
Most Significant Compliance Risks We See
- Lack of understanding of the Big Four Steps to compliance as we see it
- Lack of differentiating medical necessity from clinical appropriateness
- Disconnecting from the rules of billing because "I'm the Provider of Service" not the biller
- The attitude that the rules don't apply to me because I run a cash practice
- And, by the way, I don't keep up with the rules because I'm too busy... but I try to belong to lots of random free Facebook groups to get my advice

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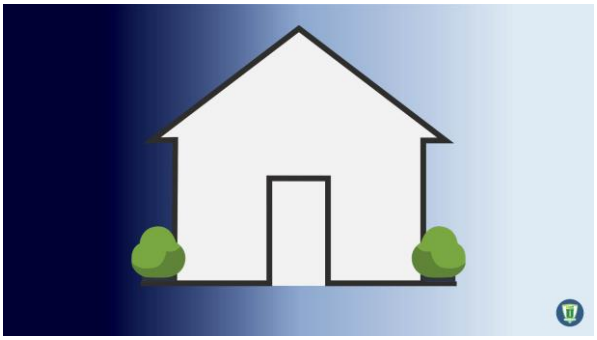

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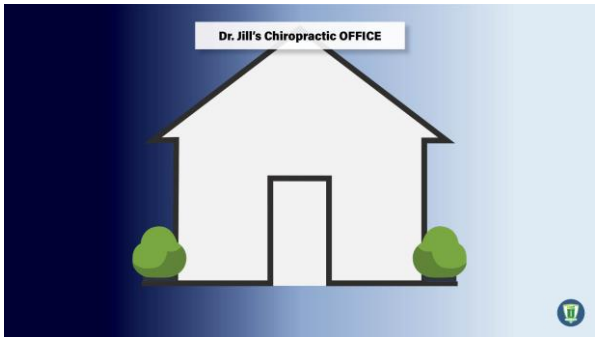
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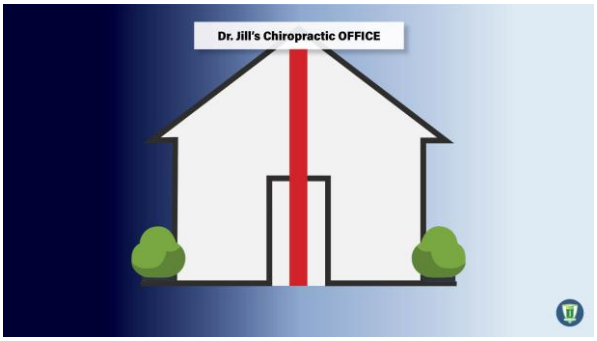
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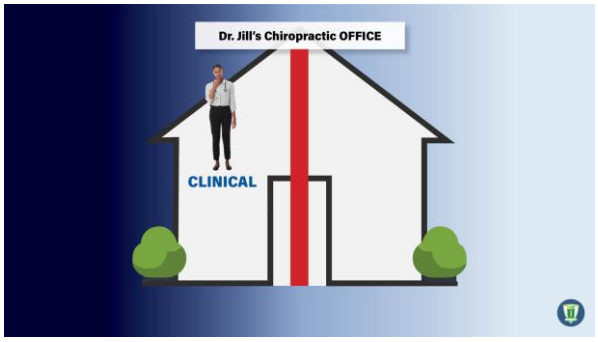
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Policy and Procedure Govern Both Sides of the House

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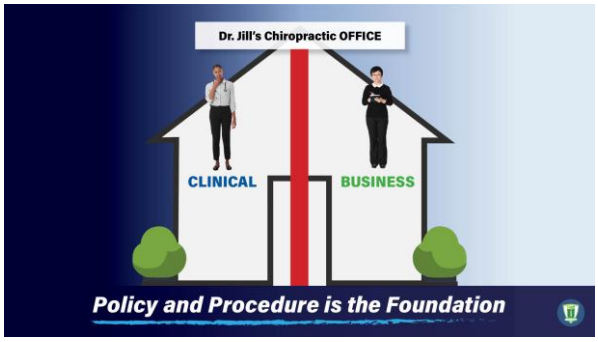
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Policy and Procedure is the Foundation

