Medicare, Coding and Billing…. Oh My!
Kathy Mills Chang, MCS-P, CCPC, CCCA
Sponsored by Foot Levelers

Where in the World is my MAC?

What Does a MAC Do?
A Medicare Administrative Contractor (MAC) is a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee- For-Service (FFS) beneficiaries.

What Does a MAC Do?
CMS relies on a network of MACs to serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program. MACs are multi-state, regional contractors responsible for administering both Medicare Part A and Medicare Part B claims.

What Does a MAC Do?
• MACs perform many activities including:
  • Process Medicare FFS claims
  • Make and account for Medicare FFS payments
  • Enroll providers in the Medicare FFS program
  • Handle provider reimbursement services and audit institutional provider cost reports
  • Handle redetermination requests (1st stage appeals process)

• Respond to provider inquiries
• Educate providers about Medicare FFS billing requirements
• Establish local coverage determinations (LCD’s)
• Review medical records for selected claims
• Coordinate with CMS and other FFS contractors

Like Any Other Government Contractor

Summary of Section 503 of MACRA of 2015
The Medicare Access and CHIP Reauthorization Act (MACRA) enacted on April 16, 2015, included language in Section 503 that limits Medicare Administrative Contractors (MAC) contract terms from five to ten years. The legislation also requires the Agency to publish on()!=’information’@€or each MAC to the extent that such information does not interfere with contract procurements. The legislation applies to all contracts in effect at the time of enactment, meaning that current MAC contracts in place can be extended another five years to a maximum of ten. This also means that the Agency is required to immediately make public performance information on each MAC. Read the full text of this legislation at Public Law No. 114-10.
DME Handled by Different MAC

Do You Know Your Carrier?

- What can you do on your carrier’s website?
  - Look up fee schedules
  - Review policy and procedure
  - Find your LCD
  - Sign up for bulletin board notices
  - Get training
  - Use the IVR

Look Up Fee Schedules

Largely a Self-Serve Process

Physician’s Fee Schedule Code Search & Downloads

Search using a single code
- Procedure Code: 98940
- Date Of Service: 7/1/2016
- State: Colorado
- Locality: Entire State (01)
- Search

Look Up for 98940

Chiropractic Lookups
Specific Training: Basic and Chiropractic

Verification and the IVR

Lots of Items to Self-Serve

Partner with Your MAC

Objectives

Why Verify Medicare?
Provider Numbers and Medicare

MEDICARE ENROLLMENT APPLICATION
REASSIGNMENT OF MEDICARE BENEFITS

CMS-855R

NPI Numbers

• National Provider Identifier: both personal and group
• A unique identification number for covered health care providers
• HIPAA established this number
• Is a 10-position, intelligence-free numeric identifier
• The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions

PTAN Numbers

• Provider Transaction Access Number
• MAC’s Provider Enrollment department issues to Medicare Providers
• The PTAN is the same number as a previously issued Unique Provider Identification Number (UPIN)

Tax-ID Number

• With Medicare, all numbers are assigned to the group if there is one
• Your federal ID number is the master number that identifies your practice
• All other numbers are attached to that

Types of Medicare Coverage: Part B

• Basic Medicare Part B coverage is what the majority of the senior population have
• Medicare Part B is optional
• Will usually be primary coverage

Types of Medicare Coverage: Part C

• Also known as Medicare Advantage Plans or Replacement Plans
• Better known as the “Managed Care Medicare”
• Redirected benefit to a private carrier
• Will not have Part A or B
Types of Medicare Coverage: Supplemental

- Purchased by the beneficiary to cover the “gap”
- 10 different standardized plans available
- You must know which of the 10 your patient has
- Most common covers only the 20% of allowable charges

Crosswalk Feature

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

Types of Medicare Coverage: True Secondary

- Resembles eligible group health plans (GHP)
- Could be from retirement benefits
- Often behaves like a GHP rather than a supplemental

Verify ALL Coverage

- Confirm Medicare Part B eligibility
- Confirm secondary or supplemental eligibility
- Confirm actual chiropractic benefits for any secondary or supplemental
- If Medicare Part C confirm all benefits

Online vs. IVR vs. Phone

- You have to get the answers you want
- What will the patient be responsible for?
- Eligibility is one thing, benefits are another
- Secondary, Supplemental and Part C—biggest errors we see
Master Medicare

Customize Your Form

• Customize a master
• “Save as” or print
• Keep your original unedited file for future use
• Print a group of masters to have on hand, ready for verification

These Numbers Won’t Change

NOTE: If you have more than one provider for whom you verify, make a master verification for each provider. List the Provider’s Name next to the NPI number
Use This Section to Rule In/Rule Out

Section B - Identify Coverage

- Auto Accident? Yes ☐ No ☐ Work Injury? Yes ☐ No ☐ Personal Injury? Yes ☐ No ☐
- If any Yes responses above, Medicare is secondary. If so, go to Major Medical Insurance Verification Form 1st and verify other insurance as primary.
- Patient is working aged? Yes ☐ No ☐ Patient’s spouse is working aged? Yes ☐ No ☐
- If any Yes responses above, Medicare may be secondary. If so, use Major Medical Insurance Verification Form to verify primary insurance.
- Patient has Medicare Advantage Card (This is Part C Coverage)? Yes ☐ No ☐
- If Yes, go to Section D - Medicare Advantage Verification.
- Patient has Medicare card? Yes ☐ No ☐ Insured Medicare card? Yes ☐ No ☐
- If Yes, go to Section C - Medicare Coverage Verification.

Verify Traditional Medicare

Section C - Medicare Coverage Verification

- Number Calls: ☐ ☐ ☐ Time: ☐ ☐ ☐ Date: ☐ ☐ ☐ ☐
- Used IVR Yes ☐ No ☐ Used Online Service Yes ☐ No ☐
- Insurance Match on Card Yes ☐ No ☐ Effective Date: ☐ ☐ ☐ ☐
- Medicare Deductible remaining this year: ☐ ☐ ☐ ☐ ☐
- Address match verified Yes ☐ No ☐
- Supplemental/Secondary Information available Yes ☐ No ☐ (Section E)
- Part B Expiration date? Yes ☐ No ☐ If Yes, this may mean the patient is enrolled in a Medicare Advantage Plan. Please confirm with provider.

NOTE: Use the IVR, the online service, or call the provider services phone number. Have your Carrier and Verification Reference Tool handy.

Verify Secondary/Supplemental

Section E - Secondary/Supplemental Coverage

- Carrier Name: AARP United Healthcare
- Phone Number: 1-800-336-3768
-Subscriber ID: 243-567-146
- Relationship to Patient: Self ☐ Spouse ☐ Other ☐
- Deductible: $1500 ☐ Yearly ☐ Monthly ☐
- Maximum per day: ☐ $1500 ☐
- Automatic Crosscover established? Yes ☐ No ☐
- Follows Medicare guidelines? Yes ☐ No ☐
- Covers statutorily non-covered service? Yes ☐ No ☐

NOTE: When the Secondary carrier’s coverage mirrors Group Health Insurance (GHP) such as covering all chiropractic services, opt to use the GHP verification form to collect all pertinent data.

