Medicare and Beyond!
Presented by KMC University

Today's Agenda

• What's really different about Medicare?
• Medicare's procedure codes, diagnosis codes, and modifiers
• How your carrier shares special billing instructions
• Billing for non-covered services in Medicare
• Medicare's Timely Filing rules

We Assume…

• The billing that is sent to you is accurate
• Your doctor understands everything about Medicare maintenance definitions
• The services you're billing are medically necessary

Today's Agenda

• Medicare as a secondary payer
• Secondary and supplemental policies for Medicare patients
• The rules that govern treating immediate family members
• Proper Medicare fee schedule, legally discounted fees for excluded services, and the specifics of when you are allowed to collect from your Medicare patient.
• The detailed Appeals Process that has been proven to overturn Medicare denials more than 50% of the time

We Assume…

• The billing that is sent to you is accurate
• Your doctor understands everything about Medicare maintenance definitions
• The services you're billing are medically necessary
Submitting Claims to Medicare

- Requirements to bill Medicare
- Covered Services Versus Non-covered
- Special Requirements

Requirements to Treat Medicare Patients

- Providers must be registered with their Medicare carrier
- Must choose participating or non-participating
- Maintain status, must re-verify
- May not “opt-out” to avoid billing Medicare

Provider Numbers and Medicare

- NPI
- PTAN
- UPIN
- TAX ID or EIN

Entering Provider Information

- Box 31 – Physician Signature
- Box 32 – Service Facility Information
- Box 33 – Provider of Service Information

Lots of Different Coverage to Be Aware Of

Understand Different Types of Medicare Coverage
Medicare Replacement Plans

**FACT SHEET**

What is “deeming” under Medicare Advantage?

When an enrollee is in a private fee for service (PFS) plan offered by a Medicare Advantage (MA) organization, the services from a provider, unless for those services, that provider is deemed to be one of the following three mutually exclusive provider types:

- **A provider is a direct contracting provider if that provider has a direct contract (that is), a signed contract with the MA Organization.**
- **A provider is deemed contracting provider if:**
  - The provider is in a signed contract that requires that the provider receive contracts to provide services that the person receiving the services is enrolled in a PFS plan.
  - The provider has access to the plan's terms and conditions of payment and the services provided are covered by the plan.
- **A provider is non-contracting provider if that provider does not have a direct contract and is not deemed.

Must Understand Verification

Insurance Secondary to Medicare

- **Supplemental Policies Defined**
  - AARP, Mutual of Omaha, “supplemental”
- **Secondary Policies Defined**
  - Small group policy, retirement benefit

Crosswalk Feature

- Patients must request from Secondary/Supplement
- Secondary Supplement sends info on patient to Medicare
- Medicare sends processed claim information to Secondary/Supplement

Verifying Crosswalk Claims

- EOMB will have code whose definition states “claim information transmitted to ….”
- Patient can verify with Medicare
- Verify on some carriers’ provider websites
**CMS Requirements**

- Onset Date for Medicare
- Use Box 14
- Date of treatment for this episode

**Other Special Requirements**

- Billing x-ray codes for denial
- Box 17 - Ordering physician
- Box 17b - NPI of ordering physician

**Carrier Required Data**

- How and when you documented presence of subluxation, x-ray or PART exam
- Box 19 may be used to report dates on claim form
- Always support this in documentation

**Treating and Billing Family Members**

- The following is taken directly from CMS Policy Manual 100-02 Medicare Benefit Policy Manual.

  **In the following discussion of relationships, the following definitions are included within the definition of immediate relatives:**

  - Husband or wife
  - Natural or adoptive parent, child, and sibling
  - Grandparent, great-grandparent, great-grandchild, and great-great-grandchild
  - Father in law, mother in law, son-in-law, daughter in law, brother in law, and sister in law
  - Grandparent and great-grandchild and great-great-grandchild

**NOTES:**

- A brother is a male sibling in law relationship does not exist between the physician, supplier or owner of a provider (ie, spouse) and the spouse of the physician, supplier or owner of a provider (ie, spouse)

- Box 19 may be used to report dates on claim form

- Always support this in documentation

**Medicare as a Secondary Payer**

- When Medicare May Not Be Billed as Primary
  - Auto accident
  - Work Injury
  - Group Health Policy – 25/50 rule

**Medicare as a Secondary Payer**

- Personal Injury/Auto Accident
  - Must be billed to other parties first
  - 120 day wait rule
  - If paid by Medicare, lien on final settlement
Medicare as a Secondary Payer

- Work Injury
- Wait until final disposition of case
- Group Policy
- Only bill Medicare if the amount paid by Group Policy is below what Medicare payment would be based on Medicare allowable charge

Chiropractic Services CMS Basics

- CPT Codes paid by CMS to Chiropractors…
  - 98940 (Chiropractic Manipulation)
  - 98941 (Chiropractic Manipulation)
  - 98942 (Chiropractic Manipulation)

- CPT codes not paid by CMS to Chiropractors…
  - 98943 (Chiropractic Manipulation / Extraspinal)
  - All Exams, Therapies, X-rays, DME, etc.

