverage requirements, medical necessity cannot be established and therefore the condition is likely maintenance care.

68

The Opposite of Active Treatment

Maintenance therapy is defined (per Chapter 15, Section 30.5.B. of the Medicare Benefits Policy Manual) as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition.

69

Maintenance

Expect Payment from Your Patient!

- Wellness
- Prevent disease
- Promote health
- Prolong/enhance the quality of life
- Supportive
- Maintain or prevent deterioration of a chronic condition

70

Use the AT Modifier Correctly!

CMS' claim data analysis and audit results suggest that chiropractors submit claims with the AT modifier regardless of whether the services were for active/corrective treatment for subluxation.

The Active Treatment [AT] modifier was developed to clearly define the difference between active treatment and maintenance treatment. The AT modifier should not be used if maintenance therapy is being performed.

Your use of the AT modifier tells Medicare that all required documentation is being accurately maintained to support medical necessity.

71

Medicare Decision Making Matrix

Use this flowchart to help determine whether a Medicare patient's visit is active or maintenance care. Follow the prompts to support your decision making for an appropriate outcome.

72

First, Some Clarity!

Mandatory ABN

- A must do... required
- Only for spinal CMT that may not be covered
- Usually only one or two reasons
- Again, no opt out

Voluntary ABN

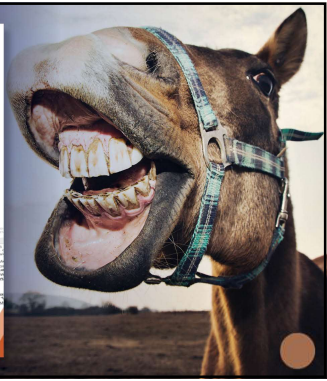
- Voluntary means not required
- Voluntary is for all statutorily non-covered services
- Good business practice...
- but not required
- Don't use the official ABN form

73

DEPARTMENT OF HEALTH & HUMAN SERVICES
Center for Medicare & Medicaid Services

Medicare Learning Network
On the go! Get the information you need.

Advance Beneficiary Notice of Noncoverage (ABN)

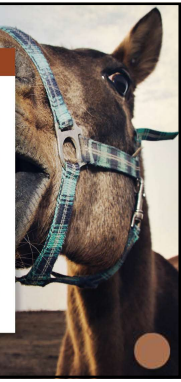


74

WHAT IS AN ABN?

An ABN, Form CMS-R-131, is a standardized notice you or your designee must issue to a Medicare beneficiary before providing certain Medicare Part B (outpatient) or Part A (limited to hospice, home health agencies [HHAs], and Religious Nonmedical Healthcare Institutions only) items or services. You must issue the ABN when:

- You believe Medicare may not pay for an item or service;
- Medicare usually covers the item or service; and
- Medicare may not consider the item or service medically reasonable and necessary for this patient in this particular instance.



75

ISSUING AN ADVANCE WRITTEN NOTICE OF NONCOVERAGE

When You Must Issue an Advance Written Notice of Noncoverage

To transfer financial liability to the beneficiary, the provider must issue an advance written notice of noncoverage:

- When an item or service is not reasonable and necessary under Medicare Program standards. Common reasons Medicare denies an item or service as not medically reasonable and necessary include care that is:
 - Experimental and investigational or considered "research only"
 - Not indicated for diagnosis or treatment in this case
 - Not considered safe and effective
 - More than the number of services Medicare allows in a specific period for the corresponding diagnosis
- When custodial care is given
- Before caring for a beneficiary who is not terminally ill (hospice providers)
- Before caring for a beneficiary who is not confined to the home or does not need intermittent skilled nursing care (home health providers)

76

Notice (Practice)

Notice (Practice)

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **Chiropractic maintenance care**, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **Chiropractic maintenance care** below.

Chiropractic Maintenance Care	Reason Medicare May Not Pay:	Estimated Cost
99040	Medicare does not pay for Chiropractic maintenance care	\$24.71
99042		\$32.54
99043		\$41.87

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **Chiropractic maintenance care** listed above. Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTION 1: I want the **Chiropractic 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. If Medicare does pay, you will refund any payments I made to you, less co-pay or deductibles.

OPTION 2: I want the **Chiropractic 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.

77

Notice (Practice)

Notice (Practice)

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **Chiropractic maintenance care**, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **Chiropractic maintenance care** below.