Use Your Custom Fields

Section F - Custom

- Do you cover acupuncture, when performed by a DC? ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Verify Medicare Advantage Plan

Create Master Templates for Common Carriers

- If you deal with certain carriers a lot, create a template
- Customize the benefits into a master
- Personalize for each patient
- Always confirm and verify each patient

The Mandatory Advance Beneficiary Notice (ABN)

Let’s Start at the Very Beginning!...(A Very Good Place to Start!)

- 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.

Mandatory ABNs are Only for Spinal CMT Codes!

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
**Episodes of Care**

- History Taken
- Functional Daily Notes
- Functional Daily Living
- Social Stabilization
- Treatment Plan

**Maintenance**

- Wellness
- Prevent disease
- Promote health
- Prolong/enhance the quality of life

- Supportive
- Maintain or prevent deterioration of a chronic condition

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**Advance Beneficiary Notice of Noncoverage (ABN)**

- Must be signed when you believe a covered service (CMT) may not be covered on this visit.
- Triggering Events
- Should be filled out in front of the patient indicating the reasons are for assuming the service is going to be denied.
  - Medicare never covers this many visits for this diagnosis
  - Medicare never covers more than one visit in the same day
  - Medicare never pays for maintenance care
  - My carrier has a published screen and this patient has exceeded the screen

**From the Horse’s Mouth!**

**WHAT IS AN ABN?**

An ABN, Form CMS-R-131, is a standardized notice you or your designee must issue to a Medicare beneficiary before providing certain Medicare Part B (outpatient) or Part A (limited to hospice, home health agencies [HHA], and Religious Nonmedical Healthcare Institutions only) items or services. You must issue the ABN when:

- You believe Medicare may not pay for an item or service;
- Medicare usually covers the item or service; and
- Medicare may not consider the item or service medically reasonable and necessary for this patient in this particular instance.

**Mandatory ABN Use**

**WHEN MUST I ISSUE AN ABN?**

**Mandatory ABN Uses**

You must issue an ABN when:

- You expect Medicare to deny payment for an item or service because it is not reasonable and necessary under Medicare Program standards;
- Medicare considers the care to be custodial care;
- Outpatient therapy services are in excess of therapy cap amounts and do not qualify for a therapy cap exception;
- A patient is not terminally ill (for hospice providers only); or
- Home health services requirements are not met: for example, the individual is not confined to the home or does not need intermittent skilled nursing care (for HHA providers).
The Patient Chooses an Option

Option 1, 2, or 3 (G)

The beneficiary, or his or her representative, must choose only one of the three options listed. Medicare does not permit you to make this decision.

- If Option 1 is chosen:
  - The beneficiary wants to get the item or services at issue and accepts financial responsibility. He or she agrees to make payment now, if required. You must submit a claim to Medicare that will result in a payment decision that the beneficiary can appeal.

  NOTE: If the beneficiary needs a Medicare claim denial as secondary insurance plan to cover the services, the beneficiary should select Option 1.

- If Option 2 is chosen:
  - The beneficiary wants to get the item or services at issue and accepts financial responsibility. He or she agrees to make payment now, if required. You do not submit a claim to Medicare at the beneficiary’s request. When the beneficiary chooses this option, you do not file a claim and there are no appeal rights.
  - You will not violate mandatory claims submission rules under Section 1848 of the Social Security Act when you do not submit a claim to Medicare at the beneficiary’s written request when he or she selects this option.

Modifiers Required When Billing CMT

- **AT Modifier:** Your assertion that the care is deemed “active”, is reimbursable, and you expect payment from Medicare.
- **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.
- **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.

Do Not Use Every Visit!

**WHEN AM I PROHIBITED FROM ISSUING AN ABN?**

What is the Routine Notice Prohibition?

Medicare prohibits you from issuing ABNs on a routine basis (i.e., where there is no reasonable basis for Medicare to not cover the item or service). You must ensure that a reasonable basis exists for noncoverage associated with the issuance of each ABN. Some situations may require a higher volume of ABN issuance, and as long as proper evidence supports each ABN use, you will not be violating the routine notice prohibition.

May I use an ABN to bill a beneficiary for services denied due to a Medically Unlikely Edits (MUE)?

No, you cannot use an ABN to bill liability and bill the beneficiary for the services denied due to an MUE. For more information on MUEs, visit http://www.cms.gov/Medicare/Coding/NationalCorrectCodesList/MUE.html on the CMS website.

The Dirty Details

**How Do I Effectively Issue an ABN?**

Medicare considers issuance of an ABN effective when the notice is:

- Issued (preferably in person) to and comprehended by a suitable recipient;
- The approved, standardized ABN with all required blanks completed;
- Provided far enough in advance of potentially noncovered items or services to allow sufficient time for the beneficiary to consider available options;
- Explained in its entirety with all questions related to the ABN answered; and
- Signed and dated by the beneficiary or his or her representative after he or she selected one option box on the ABN.
Inquiring Minds Want to Know

WHAT DO I DO WITH THE VALID ABN?

In general, you should keep the ABN for 5 years from the date-of-care delivery when no other requirements under state law apply. Medicare requires you to keep a record of the ABN in all cases including those cases in which the beneficiary declined the care, refused to choose an option, or refused to sign the ABN.

When Do I Need to Issue Another ABN for an Extended Course of Treatment?

You may issue a single ABN to cover an extended course of treatment if the ABN identifies all items and services and the duration of the period of treatment for which you believe Medicare will not pay. If the beneficiary receives an item or service during the course of treatment that you did not list on the ABN and Medicare may not cover it, you must issue a separate ABN.

A single ABN for an extended course of treatment remains valid for no more than 1 year. If the extended course of treatment continues after a year’s duration, you must issue a new ABN.

Active Says YOU...or Maybe Not!?

• Carrier may have published screen
  • > 12 CMT in 1 month
  • > 24 CMT in 12 months
  • > amount of CMT for given 2nd diagnosis
• GA modifier is used if ABN is signed and filed
• AT modifier is used if you think it’s active

Patient Friendly Medicare Education

• Patient Friendly Language
• Looks “Medicare Official”
• Starts the process on the right foot

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What About AT-GA Modifiers?

A Simple Solution

• Know WHEN an ABN is necessary for CMT
• Understand the details of when care is active vs. maintenance
• Use the ABN form correctly
• Sharpen your scripting and know the answer before the questions

Master the ABN Process
The Voluntary Advance Beneficiary Notice (ABN) Form

A KMC University Rapid Tutorial

Let’s Start at the Very Beginning!... (A Very Good Place to Start!)

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Mandatory ABNs are Only for Spinal CMT Codes!

GA Modifier

But Do I Need One for Non-CMT Services?

Voluntary Use = “MAY I?”

When May I Issue an ABN?

Voluntary ABN Uses

Medicare does not require ABNs for statutorily excluded care or for services Medicare never covers. However, in these situations, you may issue an ABN voluntarily. Refer to the “What Claim Reporting Modifiers Do I Use?” section at the end of this booklet for information on claim modifiers associated with voluntary ABN use.
ABN for Voluntary Use

You should only provide ABN's to beneficiaries in a hospital (For-Fee-Service) Medicare. The ABN allows the beneficiary to be a party to a decision whether to get services and accept financial responsibility for them. If the patient is not enrolled in Medicare, the ABN serves as proof that the beneficiary knows and understands that Medicare might not pay. If you do not issue an ABN to the beneficiary, you cannot bill the Medicare for the service and you may not charge the beneficiary.

