HANDS-ON LAB

One Powerful Event – One Solid Practice!

ITINERARY | St. Louis, MO | April 2017

Medicare Mastery: Minimize Risk and Maximize Confidence

When asked what’s the biggest thorn in the side of DCs, without question the most popular answer is Medicare…from every angle. They report that they don’t feel confident about what exactly needs to be done to stay on the right side of Medicare rules. It’s Medicare-Palooza to the rescue!

This two-day event is a one-of-a-kind training that combines live demos, workshops, and practicum-style training sessions with a direct focus on all components of Medicare. From documentation, to risk management compliance, to financial regulations that surround this Federal program, this Hands-on Lab concentrates on the specific rules that must be followed by health care providers. Using Medicare as the central hub of the training wheel, this important workshop will blend documentation instruction, regulatory compliance, self-auditing, diagnosis and case management to promote maximum risk management. With the MACRA legislation taking effect January 1, 2017, compliance with the new rules has never been more important. This event will help DCs and their teams see and understand the necessity to move from the regulatory effects of “old Medicare” into the new world of quality measurement. By the end of this Medicare-Palooza weekend, confidence will soar when Morris or Mildred Medicare sign in for their next appointment.

Friday, April 21, 2017

Medicare from 15,000 Feet: The Do’s, The Don’ts, and the Holy Cows!

We’ll start the weekend by rolling up our sleeves and diving deep into the requirements of Medicare from an overview perspective. The session will include training on the MIPS/MACRA legislation by KMC University’s very own certified MIPS instructor to lay the foundation for the weekend of learning each spoke of the Medicare wheel. As we look at Medicare from all angles, we’ll set the tone for the deeper dive into each area of Medicare throughout the weekend. With multi-modal learning opportunities, we’ll learn and become familiar with the standards of documentation in chiropractic Medicare today. Medicare financial issues and other program standards will be reviewed and discussed to maximize risk management in this Federal program.

Medicare Diagnosis: The Capstone of Medical Necessity (concurrent)

In this session targeted at DCs, we’ll explore the importance of basing all diagnostic clinical decision-making on the actual findings from history to examination and beyond. While Medicare requires that a subluxation is the primary diagnosis, without a secondary, neuromusculoskeletal condition being caused by that subluxation, medical necessity is NOT established. This session will provide all the details to ensure that patient history drives examination choices, and that history, together with the examination findings, determine whether further diagnostics are necessary. Once all this vital information is gathered, only then can the provider clearly discern the most appropriate and specific diagnosis/diagnoses. Get this step right, document it well, and watch denials disappear.

Medicare Fees and Collections: Streamlined and Simplified (concurrent)

There is always a bit of confusion about what we can charge Medicare patients and how to calculate our fees, given mandatory penalties in play. The truth is that because there are only three covered services in Medicare, the rules are simple. That doesn’t mean they are not confusing! In this session, we’ll work with teams to review actual fee schedules that they brought with them, and assist them in organizing and setting the exact fees for Medicare patients. Because of the inducement rules set forth by the Office of Inspector General, we’ll visit every service offered in the practice and review the requirements and details for setting the best, safest fee for each. We’ll leave this session with a clear understanding of what you can and can’t charge for, and a fine-tuned Medicare fee schedule ready for Monday morning.

Medicare Case Management: It’s a Team Sport!

All patients who are covered by a third-party payer get confused about why they can’t come in whenever they please, throw down their insurance card, and get the visit covered. Case management, active vs. maintenance care, and the art of treatment planning are the lynchpins in managing this safely and correctly. We’ll build upon the provider’s growing understanding of appropriate initial visit documentation by outlining the ideal treatment plan layout. We’ll empower team members to better understand and assist the doctor with knowing when the patient is in an active treatment episode and when they’re not. Mastery of ABN usage and explanations to patients about why the care might be their responsibility can be difficult. This session will review scripting and case management explanation to give confidence and certainty around the mastery of case management...thereby bringing peace of mind and safety to handling Medicare patients and their treatment.
In-Processing the Medicare Patient: Start on the Right Foot!

In this session, we’ll introduce the Medicare Decision Making Matrix. Recent reports by the Office of Inspector General have pinpointed that DCs now have one of the higher error rates in documentation out of all Part B Medicare Providers. It’s widely known that a big reason for this is the lack of understanding of the difference between clinically appropriate care and medically necessary care. As a profession, we bill Medicare for active treatment when the documentation denotes it should have been maintenance care 49% of the time. The process of discerning this is vital for every team member to understand to properly document, record and charge for Medicare encounters. By screening and properly evaluating every visit, DCs and front desk team members will gain a new understanding of the requirement for active treatment under Medicare, thus minimizing the risk of documentation error and inappropriate payment from Medicare.

Financial Compliance in Federal Programs

In this session, attendees will spend training time in both a classroom and hands-on workshop environment to understand the important financial matters surrounding Medicare and other Federal programs. Given the current audit and recoupment situation around these issues, teams must understand the law and guidelines surrounding today’s practice. This important session gives you the opportunity to apply classroom theory to practical application. This session addresses a Federal Office of Inspector General mandate that healthcare providers master Medicare’s cumbersome financial rules.

Compliance Officer Training

We all know that healthcare providers have been told to build and maintain a compliance program since 1999. Surveys show that fewer than 15% of DC offices have followed this guidance. With the implementation of PPACA (Obama Care), Compliance Programs have been mandatory since 2010. In this session, we’ll outline the step-by-step process of being the compliance officer for your practice. Whether you have a viable program, or have been meaning to build one, this session outlines the must-haves for doctors and teams to follow this mandate. Leave this session with a new appreciation for what it means to be your practice’s Compliance Officer!

The Art and Science of Billing Medicare

While it may seem simple, Medicare billing can be complicated. Covered services vs. excluded services, Medicare as the primary vs. the secondary payer, Medicare Advantage, and the myriad of supplemental insurers make billing anything but straightforward. This session will dig deep into all the options and all the possibilities of who’s who and who gets paid for what. Teams will leave this session with tools and tricks to immediately know who to bill, how much to bill, and when to appeal.

CEUs will be provided!
Please call for details.

REGISTRATION IS OPEN... CALL NOW
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You don’t need to know all the answers when you know the people who do.