AAAOM
全美中醫公會
American Association of
Acupuncture & Oriental Medicine

AAAOM FEDERAL LEGISLATION INITIATIVE

FREQUENTLY ASKED QUESTIONS

UPDATED: NOVEMBER 2013

Table of Contents

General Questions

How and who started the initiative to get acupuncture covered at the federal level?

The Federal Acupuncture Coverage Act (FACA) of 1993 (103rd Congress/HR2588[1]) was the first bill drafted and introduced in the U.S. House of Representatives by Maurice Hinchey (NY) that would have mandated acupuncture services coverage by Medicare and Federal Employee Health Benefits plans. The bill was reintroduced in the 104th,[2], 105th,[3], 106th,[4], 107th,[5], 108th,[6], 109th,[7], 110th,[8], 111th,[9], and 112th,[10] congresses by Representative Hinchey.

What was the 1997 Acupuncture Consensus Conference?

Since its inception in 1977, the National Institutes of Health (NIH) Consensus Development Program has produced evidence-based consensus statements addressing controversial medical issues important to researchers, healthcare providers, policymakers, patients, and the general public. The Consensus Development Program is strategically located in the NIH Office of Disease Prevention, which provides the leadership, infrastructure, funding, and coordination necessary to conduct Consensus Development Conferences. A Consensus Development Conference is held when there is a strong body of evidence about a particular medical topic, but the information has not yet been translated into widespread clinical practice. The goal of each conference is to consolidate, solidify, and broadly disseminate strong evidence-based recommendations for provider practice.

In 1977 at the request of Congress, a National Institute of Health (NIH) consensus conference was convened on acupuncture. The conference was sponsored by the NIH Office of Medical Applications of Research and the NIH Office of Alternative Medicine. It was co-sponsored by the National Cancer Institute, the National Heart, Lung, and Blood Institute, the National Institute of Allergy and Infectious Diseases, the National Institute of Arthritis and Musculoskeletal and Skin Diseases, the National Institute of Dental Research, the National Institute on Drug Abuse, and the NIH Office of Research on Women's Health.

The 12-member NIH panel issued a consensus statement following an extensive review of the existing medical literature and a series of presentations by 25 acupuncture research experts that there is clear evidence that acupuncture treatment is effective for

---

[1] http://www.gpo.gov/fdsys/pkg/BILLS-103hr2588ih/pdf/BILLS-103hr2588ih.pdf
[2] http://www.gpo.gov/fdsys/pkg/BILLS-104hr3292ih/pdf/BILLS-104hr3292ih.pdf
[3] http://www.gpo.gov/fdsys/pkg/BILLS-105hr1038ih/pdf/BILLS-105hr1038ih.pdf
[4] http://www.gpo.gov/fdsys/pkg/BILLS-106hr1890ih/pdf/BILLS-106hr1890ih.pdf
[5] http://www.gpo.gov/fdsys/pkg/BILLS-107hr747ih/pdf/BILLS-107hr747ih.pdf
[6] http://www.gpo.gov/fdsys/pkg/BILLS-108hr1477ih/pdf/BILLS-108hr1477ih.pdf
[7] http://www.gpo.gov/fdsys/pkg/BILLS-109hr818ih/pdf/BILLS-109hr818ih.pdf
[8] http://www.gpo.gov/fdsys/pkg/BILLS-110hr1479ih/pdf/BILLS-110hr1479ih.pdf
[9] http://www.gpo.gov/fdsys/pkg/BILLS-111hr646ih/pdf/BILLS-111hr646ih.pdf
[10] http://www.gpo.gov/fdsys/pkg/BILLS-112hr1328ih/pdf/BILLS-112hr1328ih.pdf

postoperative and chemotherapy nausea and vomiting, nausea of pregnancy, and postoperative dental pain. Additionally, the panel indicated that there are a number of other pain-related conditions for which acupuncture may be effective as an adjunct therapy, an acceptable alternative, or as part of a comprehensive treatment program. These conditions include but are not limited to addiction, stroke rehabilitation, headache, menstrual cramps, tennis elbow, fibromyalgia (general muscle pain), low back pain, carpal tunnel syndrome, and asthma.

That panel concluded that "the data in support of acupuncture are as strong as those for many accepted Western medical therapies" and there is sufficient evidence of acupuncture's value to expand its use into conventional medicine and encouraged further studies of its physiology. The panel urged broader public access to acupuncture treatment and requested insurance companies, federal and state health insurance programs including Medicare and Medicaid, and other third party payers to remove the financial barriers to access to these services and expand their coverage to include appropriate acupuncture treatments.