The ABN also serves as an optional (voluntary) notice to beneficiaries of their financial liability prior to providing care that Medicare does not cover. Medicare does not require you to issue an ABN in order to bill a beneficiary for an item or service that is not a Medicare benefit and never covered.

- When you issue the ABN as a voluntary notice, the beneficiary does not check an option box or sign and date the notice.

Option One: Do Nothing

Option Two: Use Medicare’s Official Form

ABN for Voluntary Use

Your Options for Advance Notice for Statutorily Excluded Services in Medicare

Option One: Do Nothing

Option Two: Use Medicare’s Official Form
Option Three: Make Your Own Notice

DO IT YOURSELF

Option Four: A Better Way

BETTER WAY

Patient Friendly Medicare Education

• Patient Friendly Language
• Looks “Medicare Official”
• Starts the process on the right foot

www.patientmedia.com/medicare
GY Care Does Not *Have* to Be Billed to Medicare

- A patient may decide whether or not statutorily non-covered services are submitted.
- If the patient asks you to bill Medicare, you must.
- Why would we want to do that?

Modifiers Required When Billing Non-Spinal CMT Services

- **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.
- **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.
- **GP Modifier**: Service is part of an active therapy program (Non-ABN specific).

Voluntary ABNs Can Work

- Create your strategy now.
- Decide how and when you’ll notify.
- Don’t use the official form, it’s confusing.
- Sharpen your scripting and know the answer before the questions.

How Medicare Works with Chiropractic

Basic History of Chiropractic in Medicare

- In 1972, Congress passed Public Law 92-603, which amended section 1861(r) of the Social Security Act (the Act) to define chiropractors as physicians who are eligible for Medicare reimbursement, but only for manual manipulation of the spine to correct a subluxation, or malfunction of the spine.
- Federal regulations (42 CFR § 410.21(b)) further limit Medicare payment to treatment of subluxations that result in a neuromusculoskeletal condition for which manual manipulation is appropriate treatment.
- In addition to these specific provisions, sections 1862(a)(1)(A) and 1833(e) of the Act require that all services billed to Medicare, including chiropractic manipulations, be medically necessary and supported by documentation.

History and Basics

- Chiropractic added to Medicare in 1972.
- Under the auspices of Dept. of Health and Human Services (HHS).
- Administered by Center for Medicare and Medicaid Services (CMS).
Basics of Medicare

• Chiropractic experienced considerable growth in Medicare, from 11.2 million services and $255 million allowed in 1994 to 21 million services and $683 million allowed in 2004.


Chiropractic Services CMS Basics

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  • All Exams, Therapies, X-rays, DME, Etc.

What’s the Same?

• DCs can be participating or not
• DCs are physicians
• CMT codes are a covered service under Medicare
• DCs use the same carriers as other Part B physicians
• DCs have LCDs like other Part B physicians
• DCs must document to the required standard like other Part B physicians

What’s Different about Chiropractic?

• DCs can not “opt out” of Medicare
• DCs only have three covered services
• DCs must use subluxation DX codes along with a secondary
• DCs can’t order any service other than CMT outside of the office
• DCs must document a subluxation on x-ray or with PART, but x-rays are not paid by Medicare for DCs

FACT SHEET

Opting Out of the Medicare Program

Q: Are chiropractors allowed to Opt-Out of the Medicare Program?
A: No. By definition of the CMS CR 5428 the term “physician” is limited to doctors of medicine; doctors of osteopathy; doctors of dental surgery or of dental medicine; doctors of podiatric medicine; and doctors of optometry who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the State in which such function or action is performed, no other physicians may opt out.

“The opt-out law does not define “physician” to include chiropractors; therefore, they may not opt out of Medicare and provide services under private contract. Physical therapists in independent practice and occupational therapists in independent practice cannot opt out because they are not within the opt-out law’s definition of either a “physician” or “practitioner.” (Rev. 62, issued: 12-22-06. Effective: 11-13-06, Implementation: 04-02-07).

DCs Use AT Modifier

Which Came First?

Clinically Appropriate

• Generally accepted standards of medical practice
• Within the Doctor’s scope of practice
• Based on credible scientific evidence
• May be the patient’s financial responsibility!

Medically Necessary

“The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient’s condition and provide reasonable expectation of recovery or improvement of…”

How Is Care Defined?

Active and Maintenance Care

Incidents, bursts, and episodes of care will happen throughout the patient’s experience in your office

Chiropractic Services CMS Basics

“Chiropractic service which is eligible for reimbursement, is specifically limited by Medicare to the treatment by means of manual manipulation (i.e., by use of the hands or use of manual devices that are hand-held, with the thrust of the force of the device being controlled manually) of the spine for the purpose of correcting a subluxation.”

Chiropractic Services Defined

• A subluxation usually falls into one of two categories:
  • Acute, such as strains and sprains
  • Chronic, such as loss of joint mobility
Diagnosis for Medicare Claims

- The primary diagnosis must be subluxation (except FL)
  Subluxation M99.0x
- Supporting musculoskeletal diagnosis Causal from subluxations, such as disc degeneration

CMS Subluxation Definition

“For Medicare purposes, subluxation is defined as a motion segment in which alignment, movement integrity and/or physiological function of the spine are altered although contact between joint surfaces remains intact.”

Acute Treatment

CMS defines Acute as: “A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression of, the patient's condition.”

Chronic Treatment

CMS defines Chronic as: “A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.”

Maintenance Therapy

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 payabe. 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.”

PART is only a Piece of the Picture

- Many chiropractors believe by documenting PART they have proven medically necessity for care
- PART is a very small (but important) element to Medicare documentation
- Medicare wants a lot more than documentation of PART only
What Does PART Mean, Anyway?

**Pain/tenderness** evaluated in terms of location, quality, and intensity;

**Asymmetry/misalignment** identified on a sectional or segmental level;

**Range of motion abnormality** (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); and

**Tissue, tone** changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

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Required PART Elements

- **Asymmetry or Misalignment**
  - Combine this with at least one of:
    - Range of Motion Abnormality
    - Pain
    - Tissue/Tone

- **Range of Motion Abnormality**
  - Combine this with at least one of:
    - Asymmetry or misalignment
    - Pain
    - Tissue/Tone

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**Only 2 of 4 elements are required, but one must be “A” or “R”**

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**Chiropractic Is PART of the BIGGER Picture**

- Understand the ins and outs of Medicare
- Then understand the nuances of chiropractic in Medicare
- Strive to be the most compliant and efficient possible

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**Most Common Definitions Used in E/M Coding**
E&M Coding/Documentation is Based on 7 Components

- 3 Key Components
  - Patient History
  - Examination
  - Clinical Decision Making

- 3 Contributory Components
  - Counseling
  - Coordination of Care
  - Nature of Presenting Problem

1 Additional Component: Time

3 Key Components

- History, Exam, CDM
- Code selection is based on the level of service provided in each of these key three components during the office visit.
- Depending upon whether it’s a New Patient or Established Patient visit, varying numbers of these three key components must be met.