CPT Codes Covered By Medicare

- CMT or Manipulation Codes
- Only 98940, 98941 and 98942

Non-Covered Services

- Statutorily Non-Covered
- Every other service provided except CMT
- Non-covered in this instance
- Maintenance CMT

Procedure Codes on Claims

- Box 24
  Date
  CPT Code
  Diagnosis Pointer
  Charge

Special Code Restrictions In Medicare

- 97010 – Bundled into CMT code, not billable to secondary/supplements
- 97014 – not recognized, replaced by HCPCS code G0283
Medicare covers only treatment by manual manipulation for a subluxation of the spine.
Local carrier determines how you report.
Except Florida, 739.X will be primary diagnosis.

Supporting neuromusculoskeletal diagnosis.
Supporting diagnosis list available from carrier.
Two diagnoses for each segmental level.
At least two diagnoses on a claim.

Examples 12 Visit Screen

**Group A Diagnoses**
- Covered for:
  - 307.81 TENSION HEADACHE
  - 723.1 CERVICALGIA
  - 724.1 - 724.2 PAIN IN THORACIC SPINE - LUMBAGO
  - Etc.

Examples 18 Visit Screen

**Group B Diagnoses**
Covered for:
- 720.1 SPINAL ENTHESOPATHY
- 729.1 MYALGIA AND MYOSITIS UNSPECIFIED
- 729.4 FASCIITIS UNSPECIFIED
- Etc.
Examples 24 Visit Screen

**Secondary Diagnosis Codes**  
**Group C Diagnoses**  
Covered for:  
- 353.0 - 353.4 BRACHIAL PLEXUS LESIONS - LUMBOSACRAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED  
- 353.8 OTHER NERVE ROOT AND PLEXUS DISORDERS  
- 723.0 SPINAL STENOSIS IN CERVICAL REGION

Examples 30 Visit Screen

**Secondary Diagnosis Codes**  
**Group D Diagnoses**  
Covered for:  
- 721.3 LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY  
- 721.41 - 721.42 SPONDYLOSIS WITH MYELOPATHY THORACIC REGION - SPONDYLOSIS WITH MYELOPATHY LUMBAR REGION  
- 721.7 TRAUMATIC SPONDYLOPATHY  
- Etc.

Modifiers

- Use in Box 24D  
- Multiples may be used  
- “Pricing” modifiers in first place

AT Modifier

- AT: Active treatment  
- Supporting documentation  
- Declares the covered service  
- Absent modifier will trigger denial

Other CMT Modifiers

- GA – ABN for this service that is normally covered, just not this instance  
- GZ – ABN not obtained as required through some error – no payment

What About S8990?

- The Health Care Procedure Coding System (HCPCS) is developed and maintained by CMS and consists of a letter followed by a series of numbers. The codes are categorized by the letter prefixes. The “S” codes are Private Payer Codes. The introductory paragraph of the Private Payer section states: “HCPCS “S” codes are temporary national codes established by the private payers for private payer use. Prior to using “S” codes on insurance claims to private payers, you should consult with the payer to confirm that the “S” codes are acceptable. “S” codes are not valid for Medicare use.”

- S8990 is defined as “physical or manipulative therapy performed for maintenance rather than restoration”. Maintenance care is not a covered service for Medicare beneficiaries. As such, we are not required to bill Medicare for maintenance care and would not require a specific code for that purpose.

- Not a single Medicare Administrative Contractor lists code S8990 in a Local Coverage determination. If this code is not listed in the LCD then it is not acceptable to use when billing chiropractic services.
Modifiers Required When Billing With An ABN

• Any procedures provided that require an ABN must be submitted with one of the following Medicare modifiers:
  – **GA Modifier:** Waiver of Liability Statement Issued as Required by Payer Policy. This modifier indicates that an ABN is on file and allows the provider to bill the patient if not covered by Medicare.
  – **GX Modifier:** Notice of Liability Issued, Voluntary Under Payer Policy. Report this modifier only to indicate that a voluntary ABN was issued for services that are not covered.
  – **GY Modifier:** Notice of Liability Not Issued, Not Required Under Payer Policy. This modifier is used to obtain a denial on a non-covered service. Use this modifier to notify Medicare that you know this service is excluded.
  – **GZ Modifier:** Item or Service Expected to Be Denied as Not Reasonable and Necessary. When an ABN may be required but was not obtained this modifier should be applied.

Modifiers for Statutorily Non-covered Services

• **GY** – Submitting a known non-covered service for the purpose of denial
• **GX** – Non-covered service, voluntary use of ABN declared

What is the PQRS System?