What is the AAAOM Federal Legislation Initiative?

More than 40 percent of Americans receive their health care through federally funded or federally supported programs. These include the Medicare population, active duty military members and their families, as well as veterans of the armed services. Further, federal employees select from insurance policies approved by the Federal Employees Health Benefits (FEHB) program managed by the Office of Personnel Management.

Congress has the authority to mandate access to services and to include health professionals in federal health programs. The passage of the Patient Protection and Affordability Act includes a number of provisions that were included to specifically address advancing the integration of complementary and alternative therapies and professionals across the healthcare system.

In alignment with our mission to support our members and the AOM community through education, occupational resources, media support, and legislative advocacy, the American Association of Acupuncture and Oriental Medicine (AAAOM) drafted five bills that would ensure acupuncturists are included in the aforementioned federal healthcare systems. This change would go a long way to ensure acupuncture access for patients both in the referenced systems and out of them, as the change federally would have a significant impact on private and local healthcare plans both immediately and in the long term. This inevitably will result in a healthier patient population and a more successful profession.

What is the difference between the Federal Acupuncture Coverage Act (FACA) of 1993-2011 and the current AAAOM Proposed Legislation?

More than twenty years ago, the FACA was written by congressional staff and a small team to address Medicare and Federal Employee Health Benefits (FEHB) plans, but it is no longer

representative of the modern acupuncturist or modern standards for acupuncture licensure and competency certification.

In 2009 when the AAAOM prioritized the issue and began heavily investing volunteer and staff resources in federal coverage we received a great number of comments and concerns as well as much support from the acupuncture community—both practitioners and patients. The current draft legislation is built on what we learned from the past twenty years of state and federal legislative activities, updates in professional standards and practices, and changes to our national healthcare laws. It covers the five major federal health programs: Medicare, FEHB, Tricare, Veterans Administration, and Public Health Service Corps.

The current bill drafts were written from the ground up by a panel of internal and external experts in our community. Additionally, all of the concerns raised since the 2009 campaign and the recent calls for comments on the new legislation, including the Medicare opt-out provisions, have been addressed in the latest drafts. To date, this has been the most significant effort in achieving viable, high-quality, consensus-based bill drafts to mandate inclusion of acupuncturists in federal programs.

What are the potential positive effects of this bill?

Currently, there are 126 million individuals insured by these federal programs. Reimbursement for these potential patients will help propel and properly integrate our profession into the existing health insurance system. Additionally, it will add the profession to the group of mainstream providers. It is estimated that up to 20 percent of our population will become eligible for Medicare coverage over the next 20 years. Therefore, this bill will help us provide AOM services and reimbursement to an ever-increasing number of people.

Through this legislation, AOM providers will be able to build successful primary care and specialty care practices. The legislation has the potential to significantly increase patient choice and contribute to the recognition of AOM as essential in our healthcare delivery system.

Other insurance carriers will be required to add coverage for acupuncture in their policies. (This is based on COBRA requirements, i.e, coverage for employees over 65 years old must be the same as for employees under 65 years old.) In addition, Medicare supplement and administrative services organization (ASO) entities will also be required to follow suit and include acupuncture coverage in their policies. The legislation could also facilitate integration of the profession and training programs into integrative clinical settings such as hospitals and other mainstream healthcare facilities.

In summary, federal legislation that recognizes AOM's contribution to patient care and the expansion of patient access to AOM is a necessary and important step towards equity, credibility, and parity for the AOM profession. This bill will provide access to AOM for a

large population of patients. Whether an individual acupuncturist chooses to participate as a provider in the specific program or not, patients will have this additional coverage under their insurance, creating a larger patient base and enhanced visibility of AOM.

Based on the current Medicare system, what might be the challenges to the profession of having acupuncture included?

The major challenge to our practitioners will likely be the level of training the average acupuncturists has in billing and documentation. Standardized documentation will be required to justify and support both the medical necessity for each treatment and the level of service being billed. Providers can be subject to audit and will have to issue refunds for claims lacking required documentation. While specific documentation rules will not be determined until after bill passage, the rules will be very explicit in their requirements. While we will have limited influence on many of the program terms, the AAAOM will need to be actively involved in their development and educate its members on how to fully comply.

A baseline requirement will be the ability to generate the insurance claim forms from a computer. While this may present a steep learning curve to some in our profession, software tools are already in place that can facilitate the transition. Some of these federal programs might also offer training programs for those who are motivated to learn, similar to what they provided for all other professions embarking on use of the system.

Practice Questions

How can I practice as a Medicare provider?