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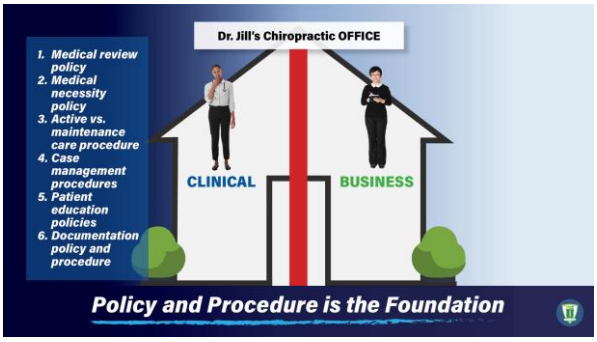
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2. Medical necessity policy
3. Active vs. maintenance care procedure
4. Case management procedures
5. Patient education policies
6. Documentation policy and procedure
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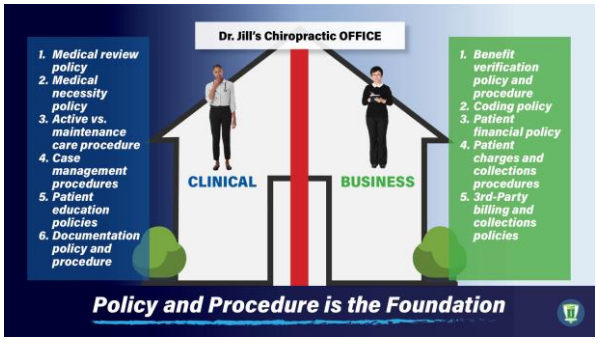
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5. 3rd-Party billing and collections policies
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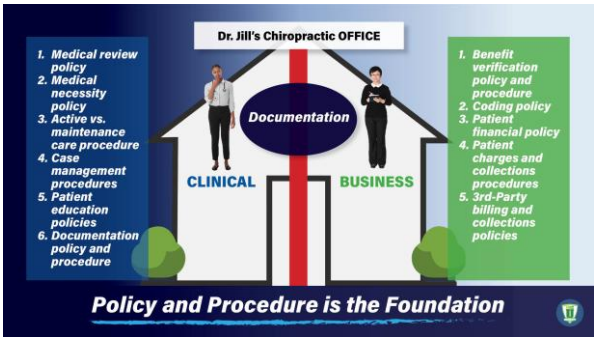
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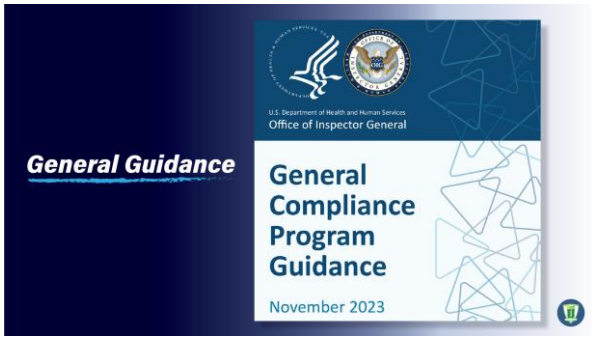

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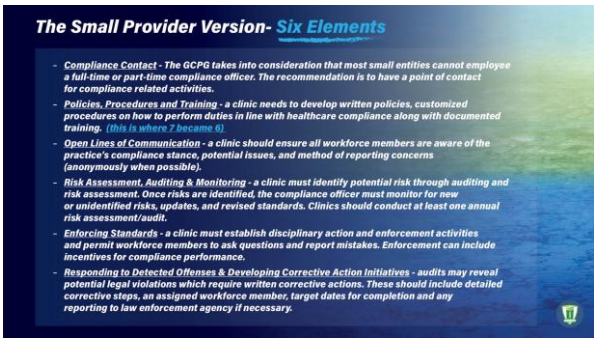

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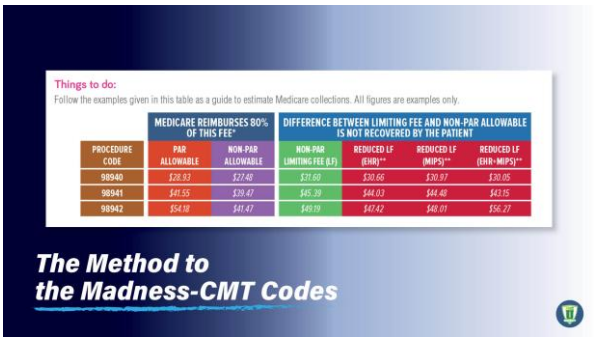

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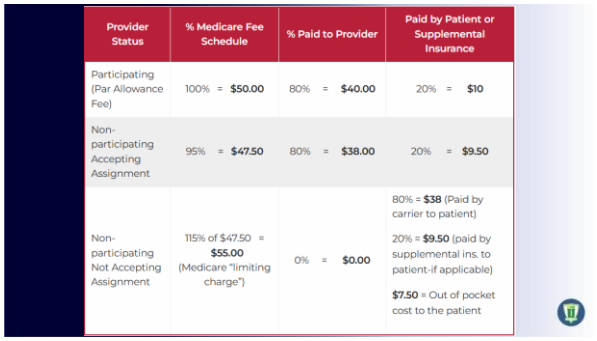