Contributory Components

- Counseling and Coordination of Care
- Nature of Presenting Problem
- Time

Counseling and Coordination of Care

- When visits consist mainly of these components, time is the controlling factor
- This is due to face-to-face time being 50% of the visit
- Resist the urge to code E/M services for the typical chiropractic ROF

Time as a Component

- When counseling and coordination of care is primary, time may be important
- More likely in a medical office
- Do not use time as a primary component

Definition of a NP

- Never been to your office before
- Have never seen anyone in your practice before. (other than multi-specialty)
- It’s been more than 3 years since they have been into the practice
Key Terms

- Problem focused (aka problem pertinent)
- Expanded problem focused
- Detailed
- Comprehensive
- Brief
- Extended
- Complete

CPT Definitions

Body Areas:

- Head, including Face
- Neck
- Chest, including Breasts and Axilla
- Abdomen
- Genitalia, Groin, Buttocks
- Back
- Trunk
- Each Extremity

CPT Definitions: Organ Systems

- Eyes
- Ears, Nose, Throat, and Mouth
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

Documentation of Consultation

- Opinion or advice regarding E/M of a specific problem is requested by another physician, insurer, employer or other appropriate source
- May initiate diagnostic and/or therapeutic services at the same or subsequent visit

25,000 Foot View

- These are general terms needed for understanding E/M
- More specific glossary terms are provided in each lesson
- Become familiar with the “lingo” for proper E/M coding knowledge

Evaluation and Management Coding

- New Patient E/M codes
- Established Patient E/M codes
- Bullet points
E/M Coding—New Patients

• Perhaps the most undervalued code in your arsenal
• Three main components: History, Exam, and Clinical Decision Making

#1 - Documentation of History

• Each type of history we will select from will contain some of all of these subcomponents
  • Chief complaint (CC)
  • History of present illness (HPI)
  • Review of systems (ROS)
  • Past, family and/or social history (PFSH)

#2 - Examination

• Examination is the quantifiable portion of the E/M service.
  • Tests and Measurements will be documented.
  • Four levels of E/M must be considered.
  • Problem Focused, Expanded PF, Detailed, Comprehensive.

#3 - Clinical Decision Making

• This is the “thinking” part of the E/M code.
  • Think of this as the “doctoring” part of the service.

Complexity of Clinical Decision Making

• The levels of E/M services recognize four types of medical decision making
  • Straightforward
  • Low complexity
  • Moderate complexity
  • High complexity
Clinical Decision Making Matrix

<table>
<thead>
<tr>
<th>Number of Diagnoses or Management Options</th>
<th>Amount and/or Complexity of Data to be Reviewed</th>
<th>Risk of Complications and/or Morbidity or Mortality</th>
<th>Type of Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>Straight-Forward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

New Patient Evaluation & Management

CMT Codes

- 98940-98943 are the basic building blocks and best description of the DC’s work.
- Most comprehensive physician code to describe chiropractic services.
- Basic service around which everything else is built.

Established Patient Evaluation & Management

CMT Codes

- 7 vertebra: C1-C7
- Occiput
- Atlas = C1
- Axis = C2
- Atlanto-Axial = C1-C2
- Cervical Lordosis: refers to the curve of the spinal: could be hypo or hyper
Thoracic Spine

- **12 Vertebra**: T1-T12
- Also called the dorsa spine
- **Kyphotic Curve**
  - From the Greek: hum
  - AKA hunchback

Lumbar Spine

- **5 Lumbar Vertebra**: L1-L5
- **Pelvic**
- **Sacrum**
- **Coccyx**
- **Lumbar lordodic curve**
- Many areas to understand below the belt

5 Spinal Regions

- 98940 – 1-2 Regions
- 98941 – 3-4 Regions
- 98942 – 5 Regions
- **Common Ratios**
  - 98940 – 40%
  - 98941 – 45%
  - 98942 – 10%

Extremity Adjusting – 98943

- **REGIONS**
  - Head
  - Upper extremities (shoulder to fingers)
  - Lower extremities (hip to toes)
  - Anterior ribs
  - Abdomen
- May be billed once per visit
- Can be billed along with spinal CMT code

HCPCS Codes

**HCPCS Codes**: HCPCS (Healthcare Common Procedure Coding System) is a coding system used to describe certain items and services provided by healthcare establishments.

- Until 1996 using HCPCS codes was optional for reporting to Medicare, Medicaid and other insurance carriers.
- The introduction of HIPAA resulted in the mandatory use of HCPCS codes when billing to Medicare, Medicaid and other insurance carriers for the purpose of creating uniform and consistent processing of insurance claims.
**Levels of HCPCS Codes**


**Level II** – Codes for products, supplies and professional services that are not assigned a current CPT code.
- DMEPOS (durable medical equipment, prosthetics, orthotics, and supplies) and are alphanumeric, consisting of a single alphabetical letter and four numbers.

**Level III** – Local codes created by state agencies, contractors and private insurers for use in specified jurisdictions and programs. *Discontinued for use in 2003 to ensure consistent coding standards.*

---

**HCPCS Level I**

CPT codes
- Traditional coding
- AMA controls and edits
- We cover these extensively in other lessons

---

**HCPCS Level II**

- Alpha numeric
- Start with a letter (A-V)
- DMEPOS codes
  - Durable Medical Equipment (DME)
  - Orthotics
  - Prosthetics
  - Supplies
- Unassigned (CPT) procedure codes
  - Services/procedures
  - Medications
  - Misc.
- Each starting letter categorizes based on type

---

**HCPS Service Codes**

**G Codes**

*Temporary Procedures & Professional Services*

G0283 - Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

GD730 - Pain assessment documented as positive utilizing a standardized tool AND a follow-up plan is documented

---

**S Codes**

Temporary National Codes (Non-Medicare)
- S8948 - Application of a modality to one or more areas; low-level laser; each 15 minutes
- S9090 - Vertebral Axial Decompression, per session
- S8930 - Electrical stimulation of auricular acupuncture points; each 15 minutes of personal one-on-one contact with the patient
CPT (HCPCS) - S8990

- S8990: Physical or manipulative therapy performed for maintenance rather than restoration
- The S8990 code can be used once per encounter
- Covers ALL CMT, modalities, and procedures
- For Non-Medicare Medicare - 9894X-GA

HCPCS Supply and Medication

A Codes

Transportation, Medical & Surgical Supplies, Miscellaneous & Experimental
- A4452 – Tape, waterproof, per 18 square inches
- A4595 - Electrodes per pair
- A9273 - Hot or cold wrap/pack
- A9300 - Exercise equipment

J Codes

Drugs Administered Other Than Oral Method, Chemotherapy Drugs Medications for injections
- J1100 - Injection, dexamethasone sodium phosphate, 1mg
- J3301 - Injection, triamcinolone acetonide, not otherwise specified, 10 mg (Kenalog)
- J3420 - Injection, vitamin b-12 cyanocobalamin, up to 1000 mcg