• Physician Quality Reporting System
• Established by Tax Relief and Health Care Act 2006
• Pay for reporting program
• Initially 74 individual measures, now 328 measures
• Only eligible professionals can report
• Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) made the PQRI program permanent
1. **Functional Outcome Assessment**: Was it performed? Was a treatment plan formed as a result?
   Measure #182

2. **Pain Scale**: Was it performed? Was it positive or negative? Was a follow-up plan created because of it?
   Measure #131

**Quality Codes for CMT**

- **G8539**: FOA done, care plan done
- **G8542**: FOA done, no deficit, no care plan needed
- **G8942**: FOA and Care plan done < 30 days ago
- **G8540**: Patient "not eligible" for assessment
- **G8541**: FOA not done, no reason
- **G8543**: FOA done, no care plan, no reason
- **G9227**: FOA done, care plan "not eligible"

**Pain Assessment Quality Code List 2014**

- **G8730**: Pain Assess. positive, follow-up planned
- **G8731**: Pain Assess. Neg., no follow-up needed
- **G8442**: Patient "not eligible" for assess.
- **G8939**: Pain Assessed, no follow-up, not eligible or appropriate
- **G8732**: No Assessment, no reason
- **G8509**: Pain Assess. Positive, no follow-up, no reason given

**What Charge to Bill Medicare**

- **Participating Providers**
  - May submit full fee and write-off down to allowable fee
  - May submit allowable fee

- **Non-participating Providers**
  - Must submit limiting charge
  - Will be reducing to non-par fee if taking assignment on individual basis

**Medicare Charges**

- Charges while in active care
- Charges while in maintenance care
- Medicare policies dictate compliance
Charges for Medicare

- Annual Fee Schedule
- Par Fee, Non-Par Fee, Limiting Charge
- Proposed Changes in Nov-Dec
- What you may charge

Poor Morris Medicare!

- Medicare is highly regulated
- How you deal with Medicare patients is highly scrutinized
- Make sure that “helping out poor Morris Medicare” doesn’t put you, your license, and your practice at risk

What We’ll Cover Today

- Understand what the limitations are on fees charged to Medicare patients
- Know what you MUST charge them for, and how to do it properly
- Find out the best ways to handle those Medicare beneficiaries with true hardship situations
- Learn about the choices you have as you consider what you will charge for Medicare Maintenance Care
- Be clear when it’s necessary to bill Medicare as a secondary payer and what you’re allowed to charge

You Must Bill Medicare

- When a Medicare patient receives coverable, AT modifier worthy care, the doctor must bill Medicare.
- When the patient is receiving maintenance care, they can elect through ABN whether that is to be submitted.
- Non-covered care MAY have to be submitted as well.

Medicare Patient Rights Rule

- You must bill when they ask you to, even non-covered services.
- Regardless of your participation level, the patient decides whether you bill Medicare.
- They can change their mind and you must comply.

Different Names for Different Fees

- Allowable fees – Fees permissible by health plans, or mandated programs such as Medicare, Medicaid or Workers Compensation and PIP
- Approved Amounts – The amount Medicare determines is reasonable for a service covered under Medicare Part B. It may be less than the actual charge.
Different Names for Different Fees

• **Contracted fees** – Fees agreed to under a managed care or preferred provider agreement
• **Regulated/Mandated fees** – Fees set by state and or federal programs such as Medicare, Medicaid, PIP and Workers’ Compensation
• **Hardship fees** – Your internal indigence policy

Charges: Participating Providers

- For (AT) Spinal CMT Codes Only
  - May submit full fee and write-off down to allowable fee
  - May submit allowable fee
    - Actual Fee: 98940 = $40
    - Allowable Fee: 98940 = $25
    - Medicare pays 80% = $20
- **Consurance** = $5
- **Write Off** = $15

Advantages of Participating

- Fee schedule is 5% higher than non-par provider
- Collections from patients are much easier
- Medicare will automatically forward Medigap claims to the proper secondary insurer
- Participation makes it easier for Medicare patients to see you since they don’t have to pay full fee up front

Charges: Non-Participating Providers

- For (AT) Spinal CMT Codes Only
  - Must charge and submit limiting charge
  - Equal to 115% of fee schedule
  - Will be reducing to non-par fee if taking assignment on individual basis

Advantages of Non-Participation

- Function more like a “cash based” practice
- Accept assignment only when you choose to
- Zero to limited A/R for Medicare
- Might discourage Medicare patients
- Attract patients ready to pay up front
Charges: Statutorily Excluded Services

- Medicare patients must be charged your ACTUAL fee for the services they pay for out of pocket
- If they qualify for a discount due to another program available in your office, they can be charged that fee

Medicare Advantage: Part C

- Dependent upon your participation
- Don’t risk becoming a deemed provider
- You set your policy and fee for this IF you are not involved with any plans
- Treat the patient like a cash patient

Secondary and Supplemental Insurance

- If the secondary will pay for excluded services
- If the secondary will only pay for allowable charges and fees
- Bill your fees as you would for Medicare
- Allowable vs. Limiting Fee for CMT

When Medicare is Secondary Payer

- Auto Accidents/No-Fault and other injuries
- If Medicare is involved, you may be limited to the Medicare Fee Schedule
- If primary pays more than Medicare would have, Medicare will not pay up to ACTUAL fee
- Very confusing, no written references
- Attorneys may cite this rule...ASK FOR REFERENCE!

