KMC University's
Chronicles
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DC Insights

Make Your Summer Practice Productive

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

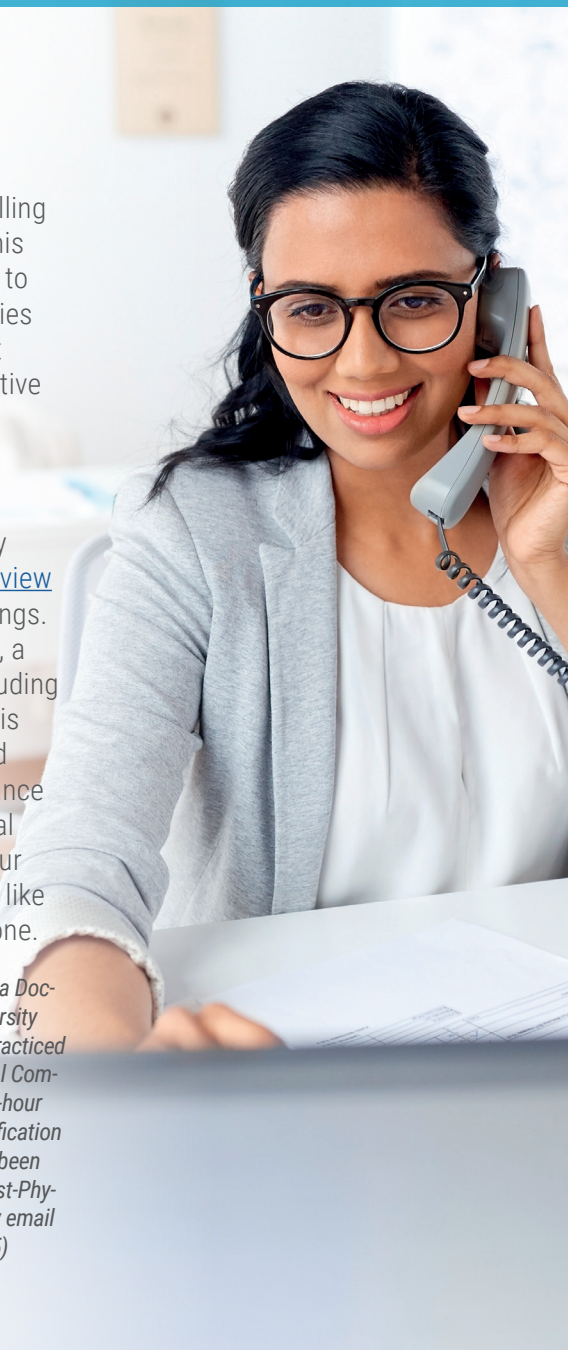
We tend to think of summer as a time for outdoor activities, vacations, and lounging in the sun! It can also be a time when our practices are less busy due to our patients' summer activities and can be a perfect opportunity to reflect and examine your practice's status.

Did you set goals at the beginning of the year? Where do you stand at the halfway mark? Are there any areas that are weak and need attention? And what needs to change moving forward? If you were to set a Treatment Plan for your practice like you do for any new episode of care for your patients, what would be the short and long-term goals? How are you tracking and measuring your practice's progress toward those goals? Just as a re-evaluation is an assessment of how a patient is progressing and responding to a treatment plan, checking in on the practice's status provides clarity and direction for what must happen to accomplish the intended goal for the year.

One of the easiest parameters to track how a practice is progressing is a thorough review of the documentation, coding, and billing habits of the practice. Using this potentially slower time of year to check-in and identify deficiencies and create steps to implement corrections would be a productive use of a less hectic summer.

Summer Suggestions

Let KMC University help you by providing a Proactive Chart Review that includes a Report of Findings. Or, for a more thorough review, a Baseline Audit of 5 charts including a full report of the findings. This deeper dive chart review would also fulfill your annual compliance requirement to conduct internal monitoring and auditing for your OIG Compliance Program. It is like feeding two birds with one scone.



Dr. Colleen Auchenbach graduated with a Doctor of Chiropractic from Cleveland University Kansas City in December of 1998 and practiced 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. You may reach her by email at info@kmcuniversity or by calling (855) 832-6562.