DME and Orthotics

Pricing, Data Analysis and Coding (PDAC)

Noridian Healthcare Solutions, LLC
PDAC Contractor since August 2008
- Officially assigns HCPCS codes for DMEPOS
- Conducts DMEPOS data analysis
- PDAC is not required but can be helpful if billed item is over $500 and 3rd Party has issues with payment
- What if DME/orthotic item does not have PDAC letter or assignment?
**E Codes**

**Durable Medical Equipment**
- E0720/E0730 TENS unit
- E0849 Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible
- E0855 Cervical traction equipment not requiring additional stand or frame
- E0856 Cervical traction device, cervical collar with inflatable air bladder
- E0860 Traction equipment, overdoor, cervical

**L Codes**

**Orthotic/Prosthetic Procedures**
- Knee braces
- Foot orthotics
- Back braces
- Wrist braces
- Cervical collars

**L Codes**

- L0648 - Lumbar-Sacral Orthosis, Sagittal Control, With Rigid Anterior And Posterior Panels, Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Produces Intracavitary Pressure To Reduce Load On The Intervertebral Discs, Includes Straps, Closures, May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf
- L1832 – Knee orthosis, adjustable knee joints ( unicentric or polycentric), positional orthosis, rigid support, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
- L3020 - Foot, insert, removable, molded to patient model, longitudinal/metatarsal support, each
- L3030 - Foot, insert, removable, formed to patient foot, each

**K Codes**

**Temporary Codes for Durable Medical Equipment Regional Carriers**
- K0901 : Knee orthosis (ko), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf
- L1843 : Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

**Can I Supply in Office?**

- Scope of practice dictates
- 3rd Party carrier
  - May or may not cover your Rx
  - May or may not let you dispense
- DME Vendor may be the only one covered
- Cash is an option (if in scope)

**DME Accreditation**

- Separate DME license
- Only a few agencies can accredit
- High Expense
- Collective bargaining
- Lots of extra work involved
- Requires multiple Onsight inspections (at least one by CMS)
Coding Physical Medicine

Supervised Modalities

• 97010-97028 DO NOT require one-on-one contact by the provider
• Billed only once per encounter
• Are not time based for billing purposes
• Expected 2-12 visits
• However documentation should include the time spent on the modality

97010 Hot/Cold Packs

• Application of hot packs, ex. hydrocollater packs or moist towels
• Application of Ice packs or cryotherapy
• Often a non-covered service
• Does NOT include applying Biofreeze or any other type of topical analgesic

97012 Mechanical Traction

• Force used to create tension of soft tissue or to separate joints
• Untimed & billed only once a visit
• Intersegmental or Roller tables meet criteria, BUT check with 3rd party payer guidelines
• Flexion Distraction technique is a CMT & should be coded as an adjustment

S9090 Decompression

S9090 - Vertebral Axial Decompression, per session

Differs from traction:
• Angle(s)
• Computer assistance
• Muscle guarding consideration
• Intent

97014 Electrical Stimulation (EMS)

• Application of Electric stimulation to a specific area for nerve or muscle disorders
• Billed only once per visit
• Some payers allow 2-4 visits
• Sometimes you must use G0283 instead of 97014 for unattended EMS
Presently United Health Care & Medicare are the only carriers that require G0283
Constant Attendance Modalities

- 97032-97039 require direct one-on-one patient contact by provider
- Expected 6-12 visits
- These are timed based codes for billing
- Documentation should include total time spent

97032 Attended Electrical Stimulation

- Application of a modality to one or more areas; electrical stimulation [manual] each 15 minutes
- Most often combo unit
- You can’t just move the pads and call it attended!

97035 Ultrasound

- Ultrasound, each 15 mins. One or more areas
- Great for adhesive scars, spasm, soft tissue

Therapeutic Procedures (97110-97546)

- Therapeutic Procedures are time-based codes for billing purposes
- The patient is ACTIVE in the encounter
- Requires direct one-on-one patient contact
- Documentation should include both the total time spent and the time spent doing each activity/exercise.
- Codes are billed per 15 min increments

97110 Therapeutic Exercise

- Therapeutic Exercise, each 15 mins. One or more areas
- Incorporates one:
  - Strength
  - Endurance
  - Range of motion
  - Flexibility
- Must show functional deficit in the above during examination

97112 Neuromuscular Re-education (NMRE)

- Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception
- Proprioceptive Neuromuscular Facilitation (PNF), Feldenkrais, Bobath, BAP’S Boards, and desensitization techniques
- Most likely indicated for neurological conditions
97150 Group Exercise Code

Therapeutic Procedure(s), group, (2 or more individuals)
• Once per encounter, not timed!
• Some carriers do not cover at all

97530 Therapeutic Activities

• Dynamic activities to improve functional performance, direct (one-on-one) with the patient (15 minutes)
• Incorporates two or more:
  • Strength
  • Endurance
  • Range of motion
  • Flexibility
• Must show functional deficit in the above during examination

97124 Massage

• Passive procedure used for restorative effect
• Used for effleurage, petrissage, and/or tapotement, stroking, compression, and/or percussion
• Considered separate and distinct from CMT

97140 Manual Therapy

• Includes soft tissue and joint mobilization, manual traction, trigger point therapies, passive range of motion, and myofascial release.
• With CMT - must be in a separate body region
• May require a -59 modifier

Is This 97140 or 97124?
When To Use 97140

• To effect changes in soft tissues, articular structures, and neural or vascular systems
• To address a loss of joint motion, strength, or mobility
• Must be part of an active treatment plan directed at a specific outcome
• Daily routine visit documentation should include progress toward those stated goals

When to Use 97124

• Used to improve muscle function, stiffness, edema, muscle spasms or reduced joint motion
• When treatment is friction based, relaxation type massage that is less specific than 97140

Timed Coding Rules

The Intersection of 15 Minutes and 8 Minutes

Timed Coding Rules

Supervised Modalities

• 97010-97028 do not require one-on-one contact by the provider
• Billed only once per encounter
• Are not time based for billing purposes
• Documentation should include the time spent on the modality

Constant Attendance Modalities

• 97032-97039 require direct one-on-one patient contact by provider.
• These are timed based codes for billing
• Documentation should include total time spent

Fact Sheet

Guidelines for Timed Codes

Physician's administrative and billing office, or an understanding proper billing and documentation of these codes is essential. When more than one therapy service is provided in a single visit, with each across having its own code, understanding these codes, modality, and billing these services can result in increased reimbursement and reduced risk for the practice.

Ritaling, and coding guidelines

There are three general levels of Physical Medicine and Rehabilitation modalities and procedures, and each has its own rules and guidelines:

• **Supervised Modalities (97010-97028)** are generally called “fewer time codes.” This means that although it’s important to document the treatment time for such, the billing for such codes is not time depended. Each session is billed one time per patient per encounter. For example, a 15-minute session will be charged once per encounter. If a patient required 2 or more treatments in a session, an additional time codes will be billed for each additional treatment. Each session is billed one time per patient per encounter. The total time spent on the modality is documented and billed. Billing for each treatment is billed only once for the patient encounter, regardless of time spent.