Appeals At a Glance

<table>
<thead>
<tr>
<th>Appeal Level</th>
<th>Time Limit for Filing Appeal</th>
<th>Monetary Threshold to be Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIRST Redetermination</td>
<td>120 days from the date of the initial determination</td>
<td>None</td>
</tr>
<tr>
<td>Reconsideration by Qualified Independent Contractor (QIC)</td>
<td>6 months from the date of the review determination</td>
<td>None</td>
</tr>
<tr>
<td>THIRD Administrative Law Judge (ALJ)</td>
<td>Must be filed within 60 days of receipt of QIC decision</td>
<td>$149.00</td>
</tr>
<tr>
<td>FOURTH Appeals Council Review</td>
<td>Must be filed within 60 days of receipt of the hearing decision (oral/nonal)</td>
<td>None</td>
</tr>
<tr>
<td>FIFTH Judicial Review in U.S. District Court</td>
<td>Must be filed within 60 days of receipt of the Appeals Council decision</td>
<td>$5,000.00</td>
</tr>
</tbody>
</table>

25,000 Foot Overview

- Most denials will be for Medical Necessity or Screen violations
- There are five distinct steps to the Appeals process
- Sometimes, you may not have to appeal, but simply correct errors and resend
- Creating a system of appeals makes it easy to do
- System can also be used for MM denials and appeals
Why Wouldn’t You Appeal?

• WASHINGTON – More than half of all Medicare claims denial appeals are overturned by administrative law judges according to a recent report by the Office of Inspector General.
• Examining some 40,000 Medicare appeals filed in the 2010 fiscal year, the OIG found about 35,000, or 85 percent, were filed by hospitals, physicians and other providers, with about one-third filed by 96 “frequent filers” appealing at least 50 claims. One unnamed provider filed more than 1,000 appeals.
• About half of all appeals made it to the third appeals level of administrative law judges, or ALJs, the penultimate authority on Medicare claims appeals, following two levels of Medicare contractors and preceding the Medicare Appeals Council.
• The OIG found ALJs reversed 56 percent of appeals in favor of appellants, overturning appeals rejections by qualified independent contractors (QICs).

Level Zero

• You might not need to appeal
• There may be simple errors to correct
• The appeals process is more suited to MN denials
• Review the Reference Tool that will allow you to get the steps for level zero

Should You Be Appealing?

• Does the documentation in the record support your appeal?
• Do the definitions apply to this claim for necessity?
• Perform a mini-audit of the records first!

Level 1: Redetermination

• Within 120 days from original denial
• Use special form that is a part of this lesson
• Will be reviewed at the CARRIER (MAC) level
• Attach supporting documentation with the cover sheet we provide

Level 2: Reconsideration by Qualified Independent Contractor (QIC)

• Reviewed by independent third party
• Must be filed within 180 days of the denial from level one
• Two different QIC depending on state you live in
• Another special form must accompany
• Review the materials sent to Level One

Level 3 : Administrative Law Judge (ALJ)

• If $140 from all claims remains outstanding, you can escalate to ALJ. (2013)
• Can be on phone or in person
•Within 60 days of QIC decision
• QIC letter gives instructions for how to do this and fill out corresponding form
• You want to really make your case here
Level 4: Review by Medicare
Appeals Council

- Request submitted in writing within 60 days of ALJ decision
- No additional monetary threshold.
- Should issue a decision within 90 days
- At this level, you must have your collective ducks in a row
- Arguing points that must be clarified with data

Level 5: Judicial Review in Federal District Court

- Amount in controversy needs to be at least $1400 in 2013.
- Must file within 60 days of Medicare Appeals Council decision
- Your literal "day in court"

What to Collect from Patients

- Participating Physicians
  - Limited to allowable charge on covered CMT
  - May have to wait until all insurances process
  - May collect full fee on statutorily non-covered
  - May collect full fee on incidental non-covered services (maintenance CMT)

What to Collect from Patients

- Non-participating Physicians
  - Limiting charge amount when not accepting assignment
  - May collect at time of service
  - May collect full fee on statutorily non-covered
  - Limiting charge on incidental non-covered services (maintenance CMT)
  - Reduce to non-par allowable when accepting assignment

Limits on How You Charge Medicare Patients

- What You May Not Do:
  1. Waive charges to induce Medicare patients
  2. Give away any service or item of value greater than $10 up to 5 times per year

Risk Areas To Avoid

- Giving away or discounting services to beneficiaries of federally funded programs is an inducement and can expose you to fines and penalties.
But, I Want to Give Medicare Patients a Break on Fees!

- Office of Inspector General has been clear about this
- Never routine, never advertised, avoid inducement
- Look for legal and clean but simple ways to have your cake and eat it too

ChiroHealthUSA

- Membership discount plan
- Used for statutorily non-covered services
- No submission to insurance
- You set your office fee for all patients
- Can be used for incidentally non-covered services (maintenance CMT)

But, I Want to Give Medicare Patients a Break on Fees!