Medicare, like any other insurance company, requires providers seeking reimbursement through the Medicare system to **enroll** and be fully credentialed. The process to becoming a Medicare Enrolled provider is detailed in Appendix A.

Provider enrollment is standard practice for providers treating Medicare beneficiaries.[11] While most acupuncturists should enroll to access the reimbursement options when available to our profession and our patients, there are exceptions to mandatory claims submission and enrollment detailed in Appendix A.

When Medicare includes acupuncture as a covered service, it should not have any affect on how you treat your patients. Care for your patients should continue to be provided based on your determination of clinically appropriate treatment and on your scope of practice.

Must I file claims for all Medicare eligible patients?

You will be required to file claims for your Medicare beneficiaries unless they opt-out. There are some exceptions detailed in Appendix A; more information on the opt-out provision is included below.

Am I obligated to file claims if I treat Medicare beneficiaries?

Yes, unless your patients fall into an exception (such as is provided by the opt-out clause) under Appendix A.

Will I be forced to enroll as a Medicare provider if I don't want to be one?

No. Those who do not wish to see or treat Medicare beneficiaries are not mandated to do so and can refer Medicare beneficiaries to other providers who will provide these services.

If you decide to treat Medicare beneficiaries, and all of your patients fall into the opt-out exception criteria outlined in Appendix A, then you do not need to enroll or submit claims.

If you decide to treat Medicare beneficiaries, and even if only one of your patients does not meet the exceptions criteria, then you must enroll and submit claims for that patient.

---

[11] A Medicare beneficiary is "a person designated by the Social Security Administration as entitled to receive Medicare benefits."

Can acupuncturists opt-out of Medicare?

The AAAOM has long been committed to including an opt-out clause in the legislation. The current legislation includes a provision that adds acupuncturists to a list of providers than can opt-out.

The opt-out provision allows enrolled providers a way to formally disengage from the Medicare system. When a provider opts-out, (s)he must enter into individual contracts with each patient. In essence, the patient agrees to pay the provider directly and acknowledge that Medicare will NOT provide any reimbursement to them for any services from this provider.

How can I enroll in Medicare system after the legislation passes?

You will need to fill out enrollment forms and become familiar with the documentation and charting requirements as well as the requirements associated with claims submission. Please see appendix A that outlines enrollment.

How will the legislation affect the business of my practice model if I currently don't take insurance?

Even if you don't take insurance, the legislation will create a broader patient base by providing patients covered by federal programs with some level of insurance reimbursement for acupuncture services.

How will the legislation affect me if I currently don't see Tricare or Medicare beneficiaries and I don't intend to treat then in the future?

Medicare and Tricare are baseline federal programs from which all other insurance plans and third party reimbursement systems take their cues. Passage of these bill will provide federally endorsed national recognition of AOM and will provide acupuncturists with more patients and referrals from physicians as AOM expands its influence in the medical community. In addition, it will increase practice opportunities in hospitals, clinics, skilled nursing facilities, and other facilities that previously would not allow acupuncturists to become credentialed because there was a lack of funding for services. Acupuncture will become mainstream and available as a revenue-generating system for hospitals and other facilities and programs.

Inclusion in Medicare will open the doors to access in other insurance plans based on what Medicare covers. NOTE: Not only seniors are covered by Medicare; those who are disabled due to certain diseases or conditions are also Medicare beneficiaries. AOM professionals can provide critical access to non-medication pain management for these populations.

Will this legislation require acupuncturists to use electronic health records?

No.

Will these federal programs send me patients?

No. Medicare, Tricare and other programs will not send patients to practitioners. A patient can find enrolled participating and non-participating providers by zip code on the Medicare.gov website.

Would services other than acupuncture (cupping, moxibustion, and Tui Na) be covered under Medicare?

Acupuncture is the one service guaranteed to be covered when this bill becomes law. Reimbursement for ancillary services is covered in the bill language but the final determination will be when the reimbursement rules are being written by CMS. In the event that ancillary services remain uncovered, they may be billed directly to the patient without regards to any fee schedule limitations.

Will this legislation impact Medicaid coverage for acupuncture?

Medicare is administrated by the federal government while Medicaid is administrated by state governments. Changes in federal laws typically result in Medicaid regulations changes at the state level. It would still be up to each state if and how they would want to incorporate acupuncture into Medicaid. Currently five states offer acupuncture coverage through Medicaid (Minnesota, New Mexico, Florida, Oregon, and California).

Billing Questions

What is the maximum fee you can charge a Medicare patient?

CMS sets the maximum rate that may be charged for a given CPT code. For a detailed explanation of how these fees are set see Appendix C

How will the covered conditions be determined?