Chiropractic Maintenance Care	Reason Medicare May Not Pay:	Estimated Cost
99040	Medicare does not pay for Chiropractic maintenance care	\$24.71
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99043		\$41.87

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- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **Chiropractic maintenance care** listed above. Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTION 1: I want the **Chiropractic 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. If Medicare does pay, you will refund any payments I made to you, less co-pay or deductibles.

OPTION 2: I want the **Chiropractic 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.

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Notifier/Practice: Kirby's Chiropractic Services
1234 Main Street, Houston, TX 99999, 999.999.7777

Patient Name: _____ **Identification Number:** _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **Chiropractic maintenance care below**, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **maintenance care** below.

Chiropractic Maintenance Care	Reason Medicare May Not Pay:	Estimated Cost
Covered Services Codes: 98940 98941 98942	Medicare does not pay for Chiropractic maintenance care	\$24.71 \$17.56 \$41.87

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **maintenance care** listed above.

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

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79

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83

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Understand the Options

85

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Understand the Options

86

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

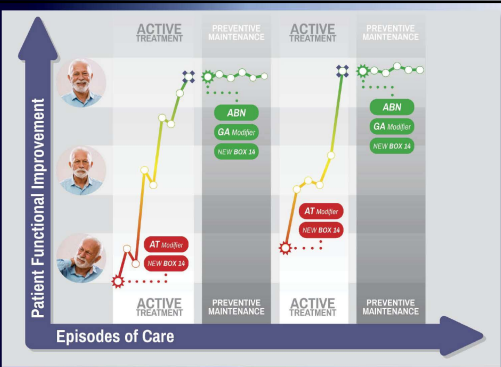
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Understand the Options

87



88

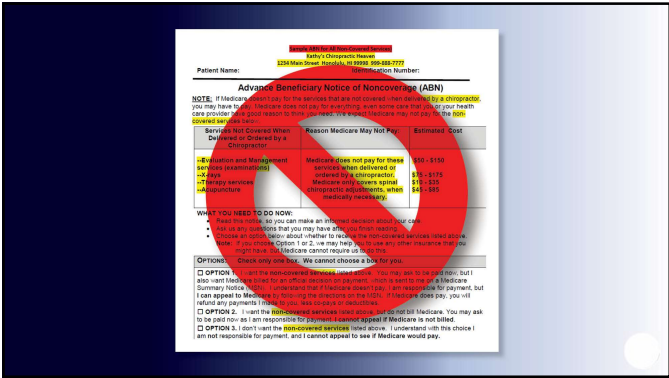
Issuing a Voluntary Advance Written Notice of Noncoverage as a Courtesy

89

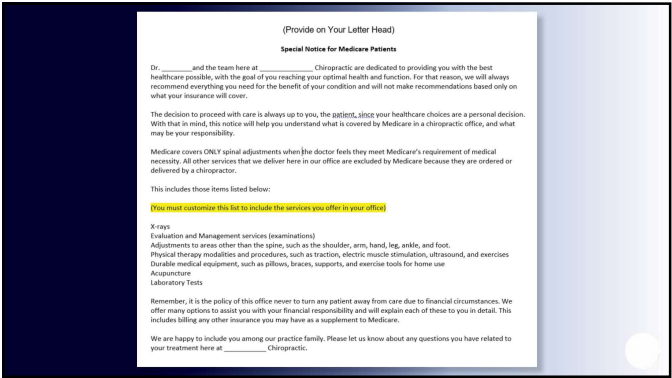
Issuing a Voluntary Advance Written Notice of Noncoverage as a Courtesy

Medicare does not require you to notify the beneficiary before you furnish an item or service Medicare never covers or is not a Medicare benefit. However, as a courtesy, you may issue a voluntary notice to alert the beneficiary about their financial liability. Issuing the notice voluntarily has no effect on financial liability, and the beneficiary is not required to check an option box or sign and date the notice. For more information about noncovered services, refer to the [Items and Services Not Covered Under Medicare](#) booklet.