• **Timed Attendance Modalities (97032-97039)** are modalities that require one-on-one attention and are billed at the specific treatment. The total time spent on the modality is documented and billed. Billing for each treatment is billed only once for the patient encounter, regardless of time spent.
Therapeutic Procedures (97110-97546)

- Therapeutic Procedures are time-based codes for billing purposes
- The patient is active in the encounter
- Require direct one-on-one patient contact by provider of the service
- Documentation should include the time spent and procedure performed

Medicare’s “8-Minute Rule” Meets “15 Minute Rule”

- For time-based codes, you must provide direct treatment for at least eight minutes in order to receive reimbursement from Medicare
- CMS and CPT have clarified that any timed based service, provided on its own, is not billable if performed for less than 8 minutes

AMA/CPT Says “Each 15 Minutes”

Timed Treatment Codes

- For a single timed code being billed in a visit:
  - Less than 8 min = 0
  - 8 up to 23 min = 1
  - 23 up to 38 min = 2
  - 38 up to 53 min = 3
  - 53 up to 68 min = 4
  - And so on

- For multiple timed codes provided in the same session, add up the total minutes of skilled, one-on-one, time based therapy and divide that total by 15
  - If eight or more minutes are left over, you can bill for one more unit
  - If seven or fewer minutes remain, you cannot bill an additional unit

6 Minutes of Therapeutic Exercise

- Do not bill any CPT code
- Threshold not met
- Document the chart to include the exercise performed and note it was 6 minutes of time spent

21 Minutes of Therapeutic Exercise

- Abdominal hollowing exercises = 12 minutes
- Cervical range of motion exercises = 9 minutes
- Total time = 21 minutes = 1 billable unit
- Note the chart with all services performed and time spent on each along with total time
28 Minutes of Therapeutic Exercise
• Lumbar Isometric Exercises = 13 minutes
• Lumbar stretching = 9 minutes
• Lumbar strengthening exercises = 6 minutes
• Total time = 28 minutes = 2 billable units
• Note the chart with all services performed and time spent on each along with total time

26 Minutes of NMR & 25 Minutes of Therapeutic Exercises
• 26 minutes of various proprioceptive strengthening exercises
• 13 minutes of lumbar stabilization exercises
• 12 minutes of lumbar stretching exercises
• Total time = 51 minutes = 3 billable units
• Documentation includes all services and time spent

10 Minutes of TherEx; 5 Minutes of Ultrasound and 5 Minutes of Manual Therapy
• $10 + 5 + 5 = 20$ total minutes = 1 billable unit
• US and MT are each less than TE
• Bill where most time was spent
• Total time didn’t reach 23 minutes

Coding Audit Overview

Why Do a Coding Audit?
• Third Party Payers use algorithms to analyze patterns of bad billing practices and have established outlier data
• Self-auditing your billing and coding allows you to have a snapshot view of your profile
• Information gathered can assist you in recognizing problem areas so they might be corrected

Coding Audits
• Your computer system should be able to provide you a listing of codes and their usage.
• Run a report, by month, of the number of times each code was used.
• Columns should be months of the year
• Rows should be each code you use
• Group by code set
What Should Be Reviewed in a Coding Audit?

• E/M Code Usage
• Statistical E/M Code Matching
• Ratio of codes within a code set: E/M; CMT; Modality and Procedure
• Modalities vs. Procedures

Evaluation and Management-NP

Compare E/M Deficit to Reimbursement Values

720 Missing Established Pt. E/M Codes (+++++++)

720 X $45.16 = $32,515.20 (99212!)
Perform Coding Audits Frequently

• Start today
• Takes very little time
• Repeat Quarterly or semi-annually to keep you on track
• Our KMCU Practice Performance Profile includes this audit

Take Action!

• Revise policies and procedures. Distribute copies of the updates that came as a result of the audit.
• Provide additional training in specific areas. For their education and to improve their coding and documentation, providers receive individual feedback as needed. For example, a physician with a pattern of under-coding may be asked to review the appropriate CPT or ICD-10 codes, as well as the documentation guidelines, to strengthen his or her coding skills.

Post Audit Necessities

• Make refunds, if appropriate: Your self-audits may reveal that incorrect codes have been submitted or that certain bills should not have been submitted at all.
• Take disciplinary action, if necessary: If a team member refuses to adapt his or her coding and documentation patterns to ensure compliance with applicable regulations, disciplinary action may be warranted.
• Change the focus of the audits: Issues and problem areas identified in a self-audit may help determine the scope of the next round of auditing.

Coding and Billing Compliance is Critical

• Your billing must match your documentation
• Understanding how to report timed codes = peace of mind

Don’t Let Patient Financial Policies be your WEAKEST LINK
Policies and Procedures to Address THESE Risks

Today’s Focus

Confused by Discounting Rules?

Definitions

1. Dual Fee Schedules
   • Charging more to insurance companies than you do to cash patients
   □ Illegal in many states
   □ Misrepresents charges to carriers
   □ False Claims Act violation
   □ May violate provider agreements
   □ Triggers investigations

2. Improper Time of Service Discounts
   • Discount based on bookkeeping savings
   □ May or may not be defined
   □ Often not defensible or unreasonable
   □ May not be permissible on Federally insured patients

3. Inducement Violations
4. False Claims Act Violations
5. Anti-kickback Statue Violations
3. Inducement Violations

- Per the OIG: “incentives that are only nominal in value are NOT prohibited by [inducement law]
- No more than $10 per item or $50 in the aggregate annually
- Even one free examination, x-ray, or therapy is a risk

Did Someone Say Groupon?

On March 28, 2013, the Minnesota Board of Chiropractic Examiners (MBCE) updated its website to clarify that Groupon-type advertising, where the amount paid by the patient is split between the advertising company and the provider, constitutes fee splitting and is prohibited. The following is taken directly from the Board’s website:

“It has come to the attention of the Board that certain forms of advertising/marketing may place the licensee at significant risk of being in violation of the laws related to fee-splitting. Licensees should remember that certain forms of conduct that are available to the general public may be inappropriate or impermissible for use by health care professionals. One such form of advertising/marketing is exemplified by online batch-offer companies such as Groupon and Living Social. The structure currently utilized by those and similar companies is simply not appropriate for doctors of chiropractic, as it constitutes ‘fee splitting,’ which is prohibited by this practice act.

4. False Claims Act Violations

- Establishes liability when any person or entity improperly receives from or avoids payment to the Fed
- Prohibits “knowingly presenting or causing to be presented, a false claim for payment or approval

- Examples:
  - Waiving deductibles or co-payments and not reporting to carriers
  - Up-coding for higher reimbursements
  - Down-coding based on payer type
5. Anti-Kickback Violations

A person who offers or transfers to a Medicare or Medicaid beneficiary any remuneration that the person knows or should know is likely to influence the beneficiary’s selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services may be liable for civil money penalties (CMPs) of up to $10,000 for each wrongful act. The statute defines “remuneration” to include, without limitation, waivers of copayments and deductible amounts (or parts thereof) and transfers of items or services for free or for other than fair market value.