- Office of Inspector General has been clear about this
- Never routine, never advertised, avoid inducement
- Look for legal and clean but simple ways to have your cake and eat it too

We Recommend ChiroHealthUSA

- Membership discount plan
- Used for statutorily non-covered services
- No submission to insurance
- You set your office fee for all patients
- Can be used for incidentally non-covered services (maintenance CMT)
Simple, Clean and Legal

- Do you ever NOT recommend therapy because you know they have to pay?
- Would the patient get more complete health care if financial concerns were removed?
- They qualify for the discounted, network based fee schedule that YOU set.

Clear Understanding of Hardship and Discounted Fees

- Your hardship agreement can co-exist with other fee schedules.
- You must set the standard up front, have qualifying factors, and verify eligibility.
- Utilize a standardized form and system.

Co-Pay or Deductible Waivers for Hardship

- The waiver is not offered as part of any advertisement or solicitation;
- Waivers are not routinely offered to patients;
- The waiver occurs after determining in good faith that the individual is in financial need;
- The waiver occurs after reasonable collection efforts have failed.

Mistakes and Blunders

- What may NOT be financial hardship?
  - No insurance
  - High deductible
  - I don’t wanna pay that much
  - My other doctor didn’t charge my copays
  - Pulse and a spine

2013-2014 Financial Hardship Form

<table>
<thead>
<tr>
<th>2013 ANNUAL INCOME AND PERCENTAGE OF POVERTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family size</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
</tbody>
</table>

Notice: If patient is unable to pay for care, a last effort to collect must be made before being eligible for financial hardship. All forms are filled out by the patient or their legal representative.
But, I Want to Give Medicare Patients a Break on Fees!

- Office of Inspector General has been clear about this
- Never routine, never advertised, avoid inducement
- Look for legal and clean but simple ways to have your cake and eat it too

We Recommend ChiroHealthUSA

- Membership discount plan
- Used for statutorily non-covered services
- No submission to insurance
- You set your office fee for all patients
- Can be used for incidentally non-covered services (maintenance CMT)

We Recommend ChiroHealthUSA

• Membership discount plan
• Used for statutorily non-covered services
• No submission to insurance
• You set your office fee for all patients
• Can be used for incidentally non-covered services (maintenance CMT)

Simple, Clean and Legal

- Do you ever NOT recommend therapy because you know they have to pay?
- Would the patient get more complete health care if financial concerns were removed?
- They qualify for the discounted, network based fee schedule that you set.

Episodes of Care

- History Taken
- Activities of Daily Living
- Exam Reflects Diagnosis
- Functional Daily Notes
- Treatment Plan
- Re-Exam
- Discharge
- Re-Exam
Job 4--Dr. Fixing

- Clarify and execute your plan
- Goals are associated with the plan
- Medical necessity is clear, if necessary
- It's logical to expect to see the treatment coded that you chose

Get Right To It

- S = P  (Patient’s assessment per area)
- O = ART  (DC’s assessment per area)
- A = Doctor’s Assessment (How and Why)
- P = Plan for today (what was done)

Medicare Documentation Guidelines

Initial Visit
- History
- Description of Present Illness
- Physical Exam
- Diagnosis
- Treatment Plan
- Date of initial treatment

Subsequent Visits
- History
- Review of chief complaint
- Physical Exam
- Document daily treatment
- Progress related to treatment goals/plan

Subsequent Visits Documentation Requirements

- History: (29% Documentation Error Rate)
  - Review of Chief Complaint
  - Changes since last visit
  - System review if relevant

- Physical exam: (43% Documentation Error Rate)
  - Exam of area of spine involved in diagnosis – Objective (A, R, T)
  - Assessment of change in patient condition since last visit (PE, OA, ADL, QVAS) (Same, Better, Worse)
  - Evaluation of treatment effectiveness (Same, Better, Worse, How and Why)

- Daily Treatment Documentation: (15% Documentation Error Rate)

Medicare Documentation

To document the presence of a subluxation, and therefore, medical necessity for Medicare, you may utilize the PART process:

P- Pain or Tenderness
A- Asymmetry or Misalignment
R- Range of Motion Abnormality
T- Tissue Tone Changes

At least two of your findings must come from PART and one must be from the A or the R in order to appropriately document medical necessity!
P= Pain or Tenderness
- Observed facial expressions of pain or discomfort
- Antalgic postures and movements
- Grooming deficiencies that could be due to pain limitations
- Mood
- Overt pain behaviors
- Pain scales/Pain diagrams and drawings
- Functional questionnaires
- Pain resulting from static palpation
- Pain resulting from motion palpation
- Pain reported during regional and/or segmental range of motion tests
- Pain reported during physical, orthopedic, neurological, and/or chiropractic examination procedures
- Algometry