Help Desk
Frequently Asked Questions

We are in-network with several payers in our area. One payer's fee schedule is capped at $41. Our fee for procedure code 98940 is $65.00 and this payer only reimburses $41.00. We no longer bill the payer for electric stim but would like to bill the patient. Can we charge a patient $10.00 for the electric stim?

Many payers have made a shift away from fee-for-service payments by implementing a hybrid of sorts that could be classified as a capitation payment model. We say hybrid because it is built into the fee schedule rather than a set fee, per patient, per month. If you look closely at the Provider Manual and your reimbursement agreement, it more than likely refers to all covered services in the doctor's scope of practice that is rendered during that encounter. You should refrain from billing the patient for services that are considered covered services. We recommend that you consult each of the payers to obtain a list of any excluded services. In most cases, if the procedure is considered experimental, investigational, or non-covered it can be excluded from the capped fee. A great example would be laser therapy which is not considered a payable service by most payers. In that case, you would either obtain an Advance Member Notice of Non-coverage Form from the payer or provide one to the patient. This would be billable and in addition to collecting the capped fee from the payer.

Keep in mind, some payers will agree to pay a maximum amount and then the patient is responsible for the balance portion. These fee schedules are often presented as "covered up to $45.00 per encounter", and the patient is responsible for the balance portion of the allowable amount for all services rendered. This is a completely different fee structure. Be sure to read those contracts and know the circumstances and terms of the reimbursement policy. Do not assume all reimbursement models are the same.

Can we have a blanket "non-covered services" form signed by every patient? We are tired of random denials for services and would like to protect our reimbursement. We were told by our billing service that if we have a form on file, they can bill the patient. For example, all our UHC patients sign a form because UHC will not pay for 97014 (electric stim).

Although that may appear like the best solution, it is not a compliant one. A non-covered service form is to make the patient aware that the service that they are about to receive is not covered per the payer's policy. A provider is responsible for knowing what services are considered covered prior to initiating a non-covered service notice to the patient. If you look closely at the payer resources such as provider manual, contract, or reimbursement policies, they will tell you what services are considered non-covered and how the clinic must bill for them. Most payers have an Advance Member Notice form or similar process for notifying the patient ahead of time.

If a clinic were to ignore the patient's benefits and default to a non-covered service consent form, it could be violating the payer contract. If the clinic charges a patient for a service that is covered but not payable because it did not meet medical necessity guidelines or similar documentation or billing requirements, this could be a violation of the payer contract. Not to be overlooked are the consumer empowerment-focused regulations presented by the No Surprises Act which can impact how the clinic handles non-covered services. Defaulting to a non-covered service form is not the way to work your claims and improve reimbursement.

In the example you provided, you mention using a non-covered service form when billing 97014 to UHC. This is a covered service. UHC has mirrored Medicare on its reimbursement policy for this procedure by requiring providers to bill the code G0283. This is a perfect example of ignoring payer reimbursement policies which can cost the clinic.

Not all blanket forms are bad. For example, if you know the procedure Laser is deemed experimental, unproven, and investigational after reviewing a payer's Medical Review Policy (as it is with most all payers) then it's okay to do a blanket Laser Acknowledgement for patients with that insurance plan (after checking the payer portal for a form that is required).

Library members, visit the Helpdesk FAQ on your dashboard to watch a short but helpful video from KMC on this topic. Additionally, Library members can also find an extensive number of resources to guide them through proper billing for non-covered services. See the links below when you're logged into your member dashboard.

- *https://learn.kmcuniversity.com/courses/cpt-coding-according-documentation/lessons/relationship-coding-documentation/topic/patient-acknowledgment-to-pay-non-covered/*
- *https://learn.kmcuniversity.com/rapid-solution/patients-acknowledgement-to-self-pay/*

We had a patient walk in with a Railroad Medicare insurance card. What do we do?