Consider Your “Highest” Fee

<table>
<thead>
<tr>
<th>New Patient Examinations</th>
<th>Fees/CH</th>
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<tbody>
<tr>
<td>99203-25</td>
<td>Revised</td>
</tr>
<tr>
<td>99201-25</td>
<td>Detailed</td>
</tr>
<tr>
<td>99204-25</td>
<td>Comprehensive Exam 250/0.176</td>
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</table>

Established Patient Exams

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<td>99212-25</td>
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Spinal Regions

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<td>99840</td>
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Procedures

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<td>97110-19</td>
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<td>97115-19</td>
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Regulated Fees
- By agreement, these fees are “imposed”
- Take the patient, take the fee
- Not considered a “discount”
- CMT only for Medicare
- WC, No-Fault and PIP defined by state guidelines

You Are Likely Already Discounting
When a patient that has insurance enters your office for care – they are bringing another “person” to the relationship
Are You Making This Mistake?

You Must Know the Discounts Agreed To
Clear Understanding of Hardship Fees

- Do you need a hardship fee schedule?
- 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

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
- Don’t confuse it with what a general discount is!! That’s what CHUSA is for!
### 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.

### What About Professional Courtesy?

- Who do you offer courtesy to?
- Staff?
- Other DCs? Clergy? Military?
- What about when insurance is involved?
- Is it in writing?
ChiroHealthUSA - Patient

$49

Initial Visit: $120
X-Rays: $130
CMT: $65
97014: $35
Total: $350

Routine Visit:
CMT $65
97110: $50
97014: $35
97012: $35
Total: $185

Initial Visit - Capped Fee: $150
20% Discount

Routine Visit - Capped Fee: $65
20% Discount

Modalities: $10
Procedures: $20
100% Poverty: 75% Discount
125% Poverty: 50% Discount
150% Poverty: 25% Discount

Re-Exams: $25
Each Film: $15
The Billing Process

10 Important Time Management Steps

1. Time doesn't change.
2. Are you wasting time?
3. Set time related goals.
4. Implement a time management plan.
5. Use time management tools.
6. Prioritize, Prioritize and then Prioritize some more.
7. Delegate when appropriate.
8. Install proper routines.
9. Set task related time limits.
10. Be systematic.
Administrative Time

- **Administrative Time**: Time spent on prevention and implementation that is not directly related to a service. Time spent during trainings, meetings, general planning, and time OFF the floor.
- One of the biggest offenses to organization
- Doctor admin time: marketing, Day 1.5, team meetings, planning

General Team Member Admin Time

- Insurance Follow Up
- Posting Payments
- Reactive and Proactive Calls
- Verification
- Collections Calls
- Recalls
- Doctor’s PRN or Monthly Duties

Charge Collection/Entry

- Garbage In/Garbage Out
- Use a routing slip
- Use in your balancing process
- Know the trouble spots for data entry

Why Careful Charge Entry Matters

- **Doctors**
  - Services which are performed will be billed
  - Supplies will not walk out the door
  - All the T’s are crossed and I’s are dotted

- **Team Members**
  - Systematic daily entry will ensure that you don’t get behind
  - Checks and balances will make sure you don’t miss anything

Leaky Bucket—The Doctor to Front Desk Communication Line

- Lack of the use of a routing slip
- Supplies given out without FD knowing
- New service performed other than TX plan, not communicated
- Upgrade of frequency of visits and not scheduled
Financial Data Charting

- Refers to organizing the patient chart and preparing it for billing
- Create systemized steps or checklists
- Applies to reactivations, new conditions, and NP as well

Organize and Systematize

- Copy of picture ID
- Copy of insurance card
- Diagnosis
- Treatment plan
- Verification
- History
- Consultation
- Exam forms

Important To Get It Right

- Perfect the information in the computer account
- Add all necessary data
- Final set of eyes before it goes out
- Add this process to your SOP manual

Billing Timelines

- Can vary by carrier
- With Electronic Billing can be very quick
- Paper billing takes longer
- EFTs mean your money gets to you faster
Four Categories of Organization

1) Mail to go to the doctor
2) Checks and ‘zero pays’ to post and process
3) Items which need a phone call to resolve
4) Items which need an action to resolve

RECEIVED

• Everything gets stamped with the date it was received
• It immediately gets sorted into one of the four folders
• Oldest to the front and newest to the back

Successful Follow Up is an A-R-T

• Follow this recipe for success:
  • A = Attack Immediately
  • R = React Proactively
  • T = Tickle Relentlessly

A = Collections and Follow Up Start Here With Folders 2, 3, & 4

• The insurance company returns an Explanation of Benefits (EOB)
• Sometimes it is paid correctly and sometimes not
• If incorrect... ATTACK IMMEDIATELY!
Explanation of Benefits

• Includes a detailed explanation of how the insurer/administrator determined the amount of reimbursement it made to the provider for a particular healthcare service.

• Also includes information on how to appeal or challenge the insurer’s reimbursement decision.

Overview of EOBs

• Let’s walk through the steps of determining if a claim needs to be appealed.

• Keep in mind the EOB tells us several important things like:
  • Lists payment amounts paid to provider, patient responsibility
  • Lists amount left of the deductible

Contracted Rate

Allowable Rate/Fee For Service

• Amounts that health insurance companies will pay to healthcare providers in their networks for services.

• Negotiated and established in the insurers’ contracts with in-network providers.

Your Fee For Service
98941 = 58.00

Your Contracted Rate w/Ins. Company = 35.75

Your Write-off = 22.25

Sample EOB/ERA

• ERAs are just electronic EOBs.

• Determine how each carrier sets their EOB.

• Knowing how to read the codes is vital to EOB processing, posting payments.

What to Look For

• Verify that all necessary information listed is correct:
  • Patient’s information
  • Primary insured information
  • Correct date of service
  • Correct codes
How to Read an EOB

Date of Service | Code | Amount Billed | Allowed Amount | Contractual Discount | Patient Responsibility | Amount Paid | Total Amount Paid
---|---|---|---|---|---|---|---
12/03/11 | 98940 | $50.00 | $32.00 | $18.00 | $6.40 | $25.60 | 123
12/03/11 | 97014 | $25.00 | $0.00 | $25.00 | $0.00 | $0.00 | C-896
12/03/11 | 97110 | $40.00 | $35.00 | $5.00 | $7.00 | $28.00 | 123
Total: | | $48.00 | Total: | $13.40 | Total: | $53.60

Is this really a write off per our contract?

What's Wrong with this Picture?

Multiple Concerns

Billing and Collections

Spot Check Audit

Follow-up

R = React Proactively
Reactive and Proactive Calls

- Phone calls are the name of the game
- You must set aside time for outbound calling
- Things will not always just come to you
- Both types of calls are necessary
  - Reactive Follow Up
  - Proactive Follow Up

Why Denials Occur

- Administrative
  - Incorrect ID number
  - Incorrect vital information of primary holder, patient, etc.
- Unsupported code
  - Therapy codes
  - Exam codes
- Medical necessity isn’t supported

Technical Errors

- Verify that all necessary information listed is correct:
  - Patient’s information
  - Primary insured information
  - Correct date of service
  - Correct codes
Coding Errors

• Are all the modifiers attached correctly?
• Is this service allowed for this patient per their benefit verification?
• What have you agreed to with your Provider Contract?