A= Asymmetry or Misalignment
- Observable region asymmetry (posture or scoliosis screening)
- Observed local asymmetry (static palpation)
- Antalgic posture
- Gait abnormalities
- Functional or anatomical leg length discrepancies
- Muscle atrophy and asymmetry

R= Range of Motion Abnormality
- Active ROM (observed and estimated)
- Passive ROM
- Resisted ROM
- Segmental motion palpation
- Joint fixation (hypomobility)
- Joint laxity (hypermobility)
- Joint crepitus
- ROM measurements

T= Tissue Tone Changes
- Observable hypertonicity, spasm, hypotonicity, and atrophy
- Fascial tone
- Edema
- Bruising, discoloration
- Heat
- Muscle-tendon crepitus
- Muscle weakness
- Heat measuring instruments

Active Complaints: Self-Assessment
- Daily documentation must include your patients’ self-appraisals
- What is their condition today?
- How have their functional deficits changed since their last visit?

Daily Documentation Must Include Patients’ Self-Appraisals
- Know your functional deficits so you can focus your conversation on how they have changed.
  - Better
  - Worse
  - Same
  - Measurable
Master Internal Systems that can Streamline this Process

- Team member driven documentation
- They gather relevant data
- You review out of sight of the patient then...
- You lead the conversation
- Save as much as an hour a day

Best Practices for Gathering Functional Self-Assessment

- First, train them that it is their job to be observant about their functional deficits
- Help them understand that measurable information helps you to assist them in faster improvement

---

**DAILY VISIT NOTE**

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Visit #</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Conditions/Conditions being treated with accompanying treatment goals:**

- PT Compliant
- TD Compliant
- TD Compliant
- TD Compliant

---

**DAILY VISIT NOTE**

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Visit #</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Conditions/Conditions being treated with accompanying treatment goals:**

- PT Compliant
- TD Compliant
- TD Compliant
- TD Compliant

---

**DAILY VISIT NOTE**

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Visit #</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Conditions/Conditions being treated with accompanying treatment goals:**

- PT Compliant
- TD Compliant
- TD Compliant
- TD Compliant

---

**DAILY VISIT NOTE**

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Visit #</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Conditions/Conditions being treated with accompanying treatment goals:**

- PT Compliant
- TD Compliant
- TD Compliant
- TD Compliant
O = ART = Doctoring

- Objective findings will quantify Subjective
- Complete for each region you intend to treat
- Use of A-R-T makes it easy and predictable
- Find your groove

Best Practices for Defining your Doctor’s Assessment

- Remember it is all about Function, Function, FUNCTION
- Identify HOW the patient has improved
- Identify WHY they need continued care
- That is Medical Necessity by definition!

Best Practices for your Plan of Action

- This is the fun part
- This is that you went to chiropractic college to learn
- Treat your patient
- Remember to treat per your treatment plan
Subjective?? NOT!

Subjective:
The patient said that overall she is feeling the same since her last visit.

Objective?? Really?

Objective:
I reviewed the recent testing and diagnostic results with the patient. 30 minutes.

Multiple subluxations with spasm, hypomobility and end point tenderness were found and adjusted at the following levels: right C1, left C4, right T2, T3, right T12, right L2 and left pelvis.

Palpation of the muscles revealed spasm in the following areas: right cervical dorsal area, right upper thoracic area, left upper thoracic area, right lower thoracic area, left lower lumbar area, right lower lumbar area and left lower lumbar area.

The posture evaluation revealed the following: a head tilt to the left, high right pelvis, high left shoulder and rotation off the trunk to the left.

Active trigger points were discovered in the cervical musculature, suboccipital, subscapular, subdeltoid, lumbar paraspinals, and pelvis area. Patters are common in these areas and are normal when treated.

Arranging a spine in a position that stretches the muscles and moves them out of their position eliminated most of the pain.

A sedate treatment included the use of a small container with a warm towel. The towel was positioned against the skin and allowed the muscle to relax.

Complications: 1. An elevated blood pressure was discovered and adjusted in the sitting and lying position.

Assessment?? Guarded?

Assessment:
Subjective:

The patient's progress is guarded and uncertain at this time. There was no change after the adjustment. This means that there is a 60% chance of a need for long-term treatment. It also means that there is a 60 to 80% chance of long-term results of Natalie's primary presenting musculoskeletal, orthopedic and neurological complaints.

Objective:

A patient's progress is guarded and uncertain at this time. There was no change after the adjustment. This means that there is a 60% chance of a need for long-term treatment. It also means that there is a 60 to 80% chance of long-term results of Natalie's primary presenting musculoskeletal, orthopedic and neurological complaints.

Subjective:
The patient continues to complain about soreness in the low back, and difficulty moving her neck since the automobile accident. She also complained about pain in the right shoulder, and pain in the right anterior hip with flexion.

Objective:

Multiple subluxations were adjusted and noted with spasm, hypomobility and end point tenderness in the cervical, dorsal, lumbar and sacroiliac regions. An extremely subluxation was adjusted in the right hip.