This will be determined after the bill passes.

How will the amount of treatments that can be given for a particular condition be determined?

This will be determined after the bill passes.

Will we be able to use a professional billing firm to do the billing?

Yes. Many billing services exist that enables billing to become routine. Acupuncturists will be able to use these services, as do other providers.

Payment Questions

How will Medicare disburse funds?

If you have accepted an assignment of benefits, they will send you a check with a detailed breakdown after processing your bill. If you haven't accepted an assignment of benefits, the patient pays you directly and you will still get the explanation of benefits (EOB) but the checks will go to your patients.

How long does it take for Medicare to reimburse for a patient treatment?

Electronically submitted claims are processed quickly, but even mailed claims are typically handled within 4 weeks.

Documentation Questions

What diagnostic codes will we use for Medicare patients?

This will be determined after the bill passes.

What are the documentation requirements for an acupuncturist?

This will be determined after the bill passes.

We Need Your Help

Why should LAcs and state associations financially support this legislation?

For the past seven years, state and national leadership as well as attendees at the AAAOM meetings have identified "recognition of acupuncture and Oriental medicine" as one of the top three important issues facing members of our profession. Recognition of our profession by federal programs includes AOM practitioners as federally mandated members of the medical teams that care for patients in this country. Expanding AOM access to millions of Americans also represents a primary growth strategy for the AOM profession.

The AAAOM and its subject matter experts have been working diligently to educate members and staffers in Congress about the benefits and cost-effectiveness of AOM. One example of this is our delivery of over 100,000 letters of support to date on Capitol Hill. In part because of our efforts, numerous senators and representatives have pledged their support.

Passage of this bill requires consistent and multi-faceted political action at this critical time. Dramatic change in health care is occurring right now. Political lobbying influence in this environment is essential. As with all bills, this legislation will need to pass in both the House of Representatives and the Senate before being signed into law by the president. After the bills are introduced, 80 to 100 co-sponsors are needed in order to schedule a hearing and move the bills out of committee and onto the floor for a vote.

The AAAOM has developed a national grassroots advocacy campaign that includes asking AOM colleges, their students, and licensed acupuncturists for their support.

By donating to the Acupuncture and Oriental Medicine Political Action Fund (AOMPAF), acupuncturists are promoting and supporting legislation that will protect and advance AOM today and for many years to come.

Who can I contact if this document doesn't fully answer my questions?

You can email info@aaaomonline.org, and your inquiry will be directed to the proper personnel.

Appendix A: Enrollment Information

Medicare Program Integrity Manual

Chapter 10 Medicare Provider/Supplier Enrollment, p 9

1. Introduction to Provider Enrollment

(Rev. 218, Issued: 08-10-07, Effective: 10-01-07, Implementation: 10-01-07)

No provider or supplier shall receive payment for services furnished to a Medicare beneficiary unless the provider or supplier is enrolled in the Medicare program. Further, it is essential that each provider and supplier enroll with the appropriate Medicare fee-for-service contractor.

Medicare Physician Guide:

A Resource for Residents, Practicing Physicians, and Other Health Care Professionals, p 28

Medicare Claims

A claim is defined as a request for payment for benefits or services received by a beneficiary. Providers and suppliers who furnish covered services to Medicare beneficiaries are required to submit claims for their services and cannot charge beneficiaries for completing or filing a Medicare claim.

In general, Medicare fee-for-service claims must be filed in a timely way, which means that they must be filed on or before December 31 following the year in which the services were furnished. Services furnished in the last quarter of the fiscal year (FY) are considered furnished in the following FY.

Providers and suppliers are not required to file claims on behalf of Medicare beneficiaries when:

- The claim is for services for which Medicare is the secondary payer;
- The primary insurer's payment is made directly to the beneficiary, and the beneficiary has not furnished the primary payment information needed to submit the Medicare secondary claim;
- The claim is for services furnished outside the U.S.;
- The claim is for services initially paid by third-party insurers who then file Medicare claims to recoup what Medicare pays as the primary insurer (e.g., indirect payment provisions);
- The claim is for other unusual services, which are evaluated by Medicare
- Contractors on a case-by-case basis;
- The claim is for excluded services (some supplemental insurers who pay for these services may require a Medicare claim denial notice prior to making payment);
- The patient refuses to give permission (under HIPAA) for you to release their medical information to Medicare;
- He or she has opted-out of the Medicare Program by signing a private contract with the beneficiary; or

- He or she has been excluded or debarred from the Medicare Program.