90



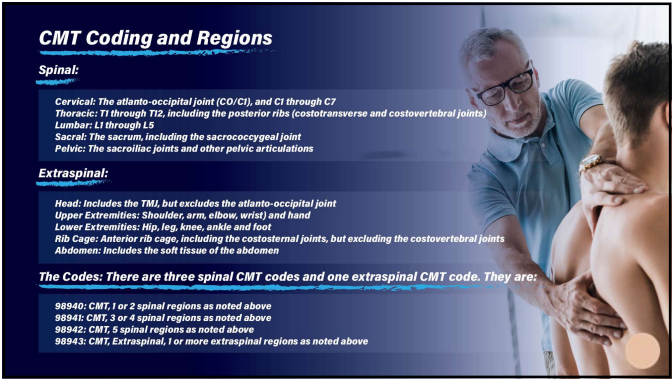
91



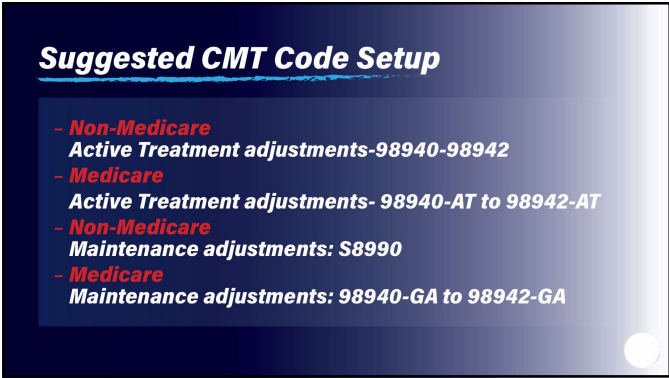
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93



94



95



96


Never Charge 97010

HOT PACKS

- For chronic pain relating to muscle aches & joint stiffness
- Increases blood flow by dilating blood vessels
- Promotes muscle relaxation & tissue healing

COLD PACKS

- For injuries and acute pain relating to inflammations
- Reduces blood flow by constricting blood vessels
- Numbs pain & reduces the effects of inflammations (swelling & redness) & bruising



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Diagnosis Hierarchy

Position 1:
Neurological/Injury: Examples of neurological diagnoses include Radiculitis and Sciatic Neuritis.

Position 2:
Structural/Subluxation: Examples of structural diagnoses for the spine include Degenerative Joint Disease, Spondylolisthesis, Scoliosis, etc.

Position 3:
Functional: Examples include Restricted Range of Motion, Deconditioning Syndrome, and muscle wasting.

Position 4:
Soft Tissue/Extraspinal/Other: Fibromyalgia, myofascitis, and myalgia are excellent diagnoses to support manual therapy. Examples of extraspinal diagnoses include Frozen Shoulder, Carpal Tunnel Syndrome, Headache or Pain Syndromes.

Position 5:
Complicating Factors: Examples include obesity, high blood pressure, diabetes, cancer, and other forms of co-morbidities.

Position 6:
External cause, Activity, and Location Codes: Examples are related to mechanisms of injury, like slips, trips, falls and accidents, and activity codes show what the patient was doing when injured. These are not required, but helpful, and if reported are only reported on the first claim.




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Group 1 Codes:

ICD-10 Codes	Description
M99.00	Segmental and somatic dysfunction of head region
M99.01	Segmental and somatic dysfunction of cervical region
M99.02	Segmental and somatic dysfunction of thoracic region
M99.03	Segmental and somatic dysfunction of lumbar region
M99.04	Segmental and somatic dysfunction of sacral region
M99.05	Segmental and somatic dysfunction of pelvic region

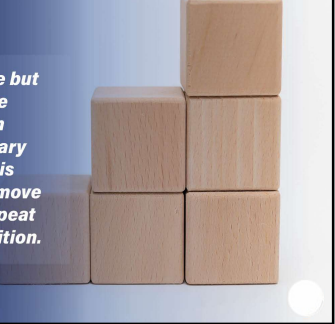
Primary DX Must Be Subluxation/Segmental Dysfunction



99

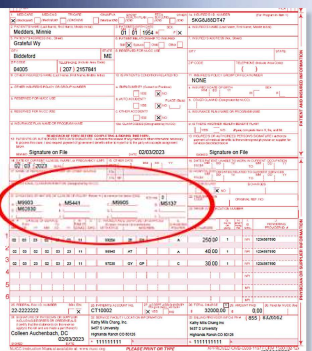
Medicare DX Coding

- The preferred order is the same but use the **required coupling** of the **primary segmental dysfunction diagnosis first**, and the **secondary neuromusculoskeletal diagnosis listed second in the pair**. Then move on to the next condition and repeat that coupling for the next condition.