Cold laser therapy was applied to both rotator cuff, cervical region, and lumbar region while doing specific movement to increase blood flow, reduce inflammation and pain, and increase range of motion, joint stability and coordination of the involved areas.

Percussion Therapy was used on the lumbosacral and adductors regions to increase the functional performance and range of motion and decrease inflammation and muscle spasm in the involved areas.

Assessment:
The patient's progress is guarded at this time.

Plan:

We will continue to adjust the patient as per the examination findings and continue the existing treatment plan. It is recommended that the patient return for treatment on Wednesday.
Maintenance

Preventative or maintenance care defined as care to reduce the incidence or prevalence of illness, impairment, and risk factors and to promote optimal function.
Episodes of Care

- History Taken
- Discharge Summary
- Functional Daily Notes
- Treatment Plan

Maintenance

- **Wellness**
  - Prevent disease
  - Promote health
  - Enhance the quality of life
- **Supportive**
  - Maintain or prevent deterioration of a chronic condition

_**Basic Daily Note**_

**Daily Encounter:** treatment for acutely active care
- **Complaint:** #1 posterior cervical neck and lumbar dull and aching discomfort.
- **Subjective/Physical Assessment:** Ryan stated this complaint has lasted the same since last the visit. A pain assessment of 6/10 using a Visual Analogue Scale (only if reporting pain score).

**Daily Objective Findings:**
- **Neurological/Substance:** C4, C5, C6, L4, L5 and right peroneal
- **Postural/Alignment:** Seated forward flexed, head down, right shoulder, and lumbar curve to the right
- **Neurologic Function:** Bilateral sciatic symptoms, right greater than left, right lower extremity weakness and right thigh pain.

**Daily Assessment:** showing improvement and meeting expectations as indicated in today’s subjective.
- **Current Status:** Improving because he is reporting less discomfort and is showing improved function.

**Today’s Treatment:**
- **Complaint:** #1 posterior cervical neck and lumbar

  **Primary Treatment:** Chiropractic Technique—Manoeuvres (C7) to the C4, C5, C6, L5, sacrum and right peroneal (
  - **Supportive Therapy:** to optimize treatment effectiveness for complaint #1: EBM Unattended low volt EM applied to left side of neck, right side of neck, left lumbar, right lumbar, left sacroiliac and right sacroiliac region(s) for 10 minutes.

  **Supportive Therapy:** to optimize treatment effectiveness for complaint #1: Hot Pack, hot moist pack

**Subluxation Documentation Policy**
It is the policy of this office to manage our patient and render the best care possible by using the least appropriate technique. According to Thompson, (1984), Chiropractic technique, because this selected technique has protocols that involve treatment of the spine, regardless of the chief complaint, the patient may be presenting with, we will define this policy and in our procedure exactly how we will delineate the difference between a primary Subluxation and any secondary Compromise that may be addressed and managed during the patient visit.

We will do a comprehensive history, examination, and the required clinical decision-making to determine the diagnosis and set forth the treatment plan for any patient we see treating an active condition. In this process, we will clearly define/identify in our treatment plan the primary areas of Subluxation. Because our chosen chiropractic technique requires clearing or addressing areas of the body other than the primary areas of subluxation, we understand it critical for us to identify and differentiate Subluxations from other areas of Compression that need to be addressed to stability, resolve and/or remove the primary Subluxations.

We will always identify every area that is addressed in our Daily Visit (SOAP) Notes to meet the documentation requirement of our license. Additionally, we will further identify the levels of subluxation (as defined in our Daily Visit Notes, Documentation SOP) to make it easier for anyone to understand the patient's condition.
Graduation to Maintenance Care

- Medicare patients will likely move in and out of active treatment while a patient in your office.
- Have a clear understanding of the definition of maintenance care and follow the rules.

Maintenance

CMS defines Maintenance Therapy as: "Chiropractic maintenance therapy is not considered to be medically reasonable or necessary under the Medicare program, and is therefore not payable. Maintenance therapy is defined 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. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy."

Episodes of Care

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

Three Choices for Fees in Maintenance Care

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

Option One: Medicare Allowable/Limiting Fee

- 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
**Should I Consider This Option?**

**Pros**
- Super simple for the front desk and the patient
- Much easier to explain when maintenance care begins
- Doesn’t feel confusing to the patient since the fee is the same all the time

**Cons**
- The doctor won’t be able to collect actual fee, even for maintenance care CMT

---

**Option Two: Charge Actual Fee for Maintenance Care**

50.7.3 - Effects of Lack of Notification, Medicare Review and Claim Adjudication
(Rcv. 2782, Issued: 09-06-11, Effective: 12-09-11, Implementation: 12-09-11)

**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.

Notifies may not issue ABN to a beneficiary as a beneficiary when full payment is made through bundled payments. In general, ABN cannot be used where the beneficiary would otherwise not be financially liable for payment for the service because Medicare made full payment. See 50.15 for information on collection of funds.