The first question is, does the provider participate with Medicare Part B? If you are enrolled with Part B, you are eligible to provide care to Railroad Medicare patients. You are in the Medicare system. There is one additional step you must take for this type of Medicare beneficiary. The provider needs to request and receive a **Railroad** Medicare Provider Transaction Access Number (PTAN). It is a very simple process that you can check out on Palmetto's website (see link below).

Keep in mind, Railroad Medicare is different than traditional Medicare and Medicare Advantage (Part C). It is specifically for railroad retirees. If you feel you need a refresher on alternative Medicare plans, Library Members can check out the Practice Finances module titled ***Medicare & Chiropractic*** (Alternative Medicare Plans-Railroad and United Mine Workers).

https://www.palmettogba.com/palmetto/rr.nsf/DID/7GLKJT3258

https://learn.kmcuniversity.com/courses/how-insurance-works/lessons/medicare-chiropractic-2/topic/alternative-medicare-plans-railroad-and-united-mine-workers-3/

Quick Tip

Managing Code Edit Denials

Clinics nationwide who submit claims to insurance can relate to the frustration of code edit denials. Most of the time, a clinic will have a back log of denied claims that stretch over a period of six to eight weeks. In defense the DC will say, " We have always been paid for that code before." Sadly, as frustrating as code edits can be, they are one of the most preventable billing issues a clinic will come across. The reason is because of the extensive resources available online.

NCCI edits have been around for a long time. Most major payers have adopted these edits and created dedicated site pages to manage updates, notices, and reimbursement policies. Even better, they normally provide a clinic 90-day notice before implementing a change. We encourage each clinic to make time to locate the Code Update resources for their network payers. It is the best investment.

Library members can access our Rapid Solutions on this topic. We show you how to find NCCI edits and where to locate them on payer websites. Be proactive today--stop the cycle of preventable denials!

Learn more at:

https://learn.kmcuniversity.com/rapid-solution/coding-edits-chiropractic-billing/

Virtual Hands-On LAB

Saturday, September 24, 2022

8:30 AM- 12:00 PM / 12:30 PM - 3:00 PM Mountain Time

Foundations for Successful Reimbursement

(Part of the KMC University "Navigating the Rocky Waters of Reimbursement" Series)

A profitable business relies on different components working together in a consistent manner. The KMC University Reimbursement System identifies the steps necessary for your practice to achieve desired financial success. One missing step, and reimbursement can grind to a halt.

Join this 6-hour Online Seminar with your key team members to plug the holes in your reimbursement bucket.

Click here to be notified when registration opens.

What's New
in KMC University Library?

Revised Information & Resources

The No Surprises Act impacted providers nationwide in a variety of ways. Although the AMA and other associations did their best in providing resources on how to interpret the many aspects of the rule, there was not much available for single provider clinics or Doctors of Chiropractic. We developed resources early this year but as we learned more, and myth was separated from fact, we felt the need to revamp these resources.

KMC University consulted with healthcare attorneys for direction on proper interpretation of the rule. As a result, we have recently updated our Rapid Solutions on the No Surprises Act to include revised resources and updated tools. For providers who want to be compliant in all things and use the No Surprises Act regulation to improve their reimbursement, we have developed a comprehensive course on everything you need to know about the No Surprises Act. Choose your way of learning. Need a quick answer and the basics, locate the Rapid Solutions titled No Surprises Act- Good Faith Estimate and No Surprises Act- Balance Billing. Would you like to develop a compliant process for implementing the Good Faith Estimate requirement? Check out our No Surprises Act course which will supply your clinic the tools they need to streamline this process.

- https://learn.kmcuniversity.com/rapid-solution/no-surprises-act-good-faith-estimate/
- https://learn.kmcuniversity.com/rapid-solution/no-surprises-act-balance-billing/
- https://learn.kmcuniversity.com/product/no-surprises-act-course/

Check out the new resources!

When one regulation changes, it can have a domino effect on other procedures and processes. With the recent No Surprises Act regulation we have updated our Practice Finances course and our CA Training course to include updated forms for new patient data collection. This includes new scripting for new patient phone calls as well as guidance on how to build a compliant intake process.