100

Clean Claim

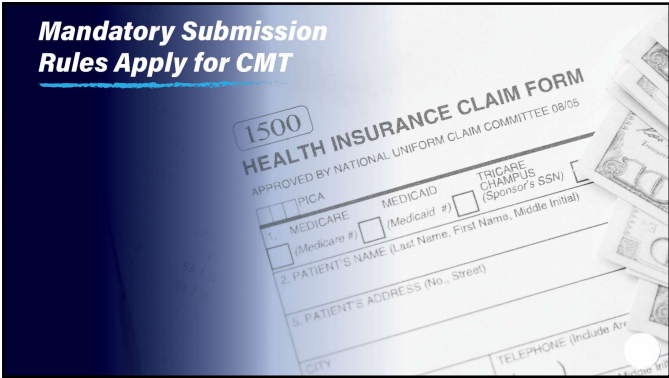


101

The Mechanics of Billing/Charging Medicare



102



103



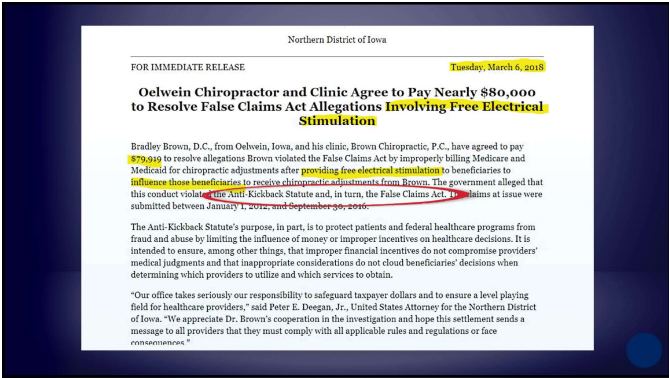
104



105



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108

Guide to
MEDICARE MODIFIERS

Code	Description/Restriction	Effect on Medicare Payment
AT	Reporting Active/Inactive Treatment Indicates service rendered was medically necessary per Medicare guideline	Medicare will consider for payment.
GA	When all Liability Payers on file for mandatory use Indicates maintenance care or visits as per Medicare rules	If patient selects ABR Option 1, you must bill Medicare. Medicare will deny as not medically necessary. Patient will be financially responsible.
GZ	Indicates you failed to collect ABR for maintenance care as required	Claim will be denied. Patient will not be deemed responsible for payment.


Code	Description/Restriction	Effect on Medicare Payment
GY	Indicates statutorily non-covered service is rendered by a DC	Billing of these services is not required unless the patient requests. Patient is financially liable.
GX	ABR on file for voluntary use	Claim will be denied/patient financially liable. We don't recommend Medicare's official ABR form for voluntary use.
GP	Used for certain therapy services in part of outpatient treatment plan	Claim will be denied/patient financially liable. Use with GT modifier on certain therapy services for routine proper denial

MANDATORY
SUBMISSION

VOLUNTARY
SUBMISSION

109

Timely Filing:
1-Year from Date of Service



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How is care
defined?

CLINICALLY
APPROPRIATE

MEDICALLY
NECESSARY

MEDICALLY
NECESSARY PER 3RD
PARTY CARRIER

MEDICALLY
NECESSARY PER
MANAGED
CARE

111

So? I'm a Full
Spine Adjuster!


- Medical necessity definition dictates that
you must prioritize each area of complaint

- Every visit:

- S + O (P + ART) for every region treated

- 2 DX codes for each region

- Treatment plan for each/short and long term goals




112

The \$64,000
Question

- Is the subluxation you found
creating a secondary,
neuromusculoskeletal condition?

- Or is it a subluxation that simply
needs to be corrected?

- Is there a lack of function?




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This Means Causally
Related in All Areas
to be Treated

- The complaint drives the examination,
which drives the diagnosis and assessment,
which drives the treatment plan

- No complaint, no covered adjustment

- Compensatory areas may be addressed
for the patient and documented as
such-correlate to examination findings



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855-832-6562

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In Conclusion

Steps to Compliant Coding and Documentation of Full Spine Adjustments

1. Using the complete history, examination, and required clinical decision-making, determine a diagnosis and treatment plan for any patient being treated for an active condition. In the course of this process, define/identify the primary areas of subluxation clearly in your treatment plan.

2. Document all treatment rendered and every segment adjusted in your patient's health record and/or daily notes. **Define** how you differentiated between areas of primary (medically necessary) subluxations in your notes or areas of secondary (clinically appropriate) compensation that were addressed.

3. Match the levels of primary subluxation treated with the appropriate Chiropractic Manipulative Treatment (CMT) code. **Do not count the areas of compensatory subluxations** addressed when selecting the appropriate CMT code level to be billed.

4. Write an office policy about your intention to seek third-party reimbursement **ONLY** for those areas that are deemed medically necessary. Further, state that you will NEVER upcharge a patient or carrier when you address other areas (compensatory subluxation) in an effort to stabilize the primary subluxation(s).