Medicare Benefit Policy Manual, Chapter 15 (rev 08-07-09)

40 - Effect of Beneficiary Agreements Not to Use Medicare Coverage
(Rev. 1, 10-01-03) B3-3044, PM-B-97-17)

Normally physicians and practitioners are required to submit claims on behalf of beneficiaries for all items and services they provide for which Medicare payment may be made under Part B.

All physicians and practitioners or suppliers are not allowed to charge beneficiaries in excess of the limits on charges (115% of Medicare's fee schedule) that apply to the item or service being furnished.

However, a physician or practitioner (as defined in §40.4) may opt out of Medicare. A physician or practitioner who opts out is not required to submit claims on behalf of beneficiaries and also is excluded from limits on charges for Medicare covered services. (Note: Opting out of Medicare and entering into a private reimbursement contract with the patient requires the patient to pay 100% out of pocket and stops Medicare's benefits for that patient for the services provided for a period of 2 years.)

Only physicians and practitioners that are listed in §40.4 may opt out.

The only situation that physicians or practitioners, or other suppliers, are not required to submit claims to Medicare for covered services is if in accordance with HIPAA, the beneficiary or the beneficiary's legal representative refuses, of his/her own free will, to authorize the submission of a bill to Medicare.

Appendix B: Advanced Beneficiary Notice

If a provider anticipates Medicare will not pay for a covered service, the provider must file an "Advance Beneficiary Notification" (ABN). An ABN is a document that the patient signs indicating that they choose to receive and pay for a service that the provider anticipates Medicare will not pay for. A claim must still be submitted to Medicare even though the provider expects the beneficiary to pay and expects that Medicare will deny the claim.

Medicare does not require providers to issue an ABN for services that are "statutorily excluded" (services that are never a Medicare benefit). However, you may still want the patient to sign a waiver of liability to ensure that they understand that they are responsible for the charges. For an excluded service, you can collect full payment for the services.

Appendix C: Medicare Fee Determination

Final Medicare reimbursement rates for acupuncture won't be determined until the bill is passed.

Important Terms

- **Work RVU:** Relative Value Unit applied to the "work" provided by the provider of service
- **Non-FAC PE RVU:** This indicates the practice expense relative value for services performed in any location other than a hospital (facility) setting
- **Facility PE RVU:** This is the practice expense relative value for services performed in a hospital or facility location
- **MP RVU:** Relative Value unit placed on the cost of malpractice insurance cost
- **Conv. Factor:** Dollar amount used to determine the customary and reasonable or CMS fee for the service based upon the formula below

Calculating the RVU and Localized CMS Fee

Examples of the new evaluations are included below. For a complete list of the codes and publications, please visit the CMS website.[12]

The CMS RVUs are published on a national basis and each of the three categories of RVUs explained above are adjusted based on a geographic price cost indices (GPCI). These values adjust the Work RVU, the Practice Expense RVU and the Malpractice RVU for the geographic location of the provider performing the service. A complete list of the GPCI adjustments is found on the CMS Website under Addendum H.[13] Simply locate your locale, and the adjustment amounts are listed.

The RVU Payment Formula
[(Work RVUs x Work GPCI) + (Practice Expense RVUs x Practice Expense GPCI) + (Malpractice RVUs x Malpractice GPCI)] = Total RVU

Total RVU x Conversion Factor = **Medicare Allowable Payment**

For the red data, the RVUS, go to CMS' website and download the 2013 RVU data, compiled in a zip file. Please note that you will have to agree to proper use of CPT codes, which are a copyright of the AMA.

NOTE: The AMA, which holds the copyright to the CPT codes, prohibits the development of tools to make the RVU calculation process easier without a license.

Example of this calculation for Los Angeles County is:

WORK RVU GPCI for LA County is: 1.049

[12] http://www.cms.hhs.gov/providers/pufdownload/rvudown.asp
[13] http://www.cms.hhs.gov/regulations/pfs/2005/AddendumH.pdf

NON-FAC PE RVU GPCI for LA County is: 1.142
Mal Practice RVU GPCI for LA County is: 0.955

Calculation for services performed in a Los Angeles County practice:

97810 [(.60 * 1.049) + (.38 * 1.142) + (.03 * .955)] * 37.8975 = $41.38

Resources:

- The AMA provides its own CPT search / RVU calculator.
- PedSource / Physician's Computer Company provides an Excel template for you to build your own RVU Calculator using the data above.

See more at: http://www.physicianspractice.com/rvu/calculate-your-rvu-payment#sthash.ewhCYviY.dpuf

NOTE: More information on understanding and calculating the CMS fee schedule and Non-FAC PE RVU and the FACILITY PE RVU amounts for acupuncture will be provided in a later version of this Guide.