Telephone Scheduling Scripts

- https://learn.kmcuniversity.com/courses/the-patient-intake-process/lessons/scheduling-basics/topic/telephone-scheduling-scripts-2/

Front Desk In-Bound Call Decision Matrix

- https://learn.kmcuniversity.com/courses/the-patient-intake-process/lessons/scheduling-basics/topic/the-in-bound-patient-call/

New Patient Data Collection Form

- https://learn.kmcuniversity.com/courses/the-patient-intake-process/lessons/new-patient-data-collection/topic/the-new-patient-phone-call-2/

New Intake Process Tutorial

- https://learn.kmcuniversity.com/courses/the-patient-intake-process/lessons/new-patient-data-collection/topic/building-a-compliant-intake-process/

Upcoming
Events, Seminars, and Webinars

Sports Chiropractic Boot Camp

- https://kmcuniversity.com/sports-chiropractic/

Required Compliance Components of the No Surprises Act

- https://learn.kmcuniversity.com/2022/05/11/june-14th-ce-webinar-required-compliance-components-of-the-no-surprises-act/

Summer Vacation
Is Your Clinic Compliant?

You might be thinking, what does compliance have to do with my summer vacation? If you plan to have someone cover for your clinic, it has a great deal to do with it. Over the years, as compliance specialists, we have seen doctors get in hot water because of mishandling billing as it relates to their out of office coverage. Depending on the circumstance, doctors will jockey between two different modifiers for Reciprocal Billing or Fee-for-Time.

What You Need to Know

Fee-for-time compensation is appropriate when a physician is absent for less than 60 days (e.g., an extended vacation, schooling, maternity leave, or temporary disability). With fee-for-time compensation, the regular physician pays the substitute physician a fixed amount per diem. The substitute physician is an independent contractor rather than an employee. Before you assume that you have checked all the boxes be sure to ask yourself, does the covering doctor have his/her own practice. With fee-for-time compensation, the substitute physician does not own a practice; rather s/he travels from one office to another as needed.

A reciprocal billing arrangement is used when a physician submits claims and receives payments (Medicare and/or other payer reimbursements) for services a substitute physician provides on an occasional or reciprocal basis (e.g., 2 physicians exchange coverage for vacations). This is an informal arrangement and does not require a written agreement. While written agreements aren't necessary, the regular physician must keep a record of services provided by the substitute physician along with his/her NPI—especially if s/he has reciprocal billing arrangements with more than one substitute physician.

One of the major differences between fee-for-time and reciprocal billing is in how the substitute doctor is paid. There are different rules for the different circumstances, and there are different modifiers depending on the type of coverage. Payers also have their own rules for credentialing and billing for covering physicians (see page 11 'Covering Physician' of UHC Provider Administrative Guide-link below). Let KMC University help you take that well deserved vacation without losing income or worrying about compliance. Learn more about billing with appropriate modifiers and setting up payment agreements in our Coding & Documentation module titled *Fee-for-Time -Locum Tenens.*

https://learn.kmcuniversity.com/courses/cpt-coding-according-documentation/lessons/coding-modifiers/topic/fee-for-time-locum-tenens/

https://www.uhcprovider.com/content/dam/provider/docs/public/admin-guides/2021-UnitedHealthcare-Administrative-Guide.pdf

Billing Maintenance Care

Great work! You just transitioned the patient to maintenance care. Now what? Although utilizing the HCPCS procedure code S8990 is the most appropriate way to code maintenance services, some third-party payers may consider it "investigational" or "experimental" and not payable. Some will not allow you to collect payment from the patient when billing this procedure code.

Avoid Reimbursement Issues with the following tips:

- If the patient is a Medicare beneficiary, Medicare does not recognize the code S8990. They require maintenance spinal manipulations to be billed with the correct spinal manipulation CPT code (98940-98942) with a –GA modifier appended instead of an -AT modifier (which is used for active treatment). Maintenance services for Medicare patients require a Mandatory ABN (Advance Beneficiary Notice) to inform the patient that the spinal manipulation is not covered when it does not meet medical necessity guidelines. The form confirms whether the patient would still like those services billed to Medicare and holds the patient responsible for out-of-pocket cost.
- Check the payer's reimbursement policy and verify the patient's benefits prior to submitting a claim or billing the patient. Payer portals are the best place to start. Keep in mind this is a very broad maintenance care code which includes not only chiropractic adjustments, but all services performed for maintenance.
- If maintenance spinal manipulation is not covered by a commercial payer, be sure to provide some type of Advance Notice for non-covered services to the patient and obtain consent. Note, some payers have their own forms. Check first!