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Is the condition likely to be treated as an INCIDENT, BURST or EPISODE?

KMC University's classification of treatment lengths for active treatment are described as incidents, bursts, and episodes. Follow these cues to verify that your documentation is sufficient to warrant the level of recommended care.

Is there a subluxation present, capable of causing or perpetuating neuromusculoskeletal (NMS) condition, and does the patient have a documented loss of function that can be improved?

YES

NO

CONSIDER: Will the condition likely be resolved within 1-3 visits?

YES

NO

DOCUMENT:

- History/Chief Complaint
- Mechanism of injury
- CMTs used and scores
- Exam/Physical Findings/PAINIT
- DX, Seg, Dys, + 2-day condition per region treated
- Measurable functional deficits
- Tx Plan including goals
- Estimated discharge or re-evaluation date

Formal CMT service **may not be necessary**. Documentation with CMT may be possible.

Incident

CONSIDER: Will the condition likely be resolved within about a month?

YES

NO

DOCUMENT:

- History/Chief Complaint
- Mechanism of injury
- CMTs used and scores
- Exam/Physical Findings/PAINIT
- DX, Seg, Dys, + 2-day condition per region treated
- Measurable functional deficits
- Tx Plan including goals
- Estimated discharge or re-evaluation date

Formal CMT service **necessary** to establish medical necessity for this treatment.

Burst

CONSIDER: Will the condition likely require treatment beyond a month?

YES

NO

DOCUMENT:

- History/Chief Complaint
- Mechanism of injury
- CMTs used and scores
- Exam/Physical Findings/PAINIT
- DX, Seg, Dys, + 2-day condition per region treated
- Measurable functional deficits
- Tx Plan including goals
- Date of next re-evaluation (re-eval at least every 30 days)

Formal CMT service **necessary** to establish medical necessity for this treatment.

Episode

116

Compliant Charging and Billing of Medicare Patients

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Billing and Collecting from Medicare Patients

The more you know:

- ★ Patients are responsible for the full charge for statutorily non-covered services, unless other insurance is available
- ★ Patient financial responsibility for CMT depends on the provider's enrollment status (Par or Non-Par) and whether the service is active (AT) or maintenance (GA)

The provider collects:

SERVICE	PARTICIPATING (PAR)	NON-PARTICIPATING (NON-PAR)
Serial CMT (AT)	Only 20% of Medicare allowed fee. Patient may have secondary insurance that will pay this amount.	Up to 100% of the Limiting Fee for non-assigned claims. 20% of non-par allowable fee for selectively assigned claims.
Serial CMT (GA)**	1 of 3 choices: Medicare's par allowable fee; the provider's actual fee; a published maintenance fee through a DMPG***	1 of 3 choices: Medicare's Limiting Fee; the provider's actual fee; a published maintenance fee through a DMPG***

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The Method to the Madness-CMT Codes

Things to do:
Follow the examples given in this table as a guide to estimate Medicare collections. All figures are examples only.

PROCEDURE CODE	MEDICARE REIMBURSES 80% OF THIS FEE*		DIFFERENCE BETWEEN LIMITING FEE AND NON-PAR ALLOWABLE IS NOT RECOVERED BY THE PATIENT			
	PAR ALLOWABLE	NON-PAR ALLOWABLE	NON-PAR LIMITING FEE (LF)	REDUCED LF (EHR)**	REDUCED LF (MIPS)**	REDUCED LF (EHR-MIPS)**
98940	\$28.93	\$27.48	\$31.60	\$30.66	\$30.07	\$30.05
98941	\$41.55	\$39.47	\$45.39	\$44.03	\$44.48	\$43.15
98942	\$54.18	\$41.47	\$49.19	\$47.42	\$48.01	\$56.27

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Treating and Billing Family Members

The following is taken directly from CMS Policy Manual 100-02 Medicare Benefit Policy Manual: Members of the Patient's Household (Rev. 1, 10-01-03) A3-3161, HO-260.12, B3-2332

B. Immediate Relative
The following degrees of relationship are included within the definition of immediate relative:

- Husband and wife;
- Natural or adoptive parent, child, and sibling;
- Steparent, stepchild, stepbrother, and stepsister;
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; Grandparent and grandchild; and
- Spouse of grandparent and grandchild

NOTE 1: A brother-in-law or sister-in-law relationship does not exist between the physician, supplier or owner of a provider (or supplier) and the spouse of his wife's or her husband's brother or sister.