---

**Sample Policy: Option Two**

This office’s providers are (participating/non-participating) with Medicare. We locate the published, regulated fee schedule applicable to our office on our Medicare carrier’s website on an annual basis and update our allowable fees accordingly. Choose one: As a participating provider, we bill our published, actual fee for each of the three spinal CMT codes during active treatment submitted to Medicare. When payment is allowed by Medicare, we take the appropriate contractual write offs as directed on the Explanation of Medicare Benefits, charging the Medicare patient ONLY the applicable co-insurance or applied deductible fees. OR As a non-participating provider, we bill the Medicare Limiting fee for each of the three spinal CMT codes during active treatment.

If a Medicare patient elects to receive Chiropractic Manipulative Treatment services that the provider deems are likely to be denied by Medicare, this patient will indicate their choice on the appropriate Medicare Advance Beneficiary Notice (ABN) form. If the patient qualifies for discounts under our available Hardship Policy or a Discount Medical Plan Organization (DMPO), we may participate in that fee schedule will be extended to the patient. In addition, this office will charge and attempt to collect any and all deductible and co-insurance due from the patient.

---

**Collect Actual Fee for Maintenance CMT**

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

---

**Sample Policy: Option One**

This office charges our full and actual published fee schedule for these services. If the patient qualifies for discounts under our available Hardship Policy or a Discount Medical Plan Organization (DMPO) we may participate in, that fee schedule will be extended to the patient. In addition, this office will charge and attempt to collect any and all deductible and co-insurance due from the patient.

---

**Should I Consider This Option?**

**Pros**
- The doctor can collect actual fee, rather than this limited fee schedule for maintenance care.

**Cons**
- Patients may have difficulty understanding the increase
- They may already have confusion around the maintenance concept, and could have pushback around increased fee
- Confusion can lead to calling Medicare raising a flag
- Par providers may go from as small a copayment as 5 to all the way to 50%
Option Three: Publish A Maintenance Fee Schedule Anyone Can Access

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

Sample Policy: Option Three

This office's providers are participating/non-participating with Medicare. We calculate the published, regulated fee schedule applicable to our office on our Medicare carrier's website on an annual basis, and update our allowable fees accordingly. (Choose one): As a participating provider, we bill our published, actual fee for each of the three spinal CMT codes during active treatment submitted to Medicare. When payment is allowed by Medicare, we take the appropriate contractual write offs as directed on the Explanation of Medicare Benefits, charging the Medicare patient ONLY the applicable portion of the maintenance fee. When Medicare payment is denied by Medicare, we charge the Medicare patient the Medicare Limiting fee for each of the three spinal CMT codes during active treatment.

All other treatment rendered in the office is considered to be statutorily non-covered under Medicare. Therefore, the office charges our full and actual published fee schedule for these services. If the patient qualifies for discounts under our available Hardship Policy or a Discount Medical Plan Organization (DMPO) we may participate in, that fee schedule will be extended to the patient. In addition, this office will charge and attempt to collect any and all deductible and co-insurance due from the patient.

If a Medicare patient elects to receive Chiropractic Manipulative Treatment services, that the provider deems are likely to be denied by Medicare, this patient will indicate their choice on the appropriate Medicare Advance Beneficiary Notice (ABN) form, and will be informed of the fee for the service prior to treatment. This office has a published "maintenance" fee schedule that is offered to any patient receiving maintenance care that is excluded services under Medicare. They will be charged this maintenance fee during any maintenance care and we will collect this fee from the patient. If it's billed to Medicare, the fee will be represented as the amount of the maintenance fee actually charged, and not any other fee.

Should I Consider This Option?

Pros
- Patient has likely already joined DMPO for excluded services—easy transition
- Much easier to explain when maintenance care begins
- Doesn't feel confusing to the patient since the fee is for "maintenance"

Cons
- Lots of confusion in this area about whether one can assign a maintenance fee outside of a DMPO
- Requires LOTS of explanation to the patient about what is maintenance
- Maintenance adjustments cost the same as active treatment to the practice

The Three Most Important Considerations

- You must CHARGE correctly...use the correct fee schedule
- You must BILL it correctly...use the right fee whether billing patient OR carrier
- You can COLLECT according to your policies

What Makes a Payment Plan Compliant?

- Use of proper fees to calculate patient responsibility
- Appropriate estimate of medically necessary care to be paid by 3rd party
- Automated payments from credit card handled properly
- No discounts given on 3rd party reimbursable portion of care

Medicare Payment Plans

- Once you have charged and billed correctly, you may collect according to your written policy
- OK to allow them to pay their portion on a monthly payment plan
- OK to incentivize excluded services 5-15% if prepaid…but we discourage this
Payment Plans = Opportunities

- Patients on payment plans:
  - stay under care longer
  - tend to get all the care they need, including rehab and other items
  - are more likely to have family under care

Mastery of Medicare Charges and Fees

- Understand and implement these options into your Fee System
- Write appropriate policy based on your decision
- Practice explaining these fees at the various touch points necessary
- Make Medicare one of the easiest demographics in your practice!

Need Help?
info@kmcuniversity.com