Medical Necessity Denial

• Has the insurance denied this service for medical necessity review?
• If so, you must prepare your documentation to send to them

Reactive Calls Include A/R Aging

• Not all money comes back in without any effort.
• Unpaid claims list must be worked
• Reasons bills go unpaid:
  • Never received
  • Pending information from the insured
  • Denied and you didn’t get the denial notice

Proactively Work it!

• Work the aging /unpaid claims list according to payer class
• Sort by carrier if you can
• Sort by highest balance if you’re just starting to work these lists
• Systematically move through these unpaid claims

Proactively Mark it!

• Mark your aging report with cryptic notes
• Black “X” when you are complete
• Highlight those items you feel need attention
• DCs and managers should review this periodically/monthly

Proactively Reconcile it!

• As you work through, reconcile all patient and insurance balances
• Apply any unapplied credit appropriately
• Strive to get through every aging within a month once you get caught up
Helpful Scripting

• Get straight to the point: “I’m calling to follow up on an unpaid/incorrectly paid bill”
• “I’m unclear about the validity of this denial”
• “By when can I expect a check?”
• “What other options do I have to speed up the decision making process?”
• “Can I fax this directly to you so that you can give me an estimated date of payment?”
• “I’m sorry that we’re having difficulty communicating. May I please speak to your supervisor?”

Internal Financial Notes

• Find a place in your software where you can keep internal notes
• What if you win the power ball?
• Less is NOT more in this situation
• “And then I said, and then he said, and then I said…”

[Images of a computer screen showing a software interface with different sections labeled as "Billing and Collections" and "Internal Financial Notes"]
**T = Tickle Relentlessly**

- Appeals and Recalculation
- Follow-up and Collections
- Data Charting and Billing
- Charge Entry
- Receiving and Posting Payments
- Verification
- AP Invoice Call

**Develop a Tickler System**

- Follow up on your follow up
- This is the crux of a system
- It’s not person dependent
- It’s your brain in a box
- Electronic/Outlook
- Card file/hanging file

**What Exactly is a Tickler File?**

- A conventional physical tickler file consists of 43 folders or dividers: 12 for each of the months of the year and 31 for each of the days of the month.
- Uniquely designed to organize and keep pieces of paper or reminders

**Electronic Tickler File**

Why Appeal?

- Not appealing looks like you are billing fraudulently
- Appealing improves the practice’s bottom line
- Improves communication between providers and insurance companies
- Defends your services
The Appeals Process

- Create and use template letters to send to the insurance company
- Have all of your documentation, research and other supporting records gathered and organized for easy review

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).

Medicare 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>SECOND Reconsideration by Qualified Independent Contractor (QIC)</td>
<td>6 months from 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 receipt of QIC decision</td>
<td>$140.00</td>
</tr>
<tr>
<td>FOURTH Appeals Council Review</td>
<td>Must be filed within 60 days of receipt of the hearing decision (Dismissal)</td>
<td>None</td>
</tr>
<tr>
<td>FIFTH Judicial Review in U.S. District Court</td>
<td>Must be filed within 60 days receipt of the Appeals Council decision</td>
<td>$1,400.00</td>
</tr>
</tbody>
</table>

Practice Makes Perfect

- The more confident you are in yourself and the policies and procedures of your office, the more effective you will be at collecting.
- Be confident, smile, be firm and look them in the eye.

The Collections Process

- Giving away or discounting services to beneficiaries of federally funded programs is an inducement and can expose you to fines and penalties.
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.

Ways to Collect

- Pay per visit
- Payment plans
- Billing after the fact

The Cash Practice 4-Step Process

Automate Payments

Automate One-Time Payments

Automate Recurring Payments

$29/mo Price for KMC Clients!

www.bodzin.net/kmc29
Over-the-Counter Collections Matter

- Strong collections procedures create a strong practice.
- Cash patients, delinquent accounts, insurance patients and even insurance companies all play a part in collections.

How Much?

- Are you collecting 100 percent of your fees?
- How much is walking out of the door?
- How much time (which is money) is spent on collections after the fact?

Over-the-Counter Collections

- Collecting for services and products is very important.
- Any monies not collected at the initial encounter, only means more time spent collecting them after the fact.
- Reduces the chances of you getting payment at all.
- Do you have a strong plan of action for collections?

What is the First Step?

- Recognize what your over-the-counter products and services are.
- Pricing should be marked or posted.
- Create a fee sheet for an at-a-glance mastery of the pricing.
- Train all staff

Overcoming Patient Excuses

- If your patients do not pay for the products and services provided, it is NOT THEIR FAULT.
- IT IS YOUR FAULT!!!
- Be one step ahead of them.
- Be prepared.

Cash Profit Collections

- Cash Profit items can be products and/or services.
- Each member of your team should know these. Do they?
- Review them in your team meetings to ensure they are known.
What About Insurance?

• Most all products are not covered by insurance.
• DME (durable medical equipment) is usually the only product possibly covered.
• Verification is needed for certainty about coverage.

Updating Financial Arrangements

Existing Financial Plan
• Duration and amount of plan?
• Is this plan completed or cut short.
• Is there a credit remaining?
• Cover the change in the existing plan with patient.

Additional Service Financial Plan
• Are any services the same as previous plan?
• When does the new plan become active?
• Overall cost with or without credits from previous plan.
• Cover this all with patient.

Sales Tax

• Each state varies in its application of sales tax.
• It may vary in percent even by County, Parish or other division.
• Know how to appropriately calculate it.
• Know when and how to report collected sales tax.

Front Desk is your First Defense

• No systems in place = loss of monies due
• Not enough time = time management issue
• Scared patient won’t understand = clarity needed

Situations Happen

• Patient forgot wallet
• Patient gets paid Friday
• The insurance benefits were incorrect
• Front desk staff makes an error

Don’t Get Stuck

• No systems in place = loss of monies due
• Not enough time = time management issue
• Scared patient won’t understand = clarity needed
Don’t Delay!
• The longer a balance remains unpaid, the less likely you will be able to recover the balance due

Schedule a Time
• Schedule time in your calendar once a month to send patient statements of past due balances or pick a common day

Know Where You Stand
• Run an account receivable aging report to determine who currently has a balance
• Collector’s calendar
• Start where you’re at

Month One
• Start in the same place for everyone.
• Send bills to all account due
• Expect phone calls and be prepared to handle them

Month Two
• Affix stamp or sticker to all balances that were billed last month, but remain unpaid
• Keep track of who was billed with notice in a notebook or digital file
• Bill new balances with no sticker

Month Four
• Bill new balances with no sticker
• Follow suit with all unpaid balances sent previously
• Affix collections stamp or sticker to all balances that were billed both first, second & third month, but remain unpaid
**Make Time for Contact**

- Call patients to collect via telephone
- Develop scripts for common circumstances

**Don’t Feel Bad 😊**

- You had an agreement with the patient, and they are not sticking to their end of the deal.
- If they are avoiding you, they are not allowing you to work with them to pay down balance.

**Streamlined Procedures = Success!**

- Stay on top of your billing monthly
- No more writing off uncollected balances
- Collections confidence

**Need Help?**
Info@kmcuniversity.com