Library Members learn more in the Rapid Solutions titled Maintenance Coding.

https://learn.kmcuniversity.com/rapid-solution/maintenance-coding/

Modifier Frustration
How to Avoid It

When a clinic provides both CMT and Physical Therapy services, it is not uncommon to receive denials on the therapy codes. There seems to always be a modifier that is required that we may have overlooked. Sometimes, it is a process error on the payer's part, which can make a billing person feel like s/he are losing his/her mind. Just when a clinic figures out the rules on appending modifiers, the rules can change. It is absolutely vital that clinics **never assume modifier requirements are the same for all payers.**

CMT & Modifier Requirements

We may not be surprised by therapy denials but when we receive a remittance advice that denies a CMT code for 'missing modifier' it can be a head scratcher. For years the only modifier that was required for CMT was when CMT was performed in addition to an evaluation/exam procedure (-25) or when reporting to Medicare (AT). Now it is common for some major payers (like Medicare) to require the AT modifier. And most recently, payers are expecting clinics to append Modifier 96 or 97 to the CMT code. Have you received similar denials based on missing or incorrect modifiers?

The Rehabilitative/Habilitative Modifier

We reached out directly to one of these major payers who recently classified spinal manipulation as requiring Modifier 96 or 97. We have yet to find any language within AMA CPT that classifies procedure codes 98940, 98941, 98942, or 98943 as requiring this modifier set. We will be sure to update our library members on the response.

In the meantime, we encourage all providers who receive a denial based on a missing modifier for CMT codes to do the following:

1. Log in to the payer portal and locate the reimbursement policies.
2. On the payer site search newsletters and other updates for the key words 'modifier 96' or 'spinal manipulation'. Look for a code edit simulator or claim editing tool on the payer portal and test the procedure code with and without a modifier.
3. Review the claim after you have confirmed the payer's coding requirements. Was the claim billed correctly? Be sure to confirm that a clean claim was submitted. That means all fields are filled out correctly, including diagnosis codes, diagnosis pointers, other modifiers, and Box 14 date of onset.
4. If the claim was clean and according to the payer's claim submission rules, follow up with an appeal. Simply request the payer to provide the AMA CPT reference for appending Modifier 96 or 97 to a CMT code. Document all communication with the payer and obtain reference numbers as they investigate the reasoning behind this code edit. If the claim was submitted incorrectly, follow the corrected claim process.

Payer Updates

Aetna Rolls Out Code Review Program

Beginning June 1, 2022, you may see new claim edits. According to Aetna, "These are part of our Third-Party Claim and Code Review Program….support our continuing effort to process claims accurately for our commercial, Medicare and Student Health members. These edits evaluate the correct coding for level 4 and 5 E&M codes (CPT codes 99204, 99205, 99214, 99215, 99244, 99245, 99204 and 92014) using the American Medical Association (AMA) E&M criteria. Based on the outcome of the review, we may adjust your payment if the claim detail doesn't support the billed level of service. We will not change the procedure code you bill."

Based on that statement, Aetna will not down code and pay you the lower fee, instead they will deny the claim all together. With this in mind, we recommend that you evaluate your documentation and billing for E/M services. Be sure it is in line with current coding guidelines. If you are not sure, refer to the KMC University Library resources titled *Evaluation and Management (E/M) Documentation-An Overview.*

Additional information from Aetna can be found on page 3 of 46 in the *March 2022 Aetna Links Update.*

https://learn.kmcuniversity.com/courses/documentation-of-evaluation-and-management-2/

https://www.aetna.com/content/dam/aetna/pdfs/olu/officelink-updates-march-2022-olu.pdf