Provider Status	% Medicare Fee Schedule	% Paid to Provider	Paid by Patient or Supplemental Insurance
Participating (Par Allowance Fee)	100% = **$50.00**	80% = **$40.00**	20% = **$10**
Non-participating Accepting Assignment	95% = **$47.50**	80% = **$38.00**	20% = **$9.50**
Non-participating Not Accepting Assignment	115% of $47.50 = **$55.00** (Medicare "limiting charge")	0% = **$0.00**	80% = **$38** (Paid by carrier to patient) 20% = **$9.50** (paid by supplemental ins. to patient-if applicable) **$7.50** = Out of pocket cost to the patient

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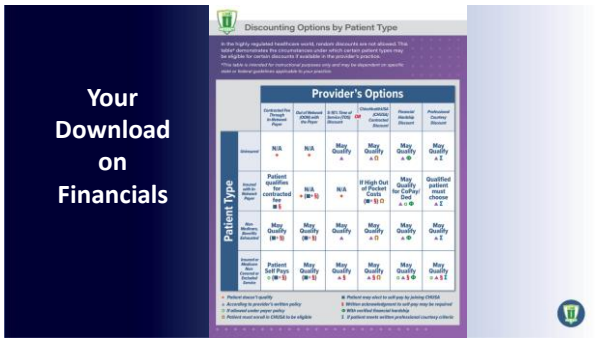

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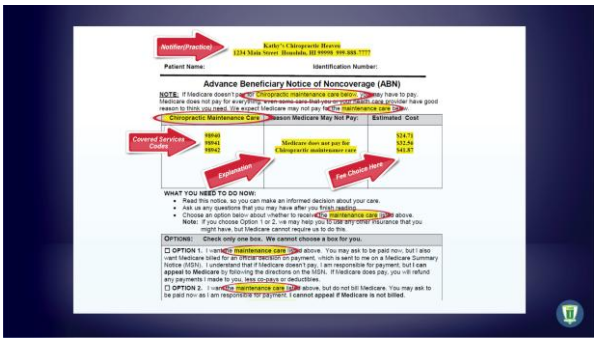

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Three Choices for Fees During Maintenance Care

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 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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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 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

MEDICARE PART C

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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 plus 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.)

MEDICARE PART C

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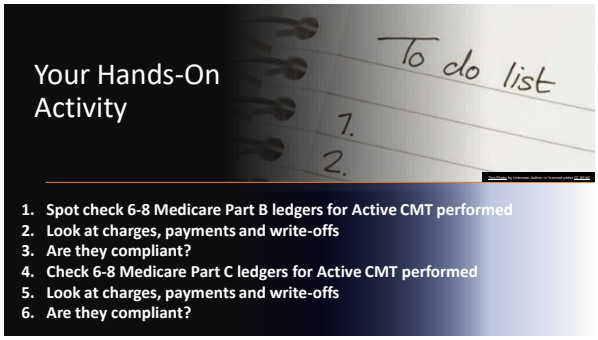

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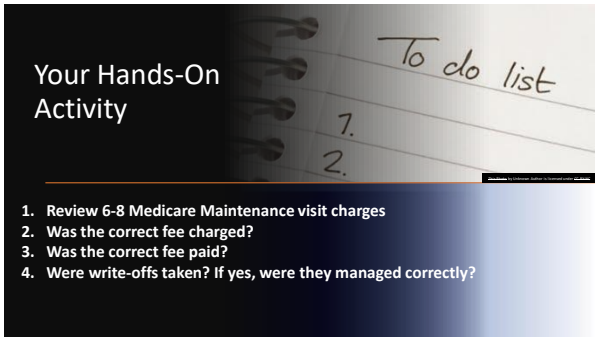

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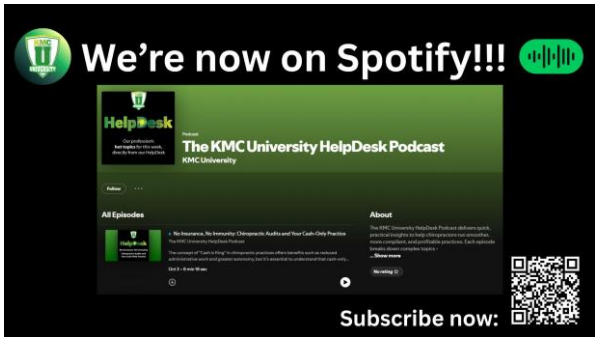

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Let's Discuss and Q/A

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