NOTE 2: A father-in-law or mother-in-law relationship does not exist between a physician or the owner of a provider and his or her spouse's stepfather or stepmother. A step-relationship and an in-law relationship continues to exist even if the marriage upon which the relationship is based is terminated through divorce or through the death of one of the parties. For example, if a provider treats the stepfather of the owner after the death of the owner's natural mother or after the owner's stepfather and natural mother are divorced, or if the provider treats the owner's father-in-law or mother-in-law after the death of their spouse, the services are considered to have been furnished to an immediate relative, and therefore, are excluded from coverage.

C. Members of Patient's Household
These are persons sharing a common abode with the patient as a part of a single family unit, including those related by blood, marriage or adoption, domestic employees and others who live together as part of a single family unit. A mere roomer or boarder is not included.

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855-832-6562

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Three Choices for Fees During Maintenance Care

1. Charge allowable fee or limiting fee
2. Charge your actual fee
3. Charge a discounted fee for maintenance if the patient qualifies and you offer this to ALL types of patients
4. Codify this in your compliance policy



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Option One: Payer's Allowable or Limiting Fee

Continue	Charge	Set
- Continue to charge the allowable or limiting fee in maintenance care	- Charge that fee when billing for active treatment	- Set policy that says THIS is your fee for all phases of care: acute, chronic, or maintenance

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Option Two: Charge Provider's Actual Fee for Maintenance Care

50.7.3 - Effects of Lack of Notification, Medicare Review and Claim Adjudication
(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Beneficiary Liability


A beneficiary who has been given a properly written and delivered ABN and agrees to pay may be held liable. The charge may be the supplier/provider's usual and customary fee for that item or service and is not limited to the Medicare fee schedule. If the beneficiary does not receive proper notice when required, s/he is relieved from liability.

Notifiers may not issue ABNs to shift financial liability to a beneficiary when full payment is made through bundled payments. In general, ABNs cannot be used where the beneficiary would otherwise not be financially liable for payment for the service because Medicare made full payment. See 50.13 for information on collection of funds.

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Collect Actual Fee for Maintenance CMT

- As the manual states, it's OK to begin charging ACTUAL fee during maintenance with signed ABN
- Requires carefully worded FROF and discharge discussion of fees
- We recommend Par providers BILL actual fee
- Non-Par Providers must bill Limiting Fee



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Option Three: Publish a Maintenance Fee Schedule Anyone Can Access

- The safest, and cleanest way to do this is to join a DMPO network like ChiroHealthUSA
- Within that fee schedule, post a fee for maintenance CMT, regardless of levels
- Anyone that is a member can access that fee schedule



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Medicare Advantage Plan Fees

- In-Network Participation: Agreed upon allowed fee
- Out-of-Network and Billing for the Patient: Must accept allowed fee
- Out of Network and Providing Superbill: No more than the allowed fee for your participation level in Part B



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Non-Contract Providers Limitation on Fees

- **In-Network Participation:**
Agreed upon allowed fee
- **Out-of-Network and Billing for the Patient:**
Must accept allowed fee
- **Out of Network and Providing Superbill:**
No more than the allowed fee
for your participation level in Part B

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Non-Contract Providers Limitation on Fees

100 - Special Rules for Services Furnished by Non-Contract Providers
(Rev. 24, 06-06-03)

Consistent with §1852(a)(2) and §1852(k)(1) of the Social Security Act, non-contract providers must accept as payment in full payment amounts applicable in Original Medicare. Thus, this provision of law imposes a cap on payment to non-contract providers of provider payment amounts plus beneficiary cost-sharing amounts applicable in Original Medicare, and ensures that non-contract providers not balance bill MA plan enrollees for other than MA plan cost-sharing amounts.

- Note that non-contract facility providers identified at §1861(u) of the Social Security Act (the Act), which includes hospitals, skilled nursing facilities and home health agencies, must accept as payment in full payment amounts applicable in Original Medicare less any payments under 42 CFR 412.105(g) concerning indirect medical education payment to hospitals for managed care enrollees and 42 CFR 413.86(d) concerning payment for direct graduate medical education costs.
- In cases where the MA organization has not arranged for the services, if the non-contract provider's bill is less than the Original Medicare amount, the MA organization is only required to pay the billed amount.

In addition, under Federal law, non-contract providers are subject to penalties if they accept more than Original Medicare amounts.

(Source: 42 CFR 422.214 and preamble to June 29, 2000, rule.)

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Let's Discuss and Q/A



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